Treating Trauma Disorders: Are PTSD treatments effective in Dissociative Identity Disorder?

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Abstract

Dissociative Identity Disorder (DID) is a highly misunderstood and complex disorder that is often misdiagnosed. Many clinicians even go as far as to claim it is false diagnosis and that the person reporting the symptoms is merely acting out to gain attention. Similar to post-traumatic stress disorder (PTSD), DID is a trauma-induced disorder, developing after severe childhood trauma. With many similarities between the two diagnoses, it begs the question of whether or not recommended PTSD treatments such as CBT or EMDR are effective at treating DID. After an extensive search, it seems that there are not many studies concerned with the treatment of DID. Most current literature is concerned with the etiology. Future studies need to focus more on resolving the issue, rather than what is causing it.

Keywords: Dissociative Identity Disorder, Post-traumatic stress disorder, DID, PTSD, trauma, CBT, EMDR

Treating Trauma Disorders: Are PTSD treatments effective in Dissociative Identity Disorder?

Dissociative Identity Disorder (DID) is a highly misunderstood and complex disorder. It has been called many things over the years, including Multiple Personality Disorder and Split Personality (Nolen-Hoeksema, 2017). It has been included as a symptom in the diagnosis of other disorders, such as schizophrenia (Nolen-Hoeksema, 2017). To make matters worse, Hollywood often uses the DID as a significant plot foundation or twist. From innovative characters such as Norman Bates in *Psycho* (Hitchcock, 1960) to recent ones such as Kevin Wendell Crumb in *Split* (Shyamalan, 2016) or Tyler Durden in *Fight Club* (Linson, Chaffin, & Bell, 1999), movies distort and dramatize an already frightening disorder.

However, as popularized as it has become in entertainment media (or perhaps due to it), DID is widely misunderstood and often misdiagnosed (Moskowitz, Schafer, & Dorahy, 2019). The official DSM-5 (American Psychiatric Association, 2013) diagnostic criteria include the existence of two or more distinct personalities with apparent alterations in behavior, consciousness, memory, perception, and functioning, as reported by the client or others around the client, that interferes with daily activities. It also includes gaps in consciousness, often referred to as blacking out or losing time, that is inconsistent with forgetting, substance use, religious or cultural practice, or other medical condition.

Even with these diagnostic criteria, many clinicians have gone as far as to dismiss it as a fake disorder stating that they believe the person who is suffering is merely acting to gain attention from those around them (Vissia et al., 2016). Fortunately, this line of thinking is slowly retreating, and the Trauma Model of DID is rising. This model suggests that severe childhood trauma is the triggering event for the disorder (Vissia et al., 2016). Sar, Dorahy, and Kruger (2017) define DID as a chronic post-traumatic disorder, and a study by Bell, Jacobson, Zeligman,

Fox, and Hundley (2015) found that 100% of their participants reported childhood abuse. Evidence uncovered by Vissia et al. (2016) also supports the Trauma Model. It is believed that the hallmark symptom of the development of multiple personalities (or alters) is in response to this trauma (Nolen-Hoeksema, 2017).

Now, compare the chaos of DID to another trauma disorder. Post-traumatic stress disorder is possibly the most well-known and probably the most studied trauma disorder. Initially diagnosed in combat soldiers, having been called shell-shock or combat exhaustion, as well as a myriad of other terms over the centuries, the recognition of this disorder dates back to ancient Greece and the Pharaohs (Anders, 2019). However, it was not until the DSM-3 that PTSD was made an official diagnosis.

Directly correlated with trauma, the DSM-5 (2013) diagnostic criteria for PTSD is as follows: to have personally experienced or witnessed a traumatic event or learning about a traumatic event happening to a family member or close friend, after which the person displays disorder-specific symptoms that cause significant distress or impairment in major interpersonal situations (APA, 2013). There are two levels of PTSD. Type I, or simple, results from a single-incident trauma in adulthood. Type II, or complex, PTSD, results from long-term, recurrent traumas (Guo et al., 2012).

In a counseling setting, the APA recommends exposure type therapies as treatment for PTSD (American Psychological Association, 2017). Two commonly used exposure type therapies are Cognitive Behavioral Therapy (CBT) and Eye-Movement Desensitization and Reprocessing (EMDR). While similar in the ultimate goal of symptom resolution, the process of each is entirely different. CBT combines cognitive and behavioral therapy techniques to overcome negative and irrational cognitive processes connected to the trauma and teach coping

strategies to deal with undesirable behaviors. EMDR, on the other hand, seeks to directly process a person's trauma memories by utilizing bilateral (side-to-side) sensory stimulation. This stimulation is used during memory recall to reduce vividness and emotionality and allow for more extensive processing and consolidation of the memory (Moskowitz et al., 2019).

There are many similarities between DID and PTSD, and they are often found to be co-morbid disorders (Vissia et al., 2016) to the point that it seems almost rare that the two do not coexist. That said, the trauma aspect of each is exceptionally intriguing. It begs the question of whether the APA recommended treatments for PTSD would be effective at treating DID. This review will look at the previously mentioned PTSD recommended treatments (CBT and EMDR) and their effectiveness in treating DID.

Methods

In searching for literature for this review, Google Scholar was explored using the following terms: Dissociative Identity Disorder and Trauma, Dissociative Identity Disorder and EMDR, Dissociative Identity Disorder and CBT, and Dissociative Identity Disorder treatments. For each of these search terms, the articles that were populated were scanned using titles and keywords, bypassing those that would not be beneficial to the current research. If a title looked promising, the article was opened in a new tab, and the abstract quickly read. If the abstract confirmed that the item would be beneficial, the full text was attempted to be found. If it was not readily available through Google Scholar, a search for it in Ebscohost, PubMed, or other databases happened using the title. At this point, if the full-text was still unavailable, the search was resumed in Google Scholar. If the full-text was located, it would be downloaded and saved to a specific folder with the other materials for this project.

After finding many intriguing items, the process of weeding through them to make sure the full content was appropriate began. If they were not, they were removed from the folder. If they were, they were printed off, and specific parts of the article highlighted for use in the review. Due to an overall lack of studies on treatment in DID specifically, some materials on general Dissociative Disorder (DD) had to be included.

Results

There is an apparent lack of available literature regarding the empirical evidence for the use of the APA recommended PTSD treatments in DID in comparison to other disorders. Despite this lack of data, the little information that was found shows that there are typically three stages of counseling for DID (Brand et al., 2012). The first stage is psychoeducational, describing the disorder to the client, completing assessments, doing daily skills training, and coming up with safety strategies that the client can use. The next builds on the first by adding in trauma-focused work, relational work, emotional regulation, and dissociation interventions. The trauma having been processed, the final stage removes the trauma focus in favor of teaching skills to help the client cope with life without dissociations (Brand et al., 2012). CBT techniques are used during both stages 1 and 2, and EMDR has been used during stage 2 (Brand et al., 2012).

Brand et al. (2012) surveyed 38 of the leading clinicians in the field of DD regarding the types of therapy interventions they were using in their treatment strategies. It was found that in the early stages of treatment, CBT techniques, such as challenging distorted cognitions, were used by over 60%, and psychoeducation (another component of CBT) was used by over 90% (Brand et al., 2012). During the trauma-focused part of treatment, nearly 50% use the exposure techniques classic to CBT, and over 70% continue to or begin to challenge distorted cognitions

(Brand et al., 2012). Unfortunately, outside of this study, there does not seem to be much else by way of empirical studies covering CBT and DID.

EMDR seems to have a bit more data backing it as a promising treatment. As stated in the introduction of this paper, EMDR is a treatment that specializes in processing and treating trauma. Developed by Francine Shapiro in the early 80s, it has only recently been recognized as an APA approved treatment for PTSD (APA, 2017). Even so, somewhat unsurprising given its trauma focus, it seems more studies are testing it in the treatment of dissociative disorders than other forms of PTSD therapy.

Gonzalez, Mosquera, & Leeds (as cited in Moskowitz et al., 2019) found that a patient with dissociative psychosis greatly improved after several sessions of a modified EMDR. Before these sessions, the client had tried various other treatments for nine years with no symptom relief, including multiple forms of psychopharmacology and talk therapy (Moskowitz et al., 2019). After the sessions, his doctor was able to reduce his medications steadily. Two years after the treatment ended, he was living symptom-free (Moskowitz et al., 2019). While this case study only discusses one person, it does give credence to the effectiveness of this treatment.

In a theoretical study completed by Van der Hart, Nijenhuis, & Solomon (2010), it is stated that EMDR is becoming more utilized in the treatment of complex-trauma disorders such as DID. They discuss how the experiences of the clinical community have taught that the standard EMDR protocol needs to be modified to effectively and safely treat chronically traumatized clients (Van der Hart et al., 2010). Theoretically, this treatment works by integrating traumatic memories within the client, thus eliminating the need for the alternate personalities created to combat those memories (Van der Hart et al., 2010). However, as previously stated, there are not many studies to support this theory, so more data is needed to claim this theory as

anything more than that. While it may look good on paper, clinically, it may not work as well as planned.

Discussion

At this time, it seems that most of the literature is discussing the possible etiology of the disorder. The argument of whether or not the symptoms are innate or created seems to be a sticking point, even amongst the authors publishing treatment studies (Moskowitz et al., 2019). Until the etiology can be agreed upon, the need for an effective treatment appears to have become secondary. This approach needs to change.

Studies specifically looking at the brain morphology of individuals with DID are finding that hippocampal volume is smaller than it is in healthy control brains (Chalavi et al., 2015). This pattern is similar to the hippocampal volume found in PTSD (Guo et al., 2012). Chalavi et al. (2015) even found that when compared to those with only PTSD, those with DID comorbid with PTSD had even less hippocampal volume. With this type of evidence, it seems almost laughable that the etiology of this disorder is even a debate. It seems apparent that the disorder is created by severe trauma, most likely in childhood.

As the Trauma Model becomes increasingly evidenced by these and other repeated studies (Moskowitz et al., 2019; Sar et al., 2017; Vissia et al., 2016), it is clear that the focus needs to shift from etiology of the disorder to the investigation of how to treat it effectively. Theoretically, it would seem that any treatment which successfully treats PTSD would also prove successful at treating and causing remission of symptoms in DID. It was wise of Brand et at. (2012) to reach out to the practicing community to gather information on how this disorder is treated in the real world. As the study showed, most clinicians are currently using CBT and, to a lesser extent, EMDR, for the trauma processing stage of treatment. However, while this type of

information is useful when planning a study, it is essentially hearsay without evidentiary data gleaned from a well-planned experiment. In the future, studies need to focus on the use of these treatments in the clinical world and complete thorough outcome studies, rather than merely relying on practitioners to participate in surveys or interviews to speculate on the effect of the treatment.

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