# Dissociative Identity Disorder and the Psychodramatist

## by Trish Reynolds

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Everybody dissociates at times and everyone is sometimes amnesic. Who of us has never driven a familiar route and arrived at our destination with no memory of how we actually got there nor of the process of getting there? Sometimes called 'highway hypnosis', this is an example of the process of dissociation and its accompanying amnesia. It is perfectly normal, and all of us do it sometimes. Some of us are fortunate enough to have only ever dissociated because of boredom, others have, in addition, dissociated as a way of coping with otherwise overwhelming trauma. I am one of the latter.

I first became interested in the subject of dissociation after, at the age of thirty-six, I recovered memories of sexual abuse which had begun at the age of two. That was in 1984 and at that time there was very little information about dissociation in the literature. Major works such as Judith Lewis Herman's *Father-daughter Incest* did not so much as mention dissociation. I remember, in my frantic search for validation of my process, writing to Herman. Her blessedly prompt reply included an apology and a copy of a paper she had just written describing the process of dissociation and repression of memories in survivors of childhood sexual abuse. I felt less crazy.

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There is a similar paucity of validation available now, in 1995, for people who went a few steps further than I did with their dissociative process, and developed multiple personalities during and after extreme early childhood abuse. Through my reading, and what I have learnt at workshops and by having now worked knowingly as a

therapist with twelve people with multiple personalities I have some understanding of what separates those people from me. It is most certainly nothing to do with superiority in strength of character or anything like that. Rather, truly relevant factors include the following: I was not required by my perpetrator to participate actively in the abuse; I was not subject to sadistic abuse; I was victim to only one perpetrator, and finally, maybe I just wasn't all that good at dissociating! In the words of Herman, people with dissociative identity disorder achieve "virtuosic feats of dissociation" (Herman, 1992:124). From what I have seen with my clients I agree with this description: the dissociative feats which facilitated their continuing function and survival are astounding and deserving of great respect.

As to the aspects of my professional identity relevant to my choice of the present topic for this paper, I was originally a medical practitioner who practised as a medical oncologist until a combination of burn-out and the emerging memories of childhood sexual abuse referred to above culminated in my leaving clinical practice for a total of six years. During that time, I wrote two books, one of which – *Tricia's Song* – was an account of my healing from childhood sexual abuse.

In 1989 I started a private practice as a psychotherapist simultaneous with commencing training as a psychodramatist. I also studied solution focussed therapy techniques and the narrative therapy of Michael White and incorporate the principles of these approaches in to my current practice. For readers who are not familiar with these models, good introductory texts include *Working with the Problem Drinker – a Solution Focussed Approach* by Insoo Kim Berg and Scott D. Miller, *Resolving Sexual Abuse* by Yvonne M. Dolan and *Ideas for Therapy with Sexual Abuse edited by Michael Durrant and Cheryl White* .

I work mainly with clients whose major therapy goal is to resolve symptoms which they attribute to early childhood abuse. Many of these clients, like myself, have used dissociation as a preferred coping strategy. Some – a total of twelve that I have recognised – have developed multiple personalities as part of their adaptation to gross, ongoing, sadistic childhood abuse. For at least eight of these clients the abuse has included abuse by organised perpetrator groups, such as Satanic cults and organised child pornography and prostitution rings.

Both my personal and professional experiences have thus contributed to my choosing to write this paper on the topic of dissociation consequent to childhood abuse. I wanted to contribute towards educating psychotherapists in general and psychodramatists in particular about this process and so help to ensure that people with multiple personalities get the validation and respect for their ways of coping with their abuse that they deserve.

## Introduction

This paper begins with a review of the general literature about dissociative identity disorder with respect to its nature, aetiology and diagnostic criteria. The evidence that this disorder is an adaptation to serious early childhood abuse is discussed. A description of dissociative identity disorder in terms of role theory and systems theory follows, with some clinical examples.

The thesis that the separate personalities of the person with dissociative identity disorder consist of role clusters rather than single roles is explained. A metaphor of a house and its internal structure is used to help explain the differing awareness that a client's personalities may have of each others presence and activities and the variable amnesia that these clients can experience. Goals of therapy include assisting the client towards awareness of their entire system and working towards a cohesive, internally consistent world view.

The importance of recognising this adaptation to serious early childhood abuse is then explained, both for the therapist in general and the psychodramatist in particular. Fragmentation must be recognised before it can be addressed. In addition, inclusion of a person with dissociative identity disorder in a psychodrama group is contra-indicated until they have developed enough awareness of their system and process to be able to honour a contract and maintain continuity through repeated role reversals.

Guidelines for recognising dissociative identity disorder in the psychodramatic setting follow, accompanied by an explanation as to why the diagnosis is often obscure and easily missed. Indicators discussed include history of abuse, indications of switching, indications of time loss/amnesia, refusal , reluctance or inability to reverse roles, use of the terms we/she/he/ not me, witnessed disavowed behaviour and evidence of internal voices.

Finally, ways of modifying the use of some psychodramatic principles in order to utilise them safely and effectively in individual sessions with the newly diagnosed multiple are described. Principles discussed include systems theory, setting out all elements of the system, using direct address, concretisation, promoting authentic encounters, role reversal, looking for the health in the system, role analysis, maximisation, and of course, promoting spontaneity in both client and therapist.

## A Psychodramatic approach to the management of dissociative identity disorder

Dissociative identity disorder is common. It is usually well disguised, and therefore is often misdiagnosed. These misdiagnoses are tragic because dissociative identity disorder is extremely treatable. This paper will help the reader to understand how and under what circumstances multiple personalities are created, to recognise clues to the presence of multiple personalities and to use the principles of psychodrama to best assist any of these clients that you encounter in your practice.

As I explain in the body of this paper, inclusion in psychodrama groups is contra-indicated for the newly diagnosed multiple. For such clients role reversal typically results in switching from one personality to another, which is physiologically demanding and likely to be accompanied by amnesia, confusion and disorientation. Such a client requires one-to-one work until they have developed both a good enough understanding of their own internal system and enough co-consciousness – personalities having an awareness of the actions and thoughts of other personalities – to be able to sustain continuity through a number of role

reversals. It is only then that they will have the capacity to honour a psychodramatic contract and to benefit from classical psychodramatic group work.

In the meantime, effective work with these clients, while best conducted on a one-to-one basis, nonetheless still demands a sound understanding of systems theory. In this paper I describe some adaptations of psychodramatic principles that I have developed for use in the one-to-one setting with newly diagnosed multiples. I have found it useful to think of the client as a group, all of whose members are within the one body! It's important however, never to lose sight of the last bit – all in the one body – because this is a reality that your client will not always be able to hold.

## Review of the literature on dissociative disorders

Dissociation is a normal, and for many children becomes a preferred and habitual, response to overwhelming and repeated trauma. (Bryant et al; 1992:5). A dissociative response is particularly likely when the trauma is experienced by the child as life-threatening e.g. forced fellatio, being beaten to the point of unconsciousness or being silenced by a pillow held forcibly over the face during sexual abuse. The definitive factor is the presence of extreme and overwhelming anxiety in the child. (Bryant, 1992:5) A child victim using simple dissociation, as opposed to creating separate, new parts of the self or alternate personalities, to cope with such trauma-induced anxiety is often subsequently amnesic for the event. When the event[s] is/are later recalled, out of body experiences are often reported, such as watching the trauma from the ceiling or the wall, including seeing details from that vantage point that would not have been visible to their physical eyes. The body is typically seen as having been passive or like a rag doll during the abuse.

In contrast, dissociative identity disorder, formerly known as multiple personality disorder, is a much more complex phenomenon. Like simple amnesia, there is good evidence that in almost all cases it occurs in people who have been subject to extreme trauma. In the case of dissociative identity disorder the trauma has virtually always been repetitive, sadistic and starting before the age of five (Marmer, 1991). Herman (1992:126) argues persuasively that this disorder is best understood as a variant of what she calls 'complex post-traumatic stress disorder. Murray (1994) provides a good review of the literature pertaining to the indisputable link between dissociative identity disorder and childhood, specifically sexual, abuse.

Putnam (1989:49) states that 'the abuse suffered by multiple personality patients tends to be far more sadistic and bizarre than that suffered by most victims of child abuse.' This is true. However, in my opinion, there is an additional key factor which leads to a child forming split off, internally-experienced-as-completely-separate parts of the self, as opposed to simply being amnesic for traumatic events.

This additional factor lies not in the child, but in the requirements of the abuser. Simple dissociation suffices for the child who is permitted by their abuser to be non-participatory. However, a child who is required by their abuser to actively participate in the abusive events in

some way, having dissociated, must then produce an aspect of the self which can do what is required e.g. manually masturbate the abuser, speak or act 'seductively' as defined and instructed by the abuser, kill an animal or hurt other children. These are all examples from my own clients histories.

What exactly is dissociative identity disorder? Here are the official criteria for diagnosis as listed in the *Diagnostic and Statistical Manual 1V* (American Psychiatric Association, 1994:477)

"A. The presence of two or more distinct 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 behaviour.

C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

D. The behaviour is not due to the direct physiological effects of a substance [eg. blackouts or chaotic behaviour during alcohol intoxication] or a general medical condition [eg. complex partial seizures]. NOTE : In children, the symptoms are not attributable to imaginary playmates or other fantasy play."

I find the following a useful description for conceptual purposes: "The person who develops dissociative identity disorder is not literally comprised of 'many people' but has a normal psyche comprising many different component parts, aspects or facets of the one psyche which have dissociated to cope with trauma or abuse and developed with varying degrees of internally perceived, apparent autonomy and identity" (Halpern & Henry, 1993).

Having now defined this disorder and provided you with the diagnostic criteria, I will refer to dissociative identity disorder from now on by the generally accepted acronym of DID. Similarly, when referring to this disorder by its previous title of multiple personality disorder I will use the generally accepted acronym of MPD.

## A description of dissociative identity disorder – formerly multiple personality disorder – in terms of role theory and systems theory

### *a. A basic description*

I want to stress that the "different component parts, aspects or facets" of Henry and Halpern's description are not each single roles but rather, complex role clusters. Look at section A of the criteria from the Diagnostic and Statistical Manual. The description of what comprises a 'distinct personality state' is a description of a complex role cluster, not of a single role. People with DID can also have one or more distinct aspects which consist only of a single role, these are usually referred to in the DID literature as fragments. The more usual role clusters are referred to as personalities or alters, which is an abbreviation of the term alternate personality.

Changing from one role cluster or personality to another is called switching in the DID literature. Switching is physiologically demanding and can result in lassitude and severe headaches. It's not like simply reversing roles is for

those of us who do not have this degree of dissociation. Demonstrable physiological differences between personalities are well documented (Putnam, 1989:123) eg. in response to prescribed medications, alcohol and other drugs, in allergies and in vision and hearing. I have one client who takes her glasses on and off with switches because of the accompanying changes in her vision. Another complains that her hearing goes 'weird' and she is partially deaf while one particular personality is 'out' but has normal hearing the rest of the time. A severe headache can vanish or appear with a switch, as can other physical symptoms such as drowsiness. Because of the accompanying physiological changes, repeated switches over a short period of time can leave a person with DID exhausted. This has obvious implications for the psychodramatist.

People with DID differ from those of us who don't have DID not in their internal complexity but in the degree of their internal compartmentalisation. Clayton (1981:5) describes it thus: 'The person described as a multiple personality has multiple role states or clusters of role states which from the point of initial trauma develop no connecting links between them and have variable connective links with the conscious regulating ego which represents only a partial expression of the creative genius.'

## *b. A metaphor for guiding therapy and explaining the disorder to the client*

I have developed a metaphorical description of DID which helps me to make sense of what I see in my clinic. This metaphor is also useful for explaining the disorder to the client.

People with DID function a bit as if they have a series of complex role clusters, each of which occupy a separate room in a house. Some rooms have open doors and some rooms have locked doors. Some role clusters can roam all over the house, some have access to only a few rooms and don't know the rest exist and some are confined to locked rooms for which they themselves do not have a key. Some role clusters hold a number of door keys, some have none. Or, in other words, some know about the whole internal system, some know about limited parts of it and some only know about themselves, i.e. they are amnesic for the other role clusters and their activities. How you as therapist perceive the system from the outside depends on which role clusters present themselves to you.

Note that amnesia is rarely consistently present throughout a system. Within any one system there will usually be some personalities or role clusters who are amnesic for all the others, some who are amnesic for some of the others and some who are not amnesic at all. In the literature, awareness of the presence and activities of other personalities is called co-consciousness. Co-consciousness, or awareness of the rest of the system is a primary goal of therapy, and obviously must precede attainment of co-operation between or integration of the personalities.

## *c. A clinical example illustrating the process of development of new personalities*

The following clinical example will concretise some of what I am saying. I will preface the example by

explaining that once the ability to develop new personalities as a means of coping with trauma is established, new personalities may be created at any age, including adulthood.

A client with fifteen personalities once described to me the process of formation of one of the chronologically later developed of them. She was being savagely beaten by her father at the age of eight when the thought occurred to her that he only beat the boys – her brothers – in this way. This was immediately followed by the thought " I must be a boy" and with that a new personality was 'born'.

Over time this personality developed a number of different roles – 'he' was the one who endured the savage beatings, who tried to run away from these beatings, who did dangerous things to try to please father like clambering quickly over water-washed rocks on fishing expeditions while trying to keep up with him etc. 'He' was outwardly bold and adventurous although inwardly quite fearful. 'He' was a loner. 'He' didn't cry. 'He' held father in high regard, this regard being facilitated by 'his' amnesia for the sexual abuse which father perpetrated on some of the female personalities. This 'boy' was not just a role but a complex role cluster with different experiences, beliefs, attitudes and behaviours than some of this client's other role clusters or personalities.

## *d. Goals of therapy with a client with dissociative identity disorder*

I have already stated that a primary goal of therapy with these clients is to facilitate awareness of their entire inner system and from there to help

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them to develop co-consciousness, which means awareness not only of the presence of the other personalities but also of the thinking, beliefs and behaviour of the other personalities. Once co-consciousness is fully attained the client will no longer experience amnesia and will have a sense of continuity which paradoxically, they may initially experience as quite bewildering.

A further, necessarily subsequent, goal of therapy is the development of more effective functioning of the person as a whole through the achievement of either cooperation between or integration of all of the personalities. This goal can only be reached after the attainment of the intermediate goal of developing a cohesive, internally consistent world

view, something that these clients never have in the early stages of therapy for reasons which I will now explain.

Clayton, (1994:124) states: "A well-functioning person may become conscious of a multitude of pictures associated with each major role in their personality and of the fact that each picture complements the others and contributes to a larger vision." People with multiple personalities are not well-functioning in the sense that before co-operation or integration is achieved it is never true for them that each picture complements the others and contributes to a larger vision. The pictures associated with each of their role clusters are always contradictory. It is precisely these inner contradictions that make the continuation of their internal compartmentalisation necessary and indeed, comfortable, compared to living concurrently with very differing pictures.

The genesis of these contradictory inner pictures lies in the contradictory external world in which they had to live as children. To return to my case example, this client as a child could not tolerate the external contradictions of being treated 'like a boy' e.g. being beaten 'like a boy' and being taken on 'boy's' fishing expeditions and also being sexually abused as the girl which she in fact was. So these contradictory aspects of her life were held, on an on-going basis, in different role clusters or personalities which were amnesic for each other. Each role cluster built up, over time, it's own set of experiences, beliefs ,emotions and behaviours, some of which were contradictory eg. beliefs like I must be a boy/ I must be a girl, dad likes me/dad hates me. This client will not achieve full cooperation between her personalities until they all pool their information about past experiences and dialogue with each to a point where they can recognise and keep external the contradictions with which they lived. For instance, as long as she internalises the beliefs that she is both male and female, she cannot achieve consistency internally and therefore cannot achieve a consistency in how she relates to or views the world.

Here is a clinical example to demonstrate how the use of role theory can assist with achieving the goals of greater inner cohesiveness and elimination of contradictions with resultant more effective functioning.

Within a DID client's system, there are typically one or more personalities whose organising role is that of 'protector'. These personalities are typically experienced by others in the system, and by the therapist , as aggressive, obnoxious, harmful to self and/or others, obstinate and unfeeling . An analysis of the 'protector' personality's roles can help the other personalities to understand that the feared, disliked and unwanted behaviour is based on different beliefs, especially with respect to the outside world.

Phenomena like fogging of thoughts, stopping of speech, and self abusive behaviour, such as drug abuse, cutting and bingeing on food, may then be seen for what they are – attempts on the part of the 'protector' personality to keep the whole person safe. Such phenomena often represent attempts on the part of the 'protector' personality to prevent or punish any talking about past abuse. The 'protector' does this because it believes that this behaviour endangers the whole

system. This motive is typically unapparent to those of the rest of the system who know that talking about past abuse is not currently dangerous. This is a common example of different beliefs and world views within a system creating problems.

Once the rest of the system understands the motives of the 'protector' they can stop viewing and treating this personality as an enemy. It is then relatively easy for them to take the next step and grasp that the 'protector' personality has been choosing certain behaviours in an attempt to achieve safety because they were lacking in the roles of 'independent thinker' and 'observer of current reality'.

The absence of 'the independent thinker' is typically evidenced by statements such as "I fog your thoughts because you're not supposed to talk about this." When asked why not, they may be at a loss, keep repeating "because you're not supposed to" or become very confused at being questioned. It's simply a fact to them, usually, of course, a 'fact' implanted by their abuser(s) in an attempt to keep secret their illegal activities.

As far as the role of 'observer of current reality' is concerned, I have worked with clients where this role was so totally absent from a 'protector' personality that they knew neither that they were in an adult body nor that their principle perpetrator had been dead for several years in one case and lived on the other side of Australia in another. This was so in spite of the fact that other personalities of the same client had strongly developed roles of 'independent thinker' and 'observer of current reality' and knew these facts.

Through a combination of the therapist's modelling and questioning and other personality's role modelling and sharing information about current reality, the 'protector' personality can develop the roles of 'observer of current reality' and 'independent thinker' remarkably quickly. With the inner system and the external world view now more consistent, the previously destructive behaviour arising from traumatic fragmentation of the personality can now be transformed towards promoting genuine safety and truly effective self-protective behaviours.

## Implications for the healing of dissociative identity disorder for the psychodramatist

### *a. Importance for the psychodramatist of recognising dissociative identity disorder*

Those of you who, to your knowledge, are not working with highly dissociative clients may well be asking what all the fuss is about. Isn't all this incredibly rare?

In a word, no. Ross (1991) found what he called "pathologic post-traumatic MPD" in 1.3% of his randomly selected sample from the general population of a large North American city. Thus, DID/MPD could be as common as 1:100 of the general population [about the same prevalence as either schizophrenia or bi-polar disorder] and constitute a much higher proportion of survivors of severe, repetitive and sadistic childhood abuse. DID/MPD may be misdiagnosed as schizophrenia in as much as 50% of cases (Bliss, 1983).

This is not just a North American phenomenon. Since becoming aware

of the frequency of this disorder and having a high index of suspicion for it, I have diagnosed DID in over 10% of my clients, the proportion being this high because my clients constitute a selected population – most being survivors of serious childhood abuse.

It is thought that 90% or more of survivors of abuse by organised perpetrator groups such as Satanic cults have this disorder. This high percentage is only partly attributable to the severity of this form of abuse. It is also explained by the fact that these groups deliberately set out to foster the creation of separate personalities in their victims (Neswald, 1994:7). They do this in order to make certain behaviours readily accessible on command and to try to ensure secrecy about their criminal activities.

Secondly, it is important to recognise DID because there is ample evidence that while it remains undiagnosed and the linkage between problematic symptoms and early childhood abuse unrecognised, therapeutic work tends to be lengthy and unproductive. Clearly core symptoms associated with fragmentation cannot be resolved as long as that fragmentation is neither recognised nor addressed. In addition, the origin of the fragmentation in childhood abuse and trauma must be named, because it is only when "survivors recognise the origins of their psychological difficulties in an abusive childhood environment [that] they no longer need attribute them to an inherent defect in the self. Thus the way is opened to the creation of new meaning in experience and a new, unstigmatised identity" (Herman, 1992:127).

Thirdly, here is an incident which high-lighted for me why, in particular, psychodramatists and other therapists using action methods should be alert for indicators of DID. A client once told me of a session with a therapist who used 'voice dialogue' with her some years before her DID was diagnosed. During that session she was asked to repeatedly move to different parts of the room and take up what she and the therapist thought were simply different roles or 'voices'. At the end of the session, she was so exhausted that she had great difficulty in getting home and subsequently was confined to bed for a week with extreme fatigue and headaches. She and I worked out that she had actually been switching between about fourteen different personalities or role clusters during that session! The concern I felt when I heard about this was a major motivating factor in my choice of topic for this paper – the parallels with psychodrama are obvious. Not only was she subject to severe physiological stress as a result of the session I have described, in addition, her fragmentation was neither recognised nor addressed at that time.

Fourthly, what little I have been able to find in the literature concerning the use of psychodrama in people with DID confirms my own belief that it should be used only with clients who have achieved enough co-consciousness and control over their switching to be able to keep a contract and not lose awareness of continuity. (Altman 1992a, Altman 1992b, Hudgins and Wnukowski 1993).

Altman confirms my experience that role reversal in the psychodramatic setting often results in switching for the DID protagonist or auxiliary, and states "some amount of co-consciousness in the

system is desirable to ensure that any emerging alters will have a sense of the psychodrama contract in progress" (1992b). Hudgins and Wnukowski word their caution like this: "Before beginning exploratory, uncovering work with people who experience multiple states of consciousness, the clinician must make sure the client can anchor in present reality if needed – otherwise experiential work is not safe and risks retraumatising the client" (1993).

### *b. Guidelines for recognising DID in the psychodramatic setting*

The diagnosis of DID/MPD requires a high index of suspicion and a knowledge of what to look for. These clients may refer in passing to dissociative symptoms but will very rarely tell you directly that they have multiple personalities. There are many reasons for this.

Firstly, they may not know that they have multiple personalities, or at least the personalities participating in the session may not know, because they are amnesic for the other personalities. Books like *The Flock* (Casey and Wilson, 1993) and *Multiple Personality from the Inside Out* (Cohen et al. 1991) provide useful descriptions of how the diagnosis can gradually become apparent to the client. All your client may know is that they are forgetful, absent-minded, and moody. They may have been told by others that they are all of these , a liar and also unpredictable – "I never know what you'll be like next time I see you". Such descriptions often seem bewildering and unjust to the person with DID. This is how they have lived for as long as they can remember. To them, it is normal to hear voices inside their head, to find clothes in their wardrobe that they don't remember buying and wouldn't dream of wearing, to feel astonished or frightened on seeing their own reflection in a mirror because what they see is not what they expected to see, to suddenly 'come to' in strange situations and have to orient themselves without anyone noticing, to 'lose time' etc.

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Many clients believe that phenomena such as these and others which are listed in the Dissociative Experiences Scale of Putnam et al. – a screening tool for multiplicity which I discuss at the beginning of [c] on page 56 – are universally experienced. One of my clients, after marking her questionnaire to indicate that she experienced most of the listed phenomena most of the time commented "I don't know how anyone could 'fail' this test." It was beyond her comprehension that people existed who did not

experience these types of occurrences on a daily basis.

On the other hand, if these people do somehow find out that not all people experience what they do, they conclude that perhaps they are crazy and of course must hide this craziness from others for their own safety.

This leads me to another reason why the multiplicity is kept secret. Multiplicity develops as a mechanism for coping with serious ongoing trauma. For the victim the beauty of multiplicity lies partly in that it is secret and therefore unapparent to the abuser. This confers some much-needed, but illusory, sense of control and mastery over their very traumatic life situations. Maintaining an illusion of control can help a person who has been subjected to extreme abuse to keep functioning. For these highly traumatised people letting someone else know about the functioning of their inner world can feel like major loss of control. Revealing their fragmentation may result in an intolerable level of vulnerability. For example, fears that a person who knows of the multiplicity may be able to call out personalities at will, or decide that the client is crazy and get them 'locked up', will ensure that multiplicity is kept secret until significant trust has been built and this can take a long time.

So, as clinicians we must be prepared to look for indicators such as the following:

- **History of abuse**

A history of severe, ongoing childhood abuse of a sadistic nature, starting before the age of five and involving more than one perpetrator or complete amnesia for large blocks of childhood or both should alert you to the possibility of multiplicity. People whom you know to have been abused by organised perpetrator groups such as Satanic cults are very likely to have multiple personalities, as explained in section 6[a].

- **Indications of switching**

At the moment of switching from one personality or role cluster to another a multiple will often avert their gaze, cover their face with their hands or hair, flick their eyes upwards or blink repeatedly. There may be a very abrupt and dramatic change in affect, which can even occur mid-sentence, and may seem inappropriate . They may suddenly appear to become very tired. Their voice, speech – accent, vocabulary etc – and mannerisms may alter suddenly.

After a switch so-called re-orienting and grounding behaviour (Putnam 1989:121) may be seen. This can include glancing round the room or at their watch, shifting restlessly, touching the face or temples and touching their chair if sitting.

These are all clues which would be hard to pick up in a psychodramatic setting when you have just asked for a role reversal , especially as each in isolation is not really remarkable. Of course, switches may also occur when a request for role reversal has not been made and these should be easier to detect. The aspect which I have found most helpful is the abruptness of changes, especially in affect.

- **Indications of time loss/ amnesia**

Glancing at a watch or clock is a classic clue to time loss but one that is so commonplace that it is easy to miss unless you also notice the constellation of other clues to

switching described above. Other indications can also be subtle. For example, a client I was seeing late one winter afternoon commented that it had suddenly got much darker. A few questions from me soon elicited that she had just switched and was amnesic for the preceding part of the session. Other relatively subtle indications of time loss/ amnesia for recent events include statements that seem out of place or inappropriate to the current context. Be alert for terminology like "I must have....." or "I would have done...." or "I probably...." when referring to very recent events. Some clients will even say something like "I seem to have lost the thread", "What were we just talking about/ doing?" Or they might just look blank.

Watch for a client having difficulty in taking up a previously enacted role or other indicators that they may be amnesic for previous parts of the current drama. I can't stress too much that these people are very unlikely to tell you directly that they don't know what has just been happening. They are very practised at hiding amnesia.

- **Refusal/reluctance/inability to reverse roles**

Have you ever had clients who have refused point-blank to reverse roles? Consider the possibility of multiplicity. As I've described above, if accompanied by switching, role reversal is tiring, physiologically taxing and can be disorienting if there is little or no co-consciousness. There may also be a fear of loss of control, of not knowing what they might do in the new role.

Another possible explanation for a refusal to reverse roles is amnesia. If the personality currently 'out' is amnesic for a previously enacted role because it was enacted by another personality with whom they are not co-conscious, they will be reluctant to role reverse for fear of revealing their amnesia. Other amnesic clients may role reverse anyway and be inexplicably bad at taking up the previously enacted role.

- **Use of terms we/she/he/ not me**

The language that people use when describing aspects of their own lives can provide important clues to the presence of multiple personality states. If, as is common, they conceptualise themselves as a group of people, they may use the pronoun 'we' about themselves. Another clue is use of the third person – she or he . This may sound peculiar to you but to them is the appropriate pronoun to use when referring to another personality who is 'not me' – not the personality speaking right now. The term 'not me' is also a clue as in : "It's just not me – I don't think like that/ do things like that/ believe that" etc.

- **Witnessed disavowed behaviour**

This is a strong indicator. Examples would include a client denying an interaction with another group member that you had witnessed the previous week or earlier in the session. This is how these people get labelled as liars

- **Evidence of internal voices**

Behaviour such as appearing preoccupied, gazing fixedly into the distance, tilting the head to one side, and saying a series of unfinished and apparently disconnected sentences are all possible indicators that your client is hearing voices. Of course they may just be 'tuning out' – or in

other words dissociating!, – tired, or watching a fly on the wall. When I suspect that a client may be hearing voices I usually ask directly, stating in a very matter-of-fact way whatever I saw that suggested the possibility to me. If voices are acknowledged, it is important to establish their experienced origin. Voices heard inside the head or experienced as "loud thoughts" and voices heard clearly and distinctly are more likely to mean DID while voices experienced as emanating outside the person and heard indistinctly are more likely to mean schizophrenia (Putnam 1989:62).

### *c. Use of psychodrama principles with the newly diagnosed multiple.....?*

It is not my purpose in this paper to detail how to confirm a diagnosis of DID. Briefly, it is necessary to confirm the criteria listed in the DSM 1V . It is essential that you yourself 'meet' at least two distinctly different personalities.

Tools that can assist in confirming the diagnosis include the Dissociative Experiences Scale of Bernstein and Putnam (1986) and the Dissociative Disorders Interview Schedule of Ross et al. (1989).

The Dissociative Experiences Scale is a screening tool consisting of a self-administered questionnaire that asks the person to indicate, by marking on a 100mm line visual analogue scale, the frequency with which certain specific dissociative and depersonalisation experiences occur. An example: "Some people sometimes find that they are approached by people they do not know who call them by another name or insist that they have met them before. Mark the line to show what percentage of the time this happens to you." All of the questions have the same form and I have found that clients tend not to feel threatened by them. In my experience it's most helpful contribution is in assisting the client to recognise dissociative phenomena for what they are.

The Dissociative Disorders Interview Schedule is a more formal instrument which is administered by the therapist and takes about an hour and a half. It not only helps to make an accurate diagnosis but also provides information on related somatic and other symptoms and history. It will distinguish MPD [as DID was called when the instrument was developed] from other dissociative disorders and identify concurrent somatization disorder, major depressive episodes and borderline personality disorder.

For the rest of this paper I will focus on how the psychodramatist can best work with the recently diagnosed person with DID ie. the client who knows little or nothing about their own system, who has little or no internal communication and little or no co-consciousness. As discussed above, psychodramatic work involving role reversal in a group setting is contra-indicated for such a client. However, this most certainly does not mean you should discard psychodramatic principles. On the contrary, they are invaluable in one-to-one work with these clients.

By trial and error I have evolved ways of using psychodramatic principles with multiples, working on a one-to-one basis without them even changing chairs or moving at all. I have found that in the early stages of therapy they are often very reluctant to move. My policy with these highly traumatised people is

almost never to override their knowing about what is best for them, so I do not push for two-chair work if they resist this suggestion. The 'host personality', who is the one who has "executive control" of the body most of the time and who is usually the one who presents for therapy, (Putnam 1989:107) can be terrified of letting go of internal control and allowing other personalities to appear and interact directly. Allowing the person to stay in the same chair and the presenting part to speak for the others, rather than pushing for switching, is much less threatening and, I believe , may actually be more effective in promoting co-consciousness.

## Systems theory

Systems theory, a cornerstone of psychodrama, is vital in working with people with DID. *The Family Inside – Working with the Multiple* by Bryant et al. (1992) is very useful in this regard. Two of the authors are family therapists, so systems thinking strongly informs their work.

It is the therapist's job to hold strongly the reality that in front of them is one person, albeit with a complex and highly compartmentalised internal system, but one person none the less. It is important to use terminology that supports this reality. I prefer to call the personalities parts to reinforce this reality and to assist myself to think systemically. My terminology has at times been strongly resisted by those clients who prefer to call their personalities or role clusters people. I respond by pointing out that I call them parts because they all share the same body, another reality which you may have to repeat often. This is one instance where I do not go along with what the client believes is best for them. I don't try to change their terminology but I do not collude with their delusion that they are separate people.

## Set out all elements of the system

Another basic principle of psychodrama is to set out all elements of the system. So, early on, I put a lot of work in to determining the components of the system. I am very curious to explore, through the presenting personality/personalities, any clues to the presence of, as yet unknown to me and the 'host', personalities or role clusters. Helpful questions include the following.

"I noticed that you just stopped in mid sentence. What happened there?"

"You've just acknowledged losing your train of thought. Does some part of you want you to stop talking about this?"

"Who?"

"Why?"

In response to "I don't know" :

"Does any part of you know?"

"Does any inside part have an idea about how we could find out more about this?"

If the 'host' personality reports out any information from another personality/role cluster, I ask for more: "Does this part know about other parts that you don't know about?"

"Can you ask this part how old the body was / what the circumstances were when they first came along?"

"What are they good at?"

"Is there anything else they would like to tell you?"

At times I have really been in the dark as to what is happening 'inside' the client. When the client does not want to report out their internal

communication I accept this. I might say something like "You're the one that needs to know..... After all, it's you that's sharing the same body with this part".

When beginning this work the host personality may be quite distressed to find other hitherto unknown parts, or even at the suggestion that they may be present. I remain calm and reassuring, saying something like "Just relax and listen inside. Everyone has parts, everyone says things like part of me wants to go out tonight and part of me wants to stay home. Your parts may just be a bit more separate than some other people's. If you get to know more about your parts your life will probably run more smoothly."

## Direct address

As is clear from the above it is not always possible to use the psychodramatic principle of using direct address – talking to the parts or 'people' most involved rather than about them. (Blatner and Blatner, 1988:151). I do try at intervals to do this and sooner or later it does become acceptable to the client. I might try by saying something like "Is there any way that I could talk directly to this part of you?"

## Concretisation

Another basic principle of psychodrama listed by Blatner and Blatner is to "make abstract situations more concrete". These clients are usually pretty good at this. As far as exploring the internal system goes I always encourage them to 'draw a map' or some other concrete representation of what there is inside, as recommended by Putnam (1989:210), Bryant et al (1992:140) and others. This falls short of the usual psychodramatic method of physically setting out the system but even this modified form of concretisation can be very threatening and may take weeks or months to gradually be produced. Another modified, relatively non-threatening form of concretisation is ask the client to use toys or dolls to 'show' something.

## Promote authentic encounters

Yet another principle is to 'promote authentic encounters whenever possible' (Blatner and Blatner 1988:152). It has often amazed me how authentic encounters between parts of a clients internal system can occur using the 'staying still' techniques I am describing here. I have often been witness to and facilitated interactions that are very emotional and promoting of future cooperation, the entire process happening inside the client's head, as opposed to through role reversal.

## Role reversal

I have spoken of the constraints on doing physical role reversals, as in two chair work, with these people. In my facilitation of internal interactions between role clusters I encourage a mental role reversal or empathy with the other part, who may previously have been seen as the enemy.

For example, when a part has been hurting the body in some way, such as by cutting, drug abuse, binge eating etc., I will encourage the presenting personality to find out from the offending part why they think it's a good idea to do whatever it is that the presenting personality doesn't like.

"What has happened to this part that they want to do this?"

"How could they be trying to help the rest of you by doing this?" etc.

## Look for the health in the system

When you are faced with a mute or terrified or self- destructive or abusive part it can be hard to remember that what you are seeing is not all there is. I ask something like "Is there any part who can help here?"

"Are there any parts who see things differently?"

"Is there a part who could help catch this part up with what is true now because I don't think this part knows?"

Initially it may be necessary to model some of the roles asked for by these kinds of questions but it is surprising how much wisdom is present in the system when you are able to get access to it.

## Role analysis

The role analysis which is another basic principle of the psychodramatic method (Clayton, 1994) can be very helpful in the person with DID. Both an analysis of roles present in separate role clusters/personalities and an analysis of roles present in the whole system are useful. Solutions to problems may involve both development of new roles within one personality and a diffusion or sharing or modelling of desired roles present in some personalities but not others. I encourage and have often seen role modelling and training occurring within the system, one personality teaching another. A clinical example of this can be found in [d] on page 49.

## Maximisation

A word of caution about the psychodramatic principle of maximising through exaggerating or amplifying behaviour. One of the many reasons for these people maintaining internal compartmentalisation is that certain role clusters or personalities hold or contain overwhelming vulnerability, terror, grief and rage. Such personalities are often kept hidden and not 'allowed out' by the rest of the system, who can then proceed unencumbered by these overwhelming affects. The task is not to amplify the affect, which is already of overwhelming intensity, but rather to 'spread it around' amongst other parts of the system and gradually facilitate expression of it in manageable increments.

Remember that in psychodrama the word maximize includes exaggerating downwards or making very small. This can be very useful in assisting personalities who have no emotions to get in touch with the emotions that are in the system and also in assisting the personalities who have overwhelming emotions to express them safely. However, when working with an affectless personality trying to maximise affect in the sense of making it much bigger will either go nowhere or result in a switch to an overwhelmed personality.

## Promoting spontaneity

Lastly, and most importantly, the primary, guiding principle of psychodrama is the development of spontaneity. Dissociation is a creative and spontaneous response to a situation the first time the client does it. In the adult client it is an old, worn-out, hackneyed response which restricts spontaneity. Development of new and spontaneous ways of responding to situations is central to the work with these clients, whether this means development of roles new to the whole system or strengthening and increasing the accessibility of present

but hitherto compartmentalised and therefore often unavailable roles.

Spontaneity must also be the cornerstone of therapeutic practice. What has struck me more than anything in my work with these people is their uniqueness and the astounding diversity encompassed by the clinical diagnosis of DID. I am frequently challenged to come up with new and unique ways of working. Formulae simply don't work and exceptions to every principle abound.

## Conclusion

Dissociative identity disorder is common in client populations, especially amongst those who have been subject to early childhood abuse. Inclusion of clients with DID in psychodrama groups is contra-indicated until they are familiar with their entire inner system and have enough co-consciousness to ensure continuity through repeated role reversals.

However, psychodramatic principles are invaluable in working with the newly diagnosed multiple. Systems theory is crucial to working effectively with these fragmented people, and can easily be adapted to the one-to-one situation.

In conclusion, I want to say that my highly dissociative clients have been, and continue to be, a source of awe and inspiration for me. It is a privilege to bear witness to such extraordinarily creative, original and diverse means of coping with otherwise unbearable trauma. It is also a privilege to assist these courageous and tenacious clingers to and seekers of life to develop their spontaneity and overcome the unwanted after-effects of their abuse.

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