Psychology and Behavioral Science
International Journal
ISSN 2474-7688

Juniper Publishers
key to the Researchers

Case Report
Volume 12 Issue 5 - August 2019
DOI: 10.19080/PBSIJ.2019.12.555850

Psychol Behav Sci Int J

Dissociative Identity Disorder in a Military Veteran: A Case Report

Jacqueline Linder*

CEO of the Spiral Phoenix Trauma Institute in Edmonton, Canada

Submission: August 11, 2019; **Published:** August 23, 2019

***Corresponding author:** Jacqueline Linder, CEO of the Spiral Phoenix Trauma Institute in Edmonton, Director of Canadian Master of Counselling Programs at City University, Alberta, Canada

Case Report

I first met Deacon when he was referred to me by a community psychologist who had been seeing him in private practice. A married father of two, he had spent many years serving in the armed forces. He was diagnosed with Posttraumatic Stress Disorder and released from service but struggled to adjust to his new life. When I greeted him at the front door of my clinic, I was intrigued by the complex clinical journey ahead of us. The referral indicated that he displayed symptoms of Dissociative Identity Disorder (DID) and required specialist care. DID is a complex disorder with a controversial history. Our clinical understanding of DID and how best to treat it remains in its infancy. Perhaps its most famous clinical feature is that clients present with multiple alternative personality states. These "alters" take separate control of executive functioning at various points in time. As individuals with DID are no more fantasy-prone, suggestible, nor likely to produce false memories than other clinical populations [1], these alters appear to reflect genuine phenomenological self-states.

Advancing technology has facilitated new explorations of this fascinating disorder. Several recent studies confirm that individuals with DID have unique brain morphology compared to healthy controls. For example, they are known to have smaller, abnormally shaped hippocampi that appear to be correlated with the severity of childhood trauma [2]. Their brains also show marked reductions in cortical thickness, volume and surface area in key regions [3]. This unusual morphology is associated with individuals who experienced early childhood trauma between 0 and 3 years of age. Rutkofsky et al. [4] note that the disrupted brain regions relate to short, working, and long-term memory and may thus underpin the personality switches observed in the DID population. So, striking are the changes to the brain structures of DID individuals that neuroimaging biomarkers may someday be used to aid clinical diagnosis [5].

As I ushered Deacon into my office, my main priority was to help him adapt to an unfamiliar space. I offered him a cup of tea and asked him to fill out the intake form while I put the kettle on. When I returned to my office, I heard him talking loudly to himself. I decided to address things in a friendly, forthright manner asking: "were you just talking to yourself?" He froze for a moment before nodding and saying "yes, there's some disagreement about whether this is the right place for us." I reassured him that all parts of him were welcome in the space and proceeded to review his developmental history. Abandoned by his birth parents then adopted into an abusive family, Deacon stated: "there have been lots of us in this body for as long as we can remember."

The International Society for the Study of Trauma and Dissociation's (ISSTD's) 2011 [6] treatment guidelines note that improved integrated functioning for the client is the ultimate clinical goal of DID treatment. This is a long-term process that can be greatly helped by a clinician thoroughly mapping the client's initial plural self-system. When I asked Deacon to describe his system to me in as much detail as he felt comfortable with, he reported that there were five personalities: 1) Deacon was the host of the system and the only one of the five that identified as being a husband and father; 2) Edward was the stabilizer or "big brother," who held the system together and negotiated conflicts between various alters; 3) Rick was described as the impulsive, self-indulgent one who destabilized things and "got everyone in trouble;" 4) Colin was the angry alter who retained all memories and feelings related to the childhood abuse; and 5) Hugo was the military professional who had served for many years in the armed forces.

After walking me through his identity landscape, Deacon declared that he was tired of sharing his body with so many people and that his alters needed to "walk the plank." The ISSTD guidelines (2011) note that "Helping the identities to be aware of one another as legitimate parts of the self and to negotiate and resolve their conflicts is at the very core of the therapeutic process" (p. 132). In other words, as vital aspects of the client's

whole self, alters are to be eventually fused back into the core personality rather than discarded. Given Deacon's bluntly stated desire to "get rid" of his alters entirely, I certainly understood why they were resistant to therapy. Much of my early work with Deacon focused on processing his dislike of his alters, particularly Rick, who was often involved in illicit activities. Whenever, Rick assumed control of executive functioning, Deacon experienced total amnesia of all Rick's activities.

Deacon found the amnesia extremely distressing as Rick's gambling and womanizing resulted in financial hardship and a marital breakdown between Deacon and his wife. Morton [7] notes that inter identity amnesia between alters varies widely in the DID population. In Deacon's case, he experienced no amnesia with some alters and total amnesia with others. Over the course of therapy, it started to become clear that Deacon was extremely possessive of his relationship with his wife. He reported that his wife wanted to meet his alters, but Deacon was adamant that she was his wife not theirs. When I pointed out the possessive hostility Deacon displayed towards his alters, he admitted that as children "everyone used to get along." However, in adulthood, he noted that tension and hostility increased as each alter felt pulled to take their lives in separate directions. We soon began exploring strategies that would allow all the aspects of Deacon's self-system greater positive expression.

One afternoon Deacon came for his appointment and I made my usual offer of tea. When I returned to my office, mugs in hand, I sensed that something was different. Deacon was fidgeting in his seat, a behavior that was atypical for him. Then he asked, "how do you like to be called, by Dr. Linder or by Jacqui?" Surprised, I said, "Deacon, you always call me Jacqui." He replied, "I'm Edward not Deacon." After a moment of amazement, I broke into a smile and said, "Edward, I'm delighted to meet you!" He was taken aback by my warm welcome because he normally had to hide in the background pretending to be Deacon. This meant that our meeting was the first time he had ever truly been welcomed anywhere by anyone. In both speech and body language, Edward was very different from Deacon. He sat up straighter in his chair, his voice was deeper, and he spoke using a far more complex vocabulary. I was excited because this was an opportunity to establish a direct alliance with a key alter that would ultimately help facilitate reintegration.

Edward explained that he had taken over and come to session instead of Deacon because he wanted to meet me personally and share some information. He wanted me to know that his long-term counselling objective was to support a positive realignment of the various alters into a cooperative, multi-self-system. This agenda was quite different from Deacon's desire to annihilate his alters. Edward noted that, in his opinion, Deacon had a lot in common with Rick, the troublemaker as "they both always wanted things their own way." At this point in the session, Edward started to jerk in his chair then leaned forward and pressed his feet firmly into the floor. When I asked if he was ok, he replied that Rick had tried to take over, but Edward had stopped him. As he left my office, Edward thanked me for the work I was doing with Deacon. He stated that our counselling sessions were making a positive impact and he strongly supported it. He also told me that he would brief Deacon on everything that happened in the day's session and that Deacon would be present at our next appointment.

When I next saw Deacon, our session focused primarily on processing his frustration and anxiety over Edward's "hijacking" of our previous session. From Deacon's point of view, this was a violation and he expressed deep resentment towards Edward. I shared with Deacon some of Edward's insights into Deacon's unwillingness to work cooperatively with his alters. Deacon was shocked to hear Edward's perspective but admitted that he was always afraid his alters would derail his marriage and consume his life. What followed was a rich and fruitful discussion on the importance of building trust with his alters so he could stop living like "a house divided." Therapy subsequently focused on exploring incremental clinical improvements including Deacon's increased willingness to work collaboratively with his alters. One tool he used in service of this goal was to implement a voluntary "turn-taking rule" in which his alters were provided with reasonable opportunities for positive self-expression.

The turn-taking strategy appeared to reduce the frequency of Deacon's amnesia episodes. It is conceivable that because his alters were no longer being continuously suppressed, they had less incentive to seize full executive control. Some months into our clinical work together, Deacon came to my office and I immediately noticed his body-language was different. I asked, "Edward is that you?" He replied, "Yes it's me. I came today because I want you to know something is going on with Colin but I'm not sure what." Because Colin was the alter who carried all the cognitive and somatic memories of abuse and neglect for the system, I was immediately concerned. Then Edward began jerking in his chair and pressing his feet into the floor as he had done in one of our early sessions. I asked, "who trying to come through?" He replied, "Got him! Nice to meet ya luv. I'm Rick!" and burst into laughter.

The ISSTD guidelines [6] warn that "The therapist should not "play favorites" among the alternate identities or exclude apparently unlikable or disruptive ones from the therapy" (p. 132). Thus, I welcomed Rick into my office with the same enthusiasm that I had welcomed Edward. When I asked why he had come to session he replied, "I came to see for myself what the hype is all about and why everybody is so excited about you." Rick had a gregarious, swashbuckling personality that I found utterly charming. Unlike Deacon and Edward, Rick was unable to remain seated for long and wandered around my office inspecting all the various items. He informed me that he did not believe in "this therapy bullshit" and was resolved that the best way to live one's life was to do only as one pleased. He expressed contempt for both Deacon and Edward as well as disdain for Deacon's wife, whom he referred to as The Controller. He told me that it was fun to live life just doing what he wanted and not having to answer to anyone.

How to cite: Jacqueline Linder. Dissociative Identity Disorder in a Military Veteran: A Case Report. Psychol Behav Sci Int J. 2019; 12(5): 555850. DOI: 10.19080/PBSIJ.2019.12.555850

Rick was emphatic that he loved to gamble and cruise the internet for women whenever he "got out". However, something about the brittleness of his demeanor left me unconvinced. When I noted gently that for someone who oversaw fun he did not look very happy, he gaped at me completely nonplussed. After reassuring Rick that he would always be welcome in my office, I asked if he had any idea why Colin was so upset. Rick reported that while Deacon had no memory of his or Colin's activities, Rick was aware of and able to communicate directly with Colin. He told me that Deacon's wife invited Deacon to join her for a bodywork therapy session. Although Edward, Rick, and Colin were opposed to the idea and Hugo was indifferent, Deacon said yes in order to please his wife. During the session, Colin felt deeply violated after being touched by the body therapists without his permission. Given Colin's function in Deacon's self-system as the repository of all traumatic memories, this was hardly a surprise.

I provided Rick with some psychoeducation on boundary violations and explained how important it was that all alters' feelings be respected when it came to physical touch. Rick appeared puzzled by how emphatic I was about respecting each alters' feelings, insisting that they be treated with dignity and respect. However, I viewed this as a crucial corrective experience that would stand in direct contrast to Deacon's childhood history of extreme abuse and neglect. In the middle of our discussion on healthy boundaries, Rick began jerking in his chair. When I looked at his face, I saw a mask of pain and rage that led me to conclude that Colin was trying to take over. After what appeared to be a fierce inner battle, Edward resumed control and demanded to know "what just happened?!" I told him that Rick had taken over because he wanted to meet me personally. Edward immediately fired a barrage of questions at me essentially wanting to know what Rick had done wrong. I reassured him that Rick had been completely appropriate during his visit. I focused on providing Edward with some psychoeducation on the importance of each alters' boundaries being respected. I then asked him to share this information with all members of the self-system as well as with Deacon's wife.

In my subsequent therapy session with Deacon, we debriefed my dramatic introduction to Rick. Deacon was extremely critical of Rick and began speculating about all the inappropriate things Rick had likely done. He was, therefore, quite surprised to learn how helpful Rick had been in helping me understand why Colin was so distressed. I shared my observation that it must be hard on Rick to feel so rejected by the other members of Deacon's self-system. Deacon became somewhat defensive and began citing a litany of transgressions to explain why Rick was so despised. I replied that while I genuinely understood everyone's frustrations, nevertheless, it must be very hard on Rick to know he was neither loved nor wanted. This insight seemed to resonate deeply with Deacon and after sitting quietly for a while he admitted that it must be very hard indeed. At the end of our session he committed to making a greater effort to be kind to Rick and his other alters. He also agreed to actively work on allowing them opportunities to become part of his day-to-day life.

The ISSTD treatment guidelines [6] note that while final fusion of all alters into the core personality is the ultimate objective of DID therapy, this goal is not achievable for all clients. Rather, for many people a long-term cooperative arrangement between alters, also known as resolution, is the more likely outcome. My clinical journey with Deacon remains in its early stages so it is too soon to know whether he will achieve resolution or full fusion. However, the fact that I have established a viable therapeutic alliance with both his host personality and two key alters is tremendously encouraging. As for the rest, only time will tell.

References

1. Vissia E, Giesen M, Chalavi S, Nijenhuis E, Draijer N, et al. (2016) Is it trauma- or fantasy-based? Comparing dissociative identity disorder, post-traumatic stress disorder, simulators, and controls. Acta Psychiatr Scand 134(2): 111-128.
2. Chalavi S, Vissia E, Giesen M, Nijenhuis E, Draijer N, et al. (2015) Abnormal hippocampal morphology in dissociative identity disorder and post-traumatic stress disorder correlates with childhood trauma and dissociative symptoms. Hum Brain Mapp 36(5): 1692-1704.
3. Reinders A, Chalavi S, Schlumpf Y, Vissia E, Nijenhuis E, et al. (2018) Neurodevelopmental origins of abnormal cortical morphology in dissociative identity disorder. Acta Psychiatr Scand 137(2): 157-170.
4. Rutkofsky I, Khan A, Sahito S, Aqeel N, Tohid H (2017) The neuropsychiatry of Dissociative Identity Disorder: Why split personality patients switch personalities intermittently? Journal of Cell Science & Therapy 8(2): 1-7.
5. Reinders A, Marquand A, Schlumpf Y, Chalavi S, Vissia E, et al. (2019) Aiding the diagnosis of dissociative identity disorder: Pattern recognition study of brain biomarkers. Br J Psychiatry 215(3): 536-544.
6. International Society for the Study of Trauma and Dissociation (2011) Guidelines for treating Dissociative Identity Disorder in adults, Third Revision. J Trauma Dissociation 12(2): 188-212.
7. Morton J (2017) Interidentity amnesia in dissociative identity disorder. Cognitive Neuropsychiatry 22(4): 315-330.

How to cite: Jacqueline Linder. Dissociative Identity Disorder in a Military Veteran: A Case Report. Psychol Behav Sci Int J. 2019; 12(5): 555850. DOI: 10.19080/PBSIJ.2019.12.555850

DOI: 10.19080/PBSIJ.2019.12.555850

How to cite: Jacqueline Linder. Dissociative Identity Disorder in a Military Veteran: A Case Report. Psychol Behav Sci Int J. 2019; 12(5): 555850. DOI: 10.19080/PBSIJ.2019.12.555850