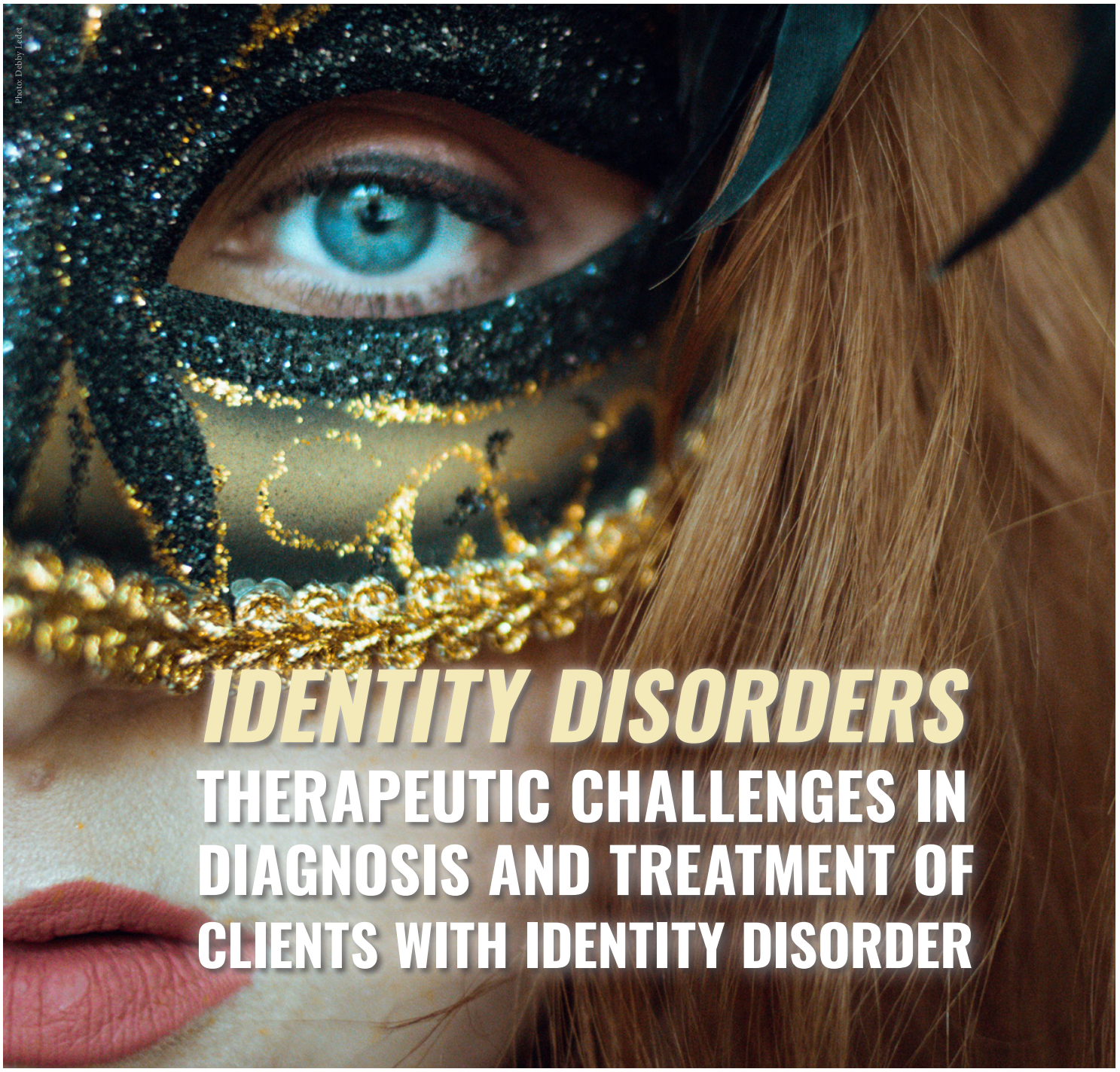

IDENTITY DISORDERS
THERAPEUTIC CHALLENGES IN DIAGNOSIS AND TREATMENT OF CLIENTS WITH IDENTITY DISORDER

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Why Talk About Identity Disorder or Disordered Identity?

In recent years, there has been an increase in the number of people who cling to diagnostic labels or symptoms. Many therapists consult about clients who introduce themselves as "multiple personality disorder" or "DID" in an overt way, without avoidance; without hiding symptoms. Some colleagues describe florid presentations that seem confusing and difficult to treat.

Confusion in adolescence, when the capacity for mentalization is already available, is common and to be expected. However, another level of confusion that we need to add to the equation, is how many of these individuals refer to ego states, even different feelings, or thoughts, as "identities," "characters" and/or "alters." These characters or identities are constructed by adding pieces that seem to fit, but are learned and copied, developing over time.

Many of the clients who present with more florid clinical pictures of DID are adolescents

who have problems fitting into groups during puberty and adolescence. Some of them present Cluster B personality disorders. Many of these young people and future adults come to believe that they have a dissociative disorder or DID diagnosis. If we do not intervene in due time, the construct that they end up developing can become chronic, and many opportunities in therapy and in life can be lost.

Identity and Identity Disorder

Identity allows us to individualize and differentiate ourselves from the world and from others. It can be defined as a set of characteristics that allow us to have a sense of who we are, what we want and where we are going - a sense of how we see ourselves in the world. Identity allows us to know with some certainty our priorities and preferences, our values, what we like, what is part of us and what is not. Identity develops roughly throughout the first 25 years of life.

Lack of peer group belonging during adolescence is a risk factor for the development of mental health disorders. Belonging to the group is necessary for the survival of the individual as the adolescent moves away from the nuclear family. Young people will often do whatever is necessary to be accepted in a group (imitate their physical appearance or behavior, conform and/or create an identity that allows them to take a place in the group). If one's identity does not feel right or effective enough to be liked by others, this creates an internal conflict that can lead to the need to be seen, liked, accepted, or valued, depending on the unmet need.

At this stage of life, some questions may arise, such as: *Do I like the way I am? Do others like me? Do I present an outward image that matches who I am? What do others see? What do others want/need to see? Can I trust my friends? Can people trust me? What do I have to do to be trusted?*
Sometimes one way of being seen or fitting in is to adapt to what they think is likeable or acceptable; often practicing or experimenting with new ways of being seen by others. Often, aspects that were not validated or accepted by the main caregivers or other relevant figures during development, are hidden; thinking that others will not like or accept these aspects either.

Life events such as a job change, a break-up, a move to a new home, or a change in lifestyle can make people rethink their current situation and, sometimes even the choices that have been made. *We may ask ourselves questions such as: What have I been doing with my life? Is this what I want for myself? Could I do better? Is this relationship or way of life really fulfilling?*

Inner conflict usually occurs in all people at different times in their lives, but adolescence seems to be a particularly difficult and vulnerable time. Although these are usually difficult moments, in most cases things become clearer over time without the need for psychological help. This is an adaptive process, not a pathological one.

In other cases, identity conflicts become more complicated if they are not recognized and treated in time. One of the reasons for not detecting a major problem is the tendency to think that it is just confusion due to adolescence. Another reason is that the person who is building an alternative/protective identity usually feels more confident and comfortable with the new *facade*, making others reluctant to intervene.

Learning to differentiate reality is key but not easy. The alternative (constructed) identity is protected by defences the person has had to put in place. It is a structure that supports the new façade/identity that is maintained to protect itself from that which touches on it's own vulnerability or aspects that feel wrong

or unacceptable. Identity in young clients with emotional instability or identity alteration can take many forms.

Some populations are more at risk of constructing defensive identities or disorders than others. These cases would be considered false positives. Among them, we can find:

- Adolescents who have difficulty fitting into a group. Some seem to fit in well but do not really feel connected and lack a sense of belonging. Some examples would be minors at risk of exclusion, victims of bullying, or those with functional diversity.

- Some young people with high capacities. Their creative ways of processing information are usually coupled with the loneliness of not finding people who share a similar way of seeing and understanding the world. This leads to issues such as the development of parallel worlds or the ability to create multiple scenarios in imagination.

- People who suffer trauma at key moments in their adolescence. Similarity with peers is necessary at this time, and the event experienced leaves an imprint that makes them different from others. Some of these events may be related to the loss of a parent or sibling, or a serious loss of the family's economic capacity.

- Clients who have spent years in psychotherapy trying to find answers to their suffering and symptoms. This is especially true for those who have access to a lot of information –psychoeducation– and who search social media for answers to mental health problems.

Dissociative Disorders and BPD

The psychopathology of Dissociative Identity Disorder (DID) revolves around the areas of consciousness, memory and identity. Dissociative disorders are mental disorders that involve disconnection and lack of continuity between thoughts, memories, environments, actions, and identity. Dissociative disorders usually occur in response to trauma and help to keep difficult memories under control. However, depending on the type of dissociative disorder that the person has, the negative symptoms, such as amnesia, may alternate after some time with positive symptoms, such as flashbacks. Periods of stress can temporarily worsen symptoms, and make them more obvious.

Some of the symptoms of dissociative disorders include the following:

- Loss of memory (amnesia) for certain times, events, people and personal information

- Feeling of being detached from oneself and from emotions

- Feeling that people and things around them are distorted or unreal

- A confused sense of identity

- Significant stress or problems in personal relationships, work and other important areas of life

- Inability to cope well with emotional or work stress

- Mental health problems, such as depression, anxiety, and suicidality

A person with a dissociative disorder avoids reality in an involuntary and sometimes unhealthy way, causing many problems in everyday functioning. But could the previous sentence apply to some people with BPD? What

about some people with autism?

Dissociative symptoms are part of the biographical history of many people with borderline personality disorder although they are not always recognized or acknowledged. On many occasions, the clinician "discovers'' dissociative symptomatology after years of treating the patient.

Identity disturbance in BPD is often related to a sense of self that is not coherent or stable and is easily influenced. Many clients search for information before and after being diagnosed. Confused individuals with personality disorders, especially BPD, tend to over identify with information they read, see or are told about.

Dissociative Disorders and Autism

In recent decades there has also been an increase in the number of clients identifying with autistic symptoms, with many young people or their families asking for an assessment to better understand their loved one's difficulties. Some people with autism may have difficulty with complex thinking, which requires the ability to make quick connections between different trains of thought. These may feel very different to each other - as may different emotions (states of mind). Some people with higher perceptual capacities may be able to process more information including irrelevant information that they may find harder to ignore.

When autism is treated as a set of behaviours that need to be reduced rather than as a reaction to overwhelming emotional, sensory and stress responses, we train people to ignore their distress. If you are taught to respond to stress by burying your feelings and suppressing your reactions, you are being trained to dissociate (Titman, 2023). Taking away the ability to identify, self-soothe, minimise, and escape stressful situations leaves few healthy coping mechanisms. Emotional regulation can be a challenge and some people with autism resort to imaginative ways of regulating (including creating imaginary inner worlds, developing characters and having imaginary conversations / interactions). It becomes a good way of avoiding the real world when resources are lacking or things become too difficult to cope with.

Keeping in mind some autistic presentations, and being trained in differential diagnosis, can also shed light on cases of disordered identity, as many identify with both DID and the autistic spectrum. If, in the search for answers, clients with identity disorder also identify with autism and receive this diagnosis, the entrenchment of symptoms will end up having a snowball effect, making the case even more challenging to treat.

The influence of the media in Identity Disorders
The image of DID is more associated with movies and literature than with recent research and clinical experience. Many of the versions presented in the media are far from reality. In fact, dissociative disorders often go unnoticed. Multiple personality disorder or dissociative identity disorder does not usually present itself with the spectacular images of the film The Three Faces of Eve or the more recent sitcom United States of Tara, but instead hides behind many symptomatic conglomerates.

Few clients with Dissociative Identity Disorder (DID) or Multiple Personality Disorder present in an overt and obvious way. Nevertheless, even when they do, the lack of training and experience that many professionals have with the disorder means that the signs go unnoticed in the presence of other symptoms or problems. Like a chameleon, DID can take on many different appearances and these patients often receive different diagnoses based on the most obvious symptoms at any given time.

A dramatic increase in media messages presenting these disorders as "cool" may contribute to some of the identity disorder problems we see in clinical settings.

How to differentiate between Dissociative

Disorder and Identity Disorder

Clients who present themselves as false positives with symptoms of Identity Disorder, do not usually show avoidance and phobia of voices and parts. In fact, they often show great interest in talking about their symptoms and diagnosis, tend to talk about them without difficulty and some even seem very comfortable doing so. Not only do they not hide their symptoms, but they introduce themselves through DID in a variety of settings, using phrases such as, I am Lorena and I have DID or I have BPD and multiple personality disorder.

There is usually no internal conflict. Instead, conflict arises when we try to understand something we are being told. They may become anxious or upset when the interpretations they have made are explored or challenged, making it difficult to manage therapy. The discomfort comes from questioning interpretations and/or explanations, not from exploring symptoms.

We will explore how these clients tend to present the various symptoms through which they try to show their dissociation.

1) Horizontal and vertical dissociation and maladaptive dreaming

Horizontal dissociation refers to a disconnection between the self and the environment that is reflected in symptoms of derealization and depersonalization. It often reflects an inconsistency between behaviour, perception and verbal expression. Vertical dissociation, on the other hand, refers to the coexistence of separate mental systems, dissociation understood as fragmentation, as described by the Structural Dissociation Theory of Personality (Van der Hart, Steel and Nijenhuis, 2008). Maladaptive dreaming involves creating imaginary inner worlds, developing characters and having imaginary conversations/ interactions.

Many clients with Identity Disorder give examples of vertical and horizontal dissociation as if they were the same. There is a tendency to focus more on textbook examples of vertical dissociation while trying to describe symptoms of horizontal dissociation. Complex inner worlds can also be described with multiple characters interacting. Clients may also have imaginary selves in the inner world which may be confused with dissociative parts.

2) Memory and dissociation

These clients tend to use technical terms and theoretical explanations (from reading, listening or watching information) that are not personalised. They tend to say things like; "I have memory gaps; I dissociate; my alter is here; or I am dissociated." Other examples of what clients might say are: "I don't remember anything, because I have amnesia, you know?" without the embarrassment and phobia associated with this kind of experience; "I don't remember anything from the previous session", even though they weren't asked about it and show no real discomfort; or "I wasn't there, alter so-and-so was there."

3) Disconnection:

We may see sudden changes that seem strange, rather than spontaneous or consistent with what is being worked on. They tend to say things such as, I'm disconnected or I've just disconnected, but often express them without any real discomfort or phobia; there's no surprise in the face of these disconnections. Sometimes these changes and/or phrases occur when they do not know what to say. This often happens when asked about details of the internal system or parts.

4) Depersonalization, derealization

Clients often speak of depersonalization and derealization, using phrases such as, "I am depersonalising or I feel derealization," which are not often used by clients with DID. What helps us most to distinguish the difference, is the lack of real discomfort and the contradictions or lack of coherence between what is happening and the symptom.

5) Fragmentation of consciousness and identity

Many of these clients often speak in the plural unnaturally, as if forced, and correct themselves by saying, "I want... Sorry! We want"..." It is also common for them to allude to being a complex system, explaining clearly and without hesitation the composition and functioning of the structure of the internal system. In session, they refer to what the parts are saying without showing conflict. Even if they haven't done any therapy, they may say things like, We are upset because you won't talk to the other entities, they have a right to be heard too. Again, if they talk easily about their parts and do not show inner conflict or dissociative phobia. They will say things like, Yes, I have many personalities, if you want to talk to one, you tell me and I'll bring it out. Another example might be blaming other parts when exploring an episode of aggression. Saying, It was the bad one, without any phobia or surprise is quite common.

6) Bodily symptoms

We may often see these clients making theatrical gestures, without genuine shock or surprise; or showing a dramatic reaction that does not fit with what is happening. They may laugh when they say, "My arm got all stiff and I couldn't move it, everyone tried to help me but I couldn't get it down"; or stop when they walk into the office and shout, "I can't move, I can't get in!!" Secondary gain is usually more obvious and we can see clearly that it is not a real protection of the system, for example, cases where fainting spells only occur with a specific person or to achieve something. They may get to the point of displaying pseudogeneralized seizures without losing motor control (for example, having a seizure while sitting in a chair and not losing posture or falling).

7) Intrusions

These clients often seem to be talking to the voices during the session, and usually explain that their parts are giving them reminders or commenting on what they are saying. We have to pay attention to whether the conversations with the voices in the session tend to happen in a friendly tone. It is common for them to say things like, Excuse me, some memories are coming up or Wait, I didn't understand what just happened, I was just tuning out, when exploring something inside that the client does not know how to respond to. Expressions such as, The voice does not like what you just said, along with a gesture of strong agreement with the voice are also common. There is a tendency to use the voices as an excuse when trying to avoid certain subjects, for example, saying things like, Wait, the voices are talking to me without being asked about this and without anything having happened.

Therapeutic Work with Identity Disorder

Some of the aspects that should considered in the therapeutic work are listed below::

- Establish a good alliance and a safe context in which to explore with curiosity. Use relational interventions.

- Prioritise understanding what the person is saying in order to create a trusting and safe environment that allows confrontation to take place from a space of concern, empathy and respect, rather than guilt and blame. By doing so, it can be received as help, not as an attack.

- Pay attention to defences and validate them.

They have an important function. They help us to adjust the pace. Premature confrontation usually activates more defences and the person will become more attached to the constructed identity.

- Connect the history and how the identity has developed as protection and defence as soon as the client can tolerate the awareness of what has happened. Help the person to make the connections whenever possible.

- Explore dissociative symptoms beyond a screening. Focus on the examples, as they will help us to distinguish between narratives, constructs, and realities. Avoid focusing on symptoms alone. It is important to get to know the person as they really are, not only as they have learned to present.

- Look for contradicting information and changing themes. This is often telling us about what the person may be struggling to access, share or realise.

- Help to identify real support that is unconditionally present, where there is no need to be different and/or act through characters or identities

Conclusion

In addition to everything else, I would like to emphasise the importance of dealing with countertransference when treating cases of disordered identity. These clients present a serious problem that goes far beyond a need for attention. The underlying issues need to be understood and treated with an attitude of curiosity and respect. Confronting our clients without really understanding what is happening and why will only lead to a worsening of symptoms, which in turn will create a greater need to seek more facts about symptoms that can help clinicians "believe" them. If clients do not feel understood, respected and validated, they will drop out, change therapists and add a new repertoire of what not to say in the next treatment, further complicating the clinical picture. The more diagnoses they receive, the more lost they will feel, the more dysfunctional learning will need to be dismantled and the more difficulty the next therapist will have in getting a glimpse of the real problem.

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