

Background to Discussion

Interview with Remy Aquarone on the nature of Dissociative Disorders and how they are treated.

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The interview was undertaken by David Maxwell, currently studying an MA in Writing for Performance at Goldsmith College, University of London. His final dissertation is a full length play exploring the effects of Dissociative Identity disorder.

[Remy] One of the analogies I often use is comparing dissociation to countries previously in a state of war but now struggling to adapt to peacetime: these are very closely tied to what happens when a person with a dissociation disorder continues to use this survival condition, when no longer necessary in adulthood: it is so templated that it's very hard to change. If you think of more recent examples – people coming back from Vietnam, trying to get back into society, hearing a car backfiring and immediately reacting by reaching for their imagined weapon – their mindset is still back on the battlefield... so that an actual backfire from a car exhaust is interpreted as gunfire raining down from the enemy: their whole system is geared to dealing with that...

The difficulty with the Second World War was not only during the war itself but the aftermath of war... peace. War is and was a question of survival so all the resources go into survival – industries are re-equipped, defence systems, radar systems, bombers, everything, the whole infrastructure, because the basic bottom line is that you have got to survive, and in fact people who were living in the blitz – their whole lives were one of dealing with the immediacy, because you don't know if there is a tomorrow – you just deal with today... you deal with the emergency of today, the bad times, and then you move on to the next thing and you don't carry in times of crisis any timeline about it, you just move from moment to moment to moment. The problem, as I said was when the war was over. Not only was it really hard for soldiers to accept the implications of being demobbed, their brain in a way was still geared to a whole structure of combat: they found it really difficult to adjust, but in fact the hard times in Britain was the psychological impoverishment afterwards when the factories went back to what they were used to doing, people had lost the ability to think about the long term and also all the other things catch up, all the psychological effects. Britain faced years of psychological depression.

It's a luxury to start thinking about and feelings things 'til its safe to. If you've got a teacher that's trained to do first aid, if something happens at their school – I remember a teacher telling me on one occasion she saw a child hit his head and cut himself really badly and fall in the playground and start crying and screaming and she said "I did everything I was trained to do – I went to him, I gave him first aid. I stopped the bleeding, I got him the attention and it's only when I got home that I burst into tears with my partner" and you can see that's an appropriate thing. If she started saying "poor you" and started comforting him, he would have died. So you only do that when there is room for that and so with someone with this condition (dissociation), you do whatever's necessary; you use every resource within you because the bottom line is to survive. And then afterwards, you still have your antennae out – you still jump at every bang and every thing is going to trigger that reaction...and also you have no experience of a timeline. In therapy, people could have been coming to see me for a year and its like every time they come for therapy it's a bit like groundhog day, it's like its the first time they've been there – because the thing about the psychological reason for having no timeline is that if you tick it off and it's then gone from consciousness, you are not going to hold on to the psychological damage of remembering and it's a bit like the psychological equivalent of a physical coma, you have just got to be able to just shut right down. So, people will deal a lot with functioning and the other thing is that they will go from crisis to crisis. They will go from hyper-arousal to hypo-arousal and if its early trauma then (as with the early development of a baby) you are all geared up to everything being experienced as physical & chemical reactions where you are either in hyper-arousal or in deep depression and there is no thinking or middle ground....

[David] That's really fascinating – especially the comparison you make between the condition and wartime...

[Remy] A lot of these things have parallels with the way people relate to each other. A lot of the work I do now is trying to get the psychiatric services to not only offer appropriate treatment but to know what's effective. I call the dynamics of what goes on in such institutions, institutional dissociation, because what you have is someone who has got this condition, its not just dissociation because it applies to anyone with significant trauma background, they act on this hyper/hypo-arousal and you get professionals re-acting in the same way and also splitting, so you get one patient who will get one professional to change what's been agreed and you will have reactions from other professionals who will get angry... and so the work that I do in an organisational way with psychiatric services (when they are open to it,) is to say that what is as important than the treatment offered, is to have a good functioning family [the analogy of a multi-disciplinary team with what happens

in a family]and that the professionals, they all have to work together. Yes you can have parents who disagree but you work as a parental couple with your children and that is not meant in a derogatory way but the same principle has to be there if you've got professionals, who are involved in trying to help a person who is in real difficulty. First of all, all the decisions are made in meetings together with the patient there so you don't change it until you meet again. Otherwise what can happen is that say 2 professionals who are very good at their work, both have got on alright together, but they start battling each other over who is right and who is wrong, and that is a projection partly from the patient, because that is their (the patients) experience and that is what they are used to perhaps from their own family.

[David] I read your article you published on the Pottergate Centre website and one of the things I found really interesting was the suggestions that a lot of outpatients in psychiatric units are misdiagnosed...

[Remy] That's often the whole problem- the whole approach from psychiatry. Not necessarily because they are being malicious at all or bloody minded but because there is ignorance, or there is insufficient support among themselves and the trouble is, as private therapists, we have someone who we are supervised by [psychological as opposed to management supervision] , so you get a fairly good structure where you get support ...whereas a lot of professionals are overworked and left working on their own and they will either take the easy route or they will get worried if they start thinking this might be different and it doesn't fit in to the norm, (to the norm they are used to) and of course they are (with a small 'c') very conservative in terms of changing things and this requires quite a leap in approach. You either get misdiagnosed, and a lot of the people that contact us here have had 10 15 or 20 years of involvement with the psychiatric services... and it's ignorance often because someone with DID may present differently at different times – they can be absolutely suicidal, make an appointment, get a referral to a psychiatrist, come along and either be cut off from the fact that they were suicidal and so they present as fine and not be quite sure why they are there and will chat away or they are very careful because they think they are going to be misdiagnosed as psychotic.. Either way the psychiatrist can in all fairness say “well you don't seem to fit into the criteria, you seem to be doing fairly well. I would just encourage you to carry on, come back and see me in six months...” and then they go away and make a serious suicide attempt. Or you get professionals who say, "you are just playing up, you are manipulating,” using some sort of derogatory word, and then the patient will either become compliant and self blaming or else become aggressive which will get the professionals' backs up....this repeats the sort of negative parental experience they have known from childhood....a repeat of

inappropriate power, it can be all about power structure and conflict , it will make it even worse, and people [the patients] will come back and see them as being unhelpful, and then the whole cycle repeats itself and continues. So familiar for someone with trauma and attachment difficulties.

[David] What is the attitude of your clients when they first come here?

[Remy] Unless they have been sent by a colleague or a partner, which is always problematic as opposed to wanting to come themselves, or sometimes when the psychiatric services have appropriately said you should go here then they would be quite apprehensive, but it's usually a relief, because I can usually understand what's going on and I can fairly quickly know whether it is that, without going through a complicated assessment which I need to do anyhow, and so being used to a language which makes sense. They are often very frightened that they are crazy, that they are weird, and it's not, it's one of the most primitive forms of survival, and if they hadn't done that they would be psychologically a complete mess. It's like the people who came out of the concentration camps, those who survived best were those that for years had a psychological coma, had no memory of it and it is a coma because the brain can't deal with it, it's too much. So, what you do, it's a bit like physically being in a coma, you shut everything down so that you are left with the minimum needed to allow for recovery of the brain. People from the war, or tank commanders, some of the people who had horrific claustrophobic experiences as well - it's only maybe ten, twenty or thirty years later that they get what would be then called 'breakdowns', where the whole ability to continue in life in an apparent normal mode collapsed, where the memory started leaking through which actually means it is ready to be dealt with which of course is a horrible thing to experience because you have these flashbacks of memories, whatever they are, which were too horrific to deal with at the time. So it's generally a relief, the difficulty then is having to try to deal with the reality – on the one hand they need help - but the reality again that they may not get funding or the right treatment for them and that is a difficulty. So, the thing that always impresses me is that - it's getting a bit easier now, but I can be writing whatever report and say all the right things, but to really get something changing it usually takes the person themselves, who know their rights and will push push and push till they've got it. That's what gets the change.

People with difficulties because they dissociate seem to come into two broad categories. You've got those who are high functioning, who may be from any profession, whether they are judges, solicitors, doctors, whatever, high up in business. People who meet them at work etc may say they don't really know them very much, but then either all that breaks down or there will be a huge contrast between how they are in their professional persona, and how they

are at home. And then, though it causes a huge crisis it may be the right time where it has got to start being processed. Until that time, people may not be aware that they are any different to anyone else. Often they say that they are aware that they lose a lot of time, everybody does...but actually it's significant, it's like not only hours, but days, or they find themselves in situations they don't know how they got there...whether it's sometimes, in bed somewhere...someone's house they don't know who it is, completely shocked and trying to get out of the place, not knowing how it happened, like someone who is so drunk that they don't know what's happened. Or, there may be two or three very different lives going on at the same time...

or you get someone who has been, right from early on, in the psychiatric system, and is on benefits and can never really...in a way so institutionalised that they have never been able to get out of it. Or is highly medicated, nothing changes, have a terror of the conflict inside and wanting more medication. Because there is the ambivalence, on the one hand some people may feel that they want the help and feel that at last they are getting it, and on the other hand, none of us would be particularly happy about finding that suddenly there is a whole other world going on in your head, and you are told it is part of you whereas all you want to do is get rid of it. And get on with your life.

[David] You say in your article that the NHS tries to promote the use of drugs in these situations...

Oh yes, they say that the voices...they are confused with psychotic voices and so they say we will help you get rid of these voices. One of the tests is that antipsychotic drugs don't usually work and so they try heavier and heavier ones and the person is more dosed up and still the voices are there. That's one of the very basic things...it doesn't happen all the time, and yet it is not recognised. The other problem is a political one. The problem of recognising it is that you then have to provide a treatment that is appropriate. It doesn't fit in to the short term CBT (Cognitive Behavioural) therapies that are all the rage now, and so it means we [at the Pottergate Centre]are doing much more trying to be realistic in our recommendations about what's needed...I mean some people with this condition may eventually need ten years or longer for treatment, but it's about getting enough going so that the person can then have choices about what to do next...including if necessary get some work to pay for therapy themselves, You have to be realistic in that public funding cannot be a bottomless resource. Usually it's 2-3 years that we recommended with once or twice a week therapy which can be seen as a lot of money but in terms of...we are still waiting to do studies with the long terms effects of someone who is not treated and you add up all the costs, in and out of hospital you get people who have 15 different professionals

involved, you add that all up and that's 10 times the cost. Like politicians, the NHS doesn't generally want to look at long-term funding for something...they look at the immediacy of the budget and the immediacy of the problem and how to minimise it.

[David] From my research, I get the impression that those who have developed dissociation later in life might be more likely to suffer from psychogenic fugue whereas those who have suffered abuse may suffer from the more extreme kinds of DID.

[Remy] First of all, Dissociative Identity Disorder (DID) under DSMIV (Diagnostic Statistical Manual used extensively in The States) is called Multiple Personality Disorder, (MPD) within the ISD 10, which is the European diagnostic manual. DSMIV criteria are used because America is the only place where they have the right assessment tools that have been validated. The thinking years ago were that it was all due to sexual/physical abuse, whereas the feeling now is that it is primarily an attachment issue from early childhood. You start from the very simple notion that no animal or human can survive without a connection (attachment) from the start. If young ducklings when they are born don't see their mother around they will go to the first moving object, even if that happens to be a human. You can see pictures of, for instance, a farmer's wife walking along and you've got ten ducklings all following her, and they can't differentiate, it's inbred, that you are not going to survive unless you attach. So, a baby born has to have that attachment, and we, in our lives, have to have that attachment, that's why...a lot of people are very stuck with this notion that we have to be absolutely sure who we are...so the notion of multiple personality is an alien one and quite unsettling, whereas it doesn't take that much for any of us to lose a sense of who we are... if you have lost your job and that job is important to you, people will describe feeling that loss, they don't know who they are anymore. Part of who you are – it's obviously based on the more your childhood was secure, the more you carry within you a positive model of parents so that you sort of have them inside you so that you can keep referring to them, they give you a sense of confidence. So that helps obviously.

Other people have very strong religious beliefs, so that is another sort of attachment, because someone like Terry Waite, when he was captured: even though everything about that experience nullified any sense of who he was, there was this other attachment, that because of his faith, it kept him going, it had a higher importance in that sense. So, we have to have that, as babies it's obviously the adult around you. Now if that is a survival thing, it doesn't matter how good or bad that connection is, in order to survive you have to maintain it. I'll give you an example. You've got a child, and mother is depressed and in psychiatric hospital most of the time, and so that the main

person who has cared for them is their father and there is no other sibling or any other adult around, and 80 or 90% of the time that father does everything that the child needs, feeding, clothing, reading stories, very kind, caring for them, then 10% of the time, (maybe when he goes out and gets drunk) he abuses or hits her or sexually gets involved with her. Neurologically, the child is not in a place to make sense of that, that the person who loves you is also the person who hurts you and even if the child doesn't know about hurt, it senses that there is something there that is not right about it. The most important thing is to preserve the attachment and to preserve the attachment what the brain does is to separate those two experiences, the same way that the concentration camps survivors separated their experience of the past with the present. The child, in order to maintain the good experience, separates that out from the bad experience, so that the two never meet. A bit like a submarine, there is no leaking between the water and the air, they are both there, you have to have both environments, they are crucial, you have to be able to breath as a member of the crew but you also have to have water as a means of travel but they are kept very separate and that works very well. The trouble is the earlier it happens to a child, the more it gets templated into the brain system but the primary thing is that the attachment has to be there, and if there is no good experience the attachment still has to be there and that is why you get wives who are beaten by their husbands and they would talk to their friends who would finally convince them to leave and they would say that their friends were right to convince them to leave, and then either they would go back to their husbands or they would find the same sort of adult male because that is the only experience they have of attachment, they only know attachment through violence. So, it is no use telling someone that this or that is not good – that they need a loving caring person, they may know this, but if their only experience of feeling connected is through violence...it's a template. Only once stronger attachments are made with other people and with the world around can it be possible to move away from abuse. Otherwise the person's whole world would collapse. What's worse for someone is to have no attachment, because for that person you find yourself in an abyss, you go into fragmentation, it's like having nothing around you to feel connected to, no solidity. It's like going into space. It's the most terrifying thing and actually being hit feels like peanuts in comparison...And that's why some professionals find it difficult to deal with self-harm. They think you must stop that but self harm may be the only way of feeling connected again. Often people don't feel the pain because they often dissociate, but that is the only time where they can feel real, because they are hitting something that is part of their body and for a little while that is a fix for them, it feels like a relief, whereas just staying there in the vacuum, that is absolutely terrifying.

In answer to your question, there is more likely to be serious physical or sexual abuse with someone where there isn't enough of the ok bit of connection. Many of the people who are in long-term psychiatric care have multiple physical problems because the body stores memory better than the brain (though I realise that ultimately everything is linked to the brain), so that people can have every conceivable physical pain and feel the pain and yet often when they go for an examinations, there is nothing that can be demonstrated. There can also be pain that is to do with scarring, to do with some really nasty stuff that's happened. And the more it is fixed in the body the more difficult it is to change, because it just seems to have found its roots in it.

[David] If they have had a physical injury in the past a long time ago, the pain has healed physically but not mentally.

[Remy] That's right. So in other words, it's like a time warp and it's a bit like dissociation, because there are often people with DID who have got younger parts and that part is stuck at say the age of eight, and sees the world as an eight year old, even though they are in a big body, they will talk like an eight year old or four year old etc and will see it and think that they are a four years old, and look and be amazed and think "who are you" even though they may have come to see me, it's the adult who has come to see me. And I don't know if you remember there was a story a few years back about a Japanese soldier, who hid in the jungle for something like 20 years thinking that the war was still on....he had just hidden surviving, not daring to come out because his duty was never to be taken alive, and when he did come out he was in a completely different world, the cars had changed, phones, whatever else in those days was different, it was like that and the research that is beginning to go on, in Holland especially, is beginning to show that when someone's memory is triggered going back to a traumatic event when they were younger it is measurable that their brain volume in some parts of the brain are different. It's a bit like modern cars where you can preset the seat so that the main driver can preset his position in the car and it is a bit like that, there are presets in the brain...

[David] What is the difference between DID and dissociative fugue?

[Remy] I think most of the DID cases, virtually all of them, are because of childhood trauma. There is a book, it's called...The Haunted Self [Steel, Van de Hart etc]...their model is called structural dissociation. Their approach is to say that all trauma has a dissociative element to it. It starts from simple PTSD, which can be from a car accident. Complex PTSD which can come from prolonged exposure to war and civil unrest and to dissociation. So that's one thing to look at. With PTSD, a car accident, you get the first split between

what the book terms 'the apparent normal personality' (ANP) and the 'emotional personality' (EP). Normally we have the ability to act in a particular way to suit the situation, it may be very formal with no emotional content, for instance we are trying to form a business plan or a loan from a bank manager, to intimate situations where of course you have a lot of emotion. But there is an overlap between the ANP and EP all of the time. We are always dealing with a recognition of our emotional self with our intellectual self. With temporary PTSD there is a temporary split between the ANP and the EP, because what happens after a car accident is that there is amnesia for a period of time leading up to and involving the accident so there is a gap. People can often be very flat about the effect and fairly non emotional and just be very practical, so there is that split where you appear to be ok and there is no physical injury, and eventually that joins up and you have to go through some sort of crisis or be in need of psychological help and it puts that back into balance. There are also natural ways in which it is appropriate to do that – for example that teacher who had to help the child in the playground. It's an automatic and involuntary process which bypasses the normal processes.

There is an interesting thing, about most parents (and mothers in particular). Let us say that a particular mother might generally be considered very mild and never lose her temper: yet if she has got young children and someone knocks on the door and someone who is seen as a threat, she will bypass her emotional ability to feel frightened and go straight for the threat and say something like "you get the fuck out of here", not realising that she could have been in trouble and not realising until afterwards that she could have been hurt, it's back to that innate maternal need to protect. The force of her conviction and determination also gets her more likely to get rid of that person in a hurry. Much like an animal who shows its colours to get rid of the enemy and then things stabilise again. Now the trouble about something more extreme is that they remain still separated. The DSM IV has 5 criteria for dissociative disorder. The two extreme ones are DID (Dissociative Identity Disorder) and what they call DDNOS (Dissociative Disorders Not Otherwise Specified). Those two are the ones that will be diagnosed the most for someone who has a dissociative condition due to childhood trauma. Dissociative Fugue is a temporary loss of identity, temporary loss of knowing who you are or knowing your past with wandering from home. Onset and termination are abrupt. So there was sometime ago someone whose canoe was found on the coast and was presumed dead and his wife then claimed the life insurance and then the man turned up a few years later at a police station and said I don't know who I am, and I don't know what's going on: and it turned out to be a hoax, because it had supposedly continued for over 2 years and was not a temporary state. You come across it with someone with

DID – they can go somewhere else and can go AWOL for two months at a most, but usually it's for a week or so.

[David] Essentially, dissociative fugue is part of the wider condition....[Remy] That's right. I think fugue is also part of an old language.[David] Just to backtrack a little, what kinds of people work with people who have DID? [Remy] Traditionally, all the work has been done in the voluntary and private sector. Even though people might not understand DID for what it was, they would stay with the person and work out what was wrong and try to make sense of it, and it's generally been either not recognised or not believed in psychiatric circles. To be honest, in training in psychiatry, dissociation is not usually covered.[David] Even today...[Remy] No. So people who are trained to spot schizophrenia are more likely to say that it is one of the psychotic voices. Traditionally, it would be people from the voluntary sectors, in drop in centres who are private therapists. Also, psychoanalysis has not helped. Although dissociation was known in Freud's time and Charcot's, one of the early ones, and Janet, who is probably the pioneer of dissociation. Charcot's thing was with people who had hysterical conversions – suddenly you had people who could not control their bodies, suddenly their hand would be up there and they wouldn't be able to bring it down is one of the earlier manifestations, and then Freud, partly because he was isolated in his world in Vienna and partly because he needed to...it was a new field anyhow and he did a huge amount of work there. But he was hearing about abuse from parents talking about when they were children or friends saying...and yet he was in a culture that wasn't going to accept the notion in those days, especially in a very middle class upright society, that there could be such a thing as incest and abuse. Even in this country we found that difficult to accept for years. First of all it didn't exist. It wasn't that long ago when people thought this just happens in the working class families and then suddenly we realise it happens in every sphere of society. You can get family abuse. And so he did a disservice, in that he called them all fantasies. He said this [fantasies] was a natural part of growing up especially into adolescence, it was all part of growing up and the Oedipal complex, he saw all of that as that. He said these were fantasies of children who in a sense had too much imagination. Or were jealous or wanting to get their own back on their parents.. It's only in the last 8 years in this country that psychoanalysis began to take on the reality that abuse does exist and it needs to be taken into account in therapy, and then interpreting from that what it was really about and what the child really felt.

I came across this twenty years ago. I was trained analytically. I will give you one example. I used to have a consulting room in town in Pottergate and I used to have a door bell that people would ring downstairs, and then they

would come up. On one occasion the bell had stopped working one morning and I had forgotten to do anything about it. So my client rang the bell and nothing happened and I couldn't hear it, and eventually they got someone to let them in and they came up and rushed in and said 'there is something wrong with the bell, I couldn't get in'. In true analytical terms, you would say to that "what did that feel like?". Now it's fine with someone who hasn't got a serious trauma attachment background, because you can find out what that felt like, does that remind them of other situations where they have felt out of control etc. But when you are dealing with someone whose whole world had been turned upside down and where their reality is never clear, where someone abuses you and tells you they love you, when one moment they behave one way and the next moment, things are turned upside down. When your guts are telling you that something is wrong and you're told that is not the case, you are just being difficult, everyone else is happy with things, that child eventually loses their ability to believe their own self. They have no grounds on which to test their own reality, so to say something like that would be re-traumatising, so you do the opposite. You say 'it's not your fault, the bell is broken. I'm sorry I didn't come down and tell you. No wonder you are upset about it.' You confirm the reality. Every intervention you make with someone whose background has been completely screwed up is to confirm the reality of what's going on. So if someone says 'there is a face there', (pointing to the wall) you say 'well I don't see that face, but you do.' You are not denying their feelings; you are the only measure of some sort of normality, or role model or template. The trouble with psychiatry is that professionals are often confused between the need to be professional and the need to be real so they will hide behind a language which they have learnt to say. It's a bit like when you get called from a call centre from someone who is going through a script and you always know they are going through a script and I am always tempted to not try and fit in with the script, and put the phone down, because they are being automatic. They have got none of their feelings there, none of their empathy there, and you've got to have empathy and not categorise someone immediately and actually listen to their story no matter how crazy it appears even if it's psychotic and that's something that a lot of professionals are not good at, and a lot of GPs used not to be good at it either, but now they are a lot better, but the secondary services are still way behind. When you've got someone with that background who goes and meets a professional you've got this multi-layered thing, where immediately when they come in front of someone with power they become infantilised, because that's what they are used to.

You take on the role of the parent figure...

That's right because trauma of any kind, whether it's physical, verbal or emotional, it's about inappropriate use of power. There is nothing wrong with power...however where psychoanalysis was and can still be detached and un-empathetic and cruel sometimes, the other kind of therapy which is person-centred and which has fantastic aspects to it, can be too much the other way at times and can give the following message: 'it's ok, all of us are the same, we are all the same' and the trouble is that doesn't help. As a therapist, you've got power; there is nothing wrong with power. It's if you abuse that power that its wrong.. You've can't have a flattened hierarchy and you've got to have appropriate use of power. So, on the one hand you have people who become infantilised, but on the other hand, they have finely tuned antennae, because it's like when at war, the more radars you've got the more ways you have of detecting what they are going to do and so you can prepare yourself and so you can pre-empt it. Survival, often for a child, is about knowing very quickly what is going to happen. Adults will tell you when they are talking about their abusive childhood, 'I knew from the moment he stepped in to the room, from his facial expression, from the way he looked at me, from the way he talked, whether it is one of those days when it was going to be alright or one of those days when it wasn't.' You have a measure of preparedness if you know ahead of time, no matter how powerless you are. What I mean by that is that most people with severe trauma will know whether someone is bullshitting, whether they are being genuine or not, whether they are hiding behind their profession. That's another area that professionals don't understand. You know, I have been to meetings where I could just tell that a professional person was just not there [not grounded in reality] and that's no good. You don't have to be unprofessional and say I am your friend, you just have to have that genuineness, and that's what people coming for help need.

There is also the risk with therapy of creating the pathology, or creating some sort of false memory...

Yes. Anyone who has power has the power to influence, and in some ways you can't stop that. Again a parent has got power, and with parenting, where things are good enough, where younger children might say 'daddy knows everything', well he doesn't know everything and as you get in to adolescence, you start rejecting your parents you start having to find your own identity, and eventually in adulthood, as you get older, you might reconcile yourself that some of it made sense, and some of it you will never forgive your parents for and some of it you will accommodate. But the notion that you should always reconcile everything about your parents is a middle class myth and sometimes people don't and nor should they.

The way you have described that reminds me of becoming a teenager, because in a way becoming a teenager involves aspects of dissociation...

That's right and if you never rejected it, you would never leave home. Teenagers can have a way of being very self-centred and oblivious, and however annoying that is it does mean that they can find a way of pushing away. You do need that, you see, and that's an appropriate thing, and sometimes assessments for teenagers are different because some of that teenage 'apparent madness' is seen as part of a natural process...so the first thing is to recognise your power as a therapist and that it's there. Then there are two things in therapy. One is, I never set an agenda. Unless there is something very urgent, I never set an agenda, because I never know what is going to be important to that person. Especially dissociation, once they have come they might have completely forgotten about something or they may be in a completely different state. So my responsibility is to fit in with their language and not the other way round. Originally with Freud, people had to learn his language and if they didn't they were either resistant, or they were 'unsuitable for therapy'. The other thing is, I never say a word that I haven't heard that person use in terms of memory. So if someone in therapy is telling me something about their childhood that sounds abusive or inappropriate, I don't say anything, I just wait and see. Any word that they have used I can use, and that's the safest way, because then you are using language that has been used by them not by me. This will avoid false memory or memory implanted by the therapist. At the same time there is no doubt that psychotherapy is about someone taking in what you, as a therapist, have said and explained and trying to see if it fits their reality. So there is a delicate balance, but with trauma, so long as you are aware of this...I have to come up with some suggestions, but not to do with trauma, because otherwise in therapy you'll end up in a vacuum. As long as you don't say "I know this is right, and this is how you should interpret your dreams etc", but instead tentatively wonder about something, then you are opening up the possibility and the other person can say 'that's nonsense', or "you are crazier than I am", or "I'll think about it" or they will say nothing at all. But unless you make some suggestions, you are often leaving a completely sterile space, and in some cases you have to do a lot of inputting, with someone whose life has somehow got impoverished and flattened, trying to build a curiosity back in life for someone who has been severely traumatised.

The other thing is about memory and my understanding of memory to do with severe trauma and therefore dissociation. The issue is not so much to do with 'is memory reliable or not', but it's a bit like a computer. If you think that a computer has two aspects to it, one is things are stored in files, secondly you can have two different log-ins, for example one I use and one my secretary

uses, so she has her password to get into her part of the computer and I've got a password to get into my part of the same computer, and you can even have partitions in terms of how much memory is used for processing and how much is used for backup and how much is for rebooting some of which you have no access to. Everything's there in someone with DID but it may be in all these different components, and none of it is being put into any directory, not only that, but have you heard of de-fragmentation of a computer? Automatically, or manually, every so often the computer, once a week or once a day will go through the whole system and get rid of unnecessary files, clean it up, so that it is functioning at its most effective. Someone with DID usually cannot do that. Whereas we will naturally, if we haven't got dissociation, we will naturally dream and in our dreams, part of it is getting rid of unnecessary information. So that a lot of our memories we cannot remember, they are insignificant, usually, but we do remember significant good ones and significant bad ones.

The paradox is that whereas someone with DID quite often has complete amnesia for things that happened in the past, for whole chunks of memory.... the problem is it's all there, more than necessary, too much..... so the whole thing slows down like a computer that hasn't been cleaned up, it's all over the place, and there is no putting into directories, into categories. I don't know if you use a computer, but you have got to put things together. Your research into DID has got to have its own area. You might have one directory and then sub directories and then files within it, to help sort it out so that you can access it and we do that naturally, if we are not too traumatised by the past, we begin to do that naturally in our brain. So, to begin with [in DID clients], it's not that there isn't memory there. It's just all over the place. So people may have a memory to begin with about an event, but it turns out later on in the therapy, either it never was there, because somehow they've held on to this and it's not there, or two events have been confused, put together as one. It's a bit like if you have seven witnesses to a car accident, you might get seven different experiences of the event when the police investigate. It's not always going to be identical. Because people will notice from different angles, different parts of it, and when you've got someone who is dissociated, you've got the ANP [the apparent normal personality] that will often have a very good recall of events but no emotional content to it and they tell you about it but are not impacted at all – “oh yes I was abused and I got up...” and meanwhile all this emotion is split off, so you have to deal with memory very cautiously.

I accept it's their personal emotional truth, I am not saying the person is lying; I'm not saying that the memory is accurate. And if they say “don't you believe me I say “everything you say I am going to take seriously; I believe that's your

actual experience". 'You will know at the end what the truth is, but that doesn't take away that something fundamentally wrong has happened.'

The trouble in this area of work....the issue is rarely with therapists that they are too distanced, because if they are going to be like that they don't want to get involved, they are going to say either I don't believe in it or it's not how I work. The error is more that you get too impacted by it, you get too involved, you become like a rescuer, your whole life is geared to worrying about them, you keep checking if they're ok, you feel like you 're responsible, and that's a disaster because you end up burnt out yourself. The bottom line is that with someone with this condition, if you become burnt out and end up saying you can't cope, it's the worst scenario because the person will feel ' here we go again, I've always known I'm too much, I must be bad.' And though someone may not like it, you are better off in the beginning, if necessary, being very clear, even appearing cold and detached if necessary, but consistently there because what someone hasn't had is that consistent structure.

So whatever arrangement you make, you don't say "perhaps", you say "this I can do, this I can't". If someone's only coming once a week but you realise that's too much space between sessions then you might say, 'it's fine to send me emails, I won't answer them, we can pick them up and discuss them in the session because you know you can offload them and not carry them.' I may have an arrangement that they are coming once a week, and they need more, that we have a telephone session for ten minutes and they pay for it, but it's a fixed time and it's there if they want it. The boundaries are so clear and it's better to do less to begin with and see how that goes and then once that's tolerable....

...It's a bit like when concentration camp victims were liberated by the Americans, and the soldiers saw how starved they were and their hearts bled, they opened up their larders, they gave them all the food they wanted and then they realised people were dying, one after the other, because their body couldn't cope with that, and they realised that they had to give them a tiny bit of food, get that digested and then a tiny bit more. It's the same psychologically, you just start very little, because they haven't had any input like that and you slowly allow the psychological digestion.

And there is a risk of professional services people getting too involved when they are admitted to hospital....

Of course. Traditionally as a therapist I worked in this bubble (the therapist and client) and what was going on out there in the world was not important. Now with trauma work, where there are other professionals involved, we have to work as a team. I go to the professional meetings with the other

professionals as well as my client. You can do that without risking any of the client confidentiality, because it's about making sure that the client knows that we are all working together as a team (in a parental role).

The Centre here started trying to do that about ten years ago. There are going to be times when clients will need respite or emergency admission for a short period of time because of the level of distress through the emotional trauma memory emerging. What would usually happen is that they would be admitted to psychiatric hospital on an acute ward and everything at outpatient level then stops (therapy etc). The classic scenario would be that for instance the duty psychiatrist looks at the symptoms and says this is definitely bipolar, changes the medication, and then of course the patient is re-traumatised (this is familiar territory) screams, gets angry, becomes a nuisance, everybody says they shouldn't be there, and the cycle starts again. Or you get the one nurse, who really understands and starts feeling concerned for the client and battles with their own boss, and then of course this is all familiar territory again, and so what we had to devise eventually was a water-tight plan. It's a bit like pregnant women into hospital with a birth plan, because you know at the time of giving birth that you are not going to be in the state of mind to deal with it so you try and ensure that it's all there beforehand, what you want done when this happens, do you want an epidural etc. When it works well the patient needs to carry the plan with them so that if you have to go to hospital in an emergency, the doctor can see it and say "don't change the medication", minimum involvement, just get her there in a safe place, so that there is a streamlining. That has more impact when it works and it will be fought like mad to begin with because that is alien to a patient's experience, but it works. The first time it happened, it was incredible, for the first year and a half, my client kept going in and out and it would all go amess, eventually we got it together, she went in and it worked, so she came out and she never went in again. Because she couldn't disrupt it anymore, and of course it's frightening for her but suddenly the cycle was broken because everybody was working from the same song sheet. And that is more important than anything else but that is not most people's experience.

It seems there is no procedure in place for people who are first diagnosed with DID in terms of what happens to them and who they see...

It varies a lot. We are one of only two centres, the other one's in London, that have tried hard to change that structure. There are lots of therapists who try but I know that you have to have an organisation and then you are more likely to be taken seriously. That's why I have a colleague who is a psychiatrist as well because I am not medically trained so we work together. Here is a typical scenario: Someone with DID might for years have been high functioning, hold down a full time job and work all hours of the day and night...then this

eventually doesn't work anymore... so they go to their GP and will probably be diagnosed as depressed and then take time off and then be on anti-depressants, ordinary anti-depressants often won't do much good, and they go through a long cycle... they are maybe referred to secondary services, which are the outpatient services, where they may or may not begin to get the right approach to help them.

What happens here now, in this locality, is that I have obtained a service level agreement, so the Norfolk and Waveney PCT have been very good at agreeing to so many hours of specialised treatment and assessment...that this is required for appropriate patients. I do an initial screening, ask the GP to refer to the outpatient services ...but it does depend on which locality (even in this area).... some localities are very good and they will allow an assessment and follow the treatment guidelines, others will have nothing to do with it, even though there is a service level agreement, that's how it is. You've got that dissociation within the service.

And I imagine it sometimes falls on the individual to take the first step...

It falls on the individual as well as the locality, and some localities decide that they are never going to refer outside the services but at the same time don't offer the appropriate help. Even when the condition is recognised they will still try and fit a round peg into a square hole and they will say that they have got the treatment protocol required, put them in groups which doesn't work on its own. Or a more recent example: The Maudsley Hospital in London, which has been very good at recognising the diagnosis of this condition, doesn't treat patients appropriately. I believe this is partly because of costs. So their approach is to only treat the adult and ignore the other parts inside (the EP's: the emotional personalities) It doesn't work unfortunately. With something developmental like that where you've got that arrested development at different ages, in therapy you have to address this...., not outside therapy (there is this confusion sometimes that some people with DID expect everybody to be able to deal with different parts and their different names, outside therapy, and that's nonsense,) but the idea is that in therapy – any part that comes out I will relate to and that needs to be facilitated, because until you can get that going,.... the primary goal is to get that internal communication, between the ANP and these internal parts (EP's) that carry the different experiences of the trauma...and so not only are you trying to get better communication between those internal parts, by getting to know them and getting them to be aware, but the most important thing is you are getting that outside part to get to know them, because they may be amnesic to it.

So, in other words, as an example, Jane may come for therapy and treat this as a bit like bringing her children (her EP's) to a child minder, leave them

here and pick them up and go away again at the end of the session, so she comes along, and she says, 'I'm not sleeping very well, I know all about dissociation, but it probably doesn't apply to me, or I am probably just making it up, I have been coming to see you for quite a while,' and then there will be a pause, and there will sort of be a blankness, [Remy demonstrates a switch into a younger alter] and if I haven't met that internal part of her before, I'd say 'oh, hello, I don't think I've met you before', and she might say 'I am 'Rebecca' (some people will have different names for their internal parts) and you start getting to know what has gone on, you are sort of mapping her internal system.

I've also got to make sure that there is an adult around at the end of each session, I might say 'can I get Jane back', and then Jane comes back, she looks at the time, and she might say: 'my god, what's been going on', she would have no idea at all that for that last twenty or twenty five minutes, there has been another part of her there, so even though she might think she has made it all up, I am the conduit that sort of holds...I've got to keep explaining what's going on, so at least intellectually she knows that I have seen another part of her, even though she has no idea of it. As time goes, I might also suggest taping the session, and she takes the tape home, so that she can listen to it, or she might listen to it the first time with me, because it might be a freaky experience, sometimes people go white, because they have known in their head the possibility, but actually hearing it, it can be horrific and very frightening. They say, 'Oh I am crazy' and you say 'no you are not crazy, that's how you survived. You've got time loss and it's happening now'. Because you are also trying to do the equivalent of brain gym, and the taping to listen at home is to try and start getting those neurological systems to start connecting, they have been disconnected for so long.

Often one of the things that therapists can find difficult and professionals can find difficult, is to work with the more aggressive, angry, hostile part of the client. Some clients will come in and say that they are really frightened of and are controlled by this really dark part - nasty, sometimes they call it the devil part, and this can be the abuser part (often the internalised abuser) that makes them do things like cut themselves, or they may be aggressive or threatening or threaten to hurt the professional or can come out of control and destroy things....Its important to understand that this part, though difficult to handle to begin with, carries the energy to progress the therapy...

If someone comes to see me and it doesn't matter whether they are dissociative or not, and they are ever so nice, they are always on time, they are always grateful for what I am offering them, they are trying really hard to put in practise what comes up in the therapy, nothing will change. Professionals feel at ease because this is someone who is really appreciative

of their work, they are not going to cause trouble, if they have to go into an acute ward, will follow all the rules, they will be helpful, try and fit in, will even help the other nurses and talk to the other people, really helpful with other people sometimes, but nothing ever changes. Everything can be tried and nothing changes.

In contrast if you have got someone coming through the services who is aggressive, who swears, who says 'who the hell do you think you are, I don't trust anyone,' (or usually more outspoken) who is aggressive, who will act out, very hard to manage but will have more of a potential for change. We know in our society that change doesn't come about through those well meaning, obedient, citizens, it's always been, ... whether it's the suffragettes, whatever it is ... what get cultures in a global sense to change is through diversity, through challenges that are difficult to handle, but if they are handled correctly, they are eventually beneficial... it is never done through being reasonable. There are extremes of course where if you are a terrorist then you have gone beyond the threshold of being able to manage it and to have an outlet for it.

So that generally my understanding, as time has gone on, is that the area of creativity and change is actually encapsulated in those areas where there appears to be the most aggression, because there is energy there, but the energy has been focussed and activated because it was stuck through the abuse and the attachment difficulties, so that's one thing to think about.

If you've got someone who is in an impossible situation as a child, where if you are going to survive, you've got to be aware what's going on, have your antennae finely tuned, you can't escape so that you have to do is make sure you don't make things worse. If the message you got was 'you tell anyone, and I will pursue you and kill you, if you ever tell anyone I have been doing thing to you, then I will kill you,' that message goes in.. And also the message you get is, 'if you cry I will make it twice as hard for you,' then what goes in is: I mustn't cry. What this actually means is that that person has to be the parent to themselves, because the natural reaction will be to cry in pain, so there's got to be a part that keeps that child in order. That's how it works, because the survival and the minimising of pain is based on one, not telling anyone, because you will die or be harmed, and two, not crying out in pain because then the abuser will do it twice as bad. And in a way you get an internal system which is what you could call a parental system which has to guard and keep in order and do whatever is necessary to stop that happening.

This is why in the early days when I didn't know much about it, a client would come for the first time, and might say 'this is the first time I can be somewhere and someone will listen to me' and start emotionally outpouring

what happened and about what was done in childhood, and the person goes away (may well feel much better from the emotional release) and next time they come, they announce they have severely self harmed. I couldn't understand at the beginning but I eventually cottoned on that they were doing something they were forbidden to do, [tell someone] it's templated in and for their internal protector, the red flags go up.... because this person is telling a stranger things that you were told if you told someone you would die or be severely hurt, so the paramount thing is to stop that person [themselves] from ever talking to anyone ever again, whatever it takes including self harm. And so that part (the internal protector/abuser) is in a real dilemma, trying to protect her, (herself) from getting into trouble.

In the same way that you take in good experiences of childhood, the good internal parents, you also take in the bad internal parent. So you've got this structure [then Remy refers to article about the ghetto model] where the survival of the whole system is always paramount, so even if it's hurting, even if it's sacrificing things, and the ghetto model was about the ghettos that were set up where the survival of the ghetto depended on Jewish members of the ghetto selecting their own people to send them off to labour camp and certain death.... so they had a whole structure of policing, social working within that structure, and that would decide who would go because even though that was doing it to your own kind, the ultimate aim was the survival of the whole. So what you've got is someone who is persecuted, they are trying desperately to get on with life, they've got dissociation, they've got this voice/s that will tell them to hurt themselves, also will tell them how awful they are, how pointless it all is, and it's not psychotic, it's all internal processors. And you've got people who are trying to work with this person who are frightened of them because occasionally they might see their client's mood change, where she/he becomes either destructive, occasionally might threaten to hit someone, certainly frightening for the therapist or professional. The professional will do everything they can to ignore or condemn this behaviour – they don't want to see that part, they will either give them medication or will say 'I don't want to see that kind of behaviour,' whereas I know that that is the key. And I also know that power is power, whether it's the Nazi's or whether it's the concentration camp commandant, whether it is the ghetto, or in more normal everyday situations. Whether it's a business manager that I have had to renegotiate a contract with, I just have to recognise that.

Right from the start the ANP might say 'I have this going on I don't know much about it, but can you get rid of it,' (their more aggressive part) I will tell them that no part is to be got rid of. I've got to make sure I respectfully get to know this part. That doesn't mean I accept this behaviour but I have to negotiate to make changes. Here is one example: if you have ANP who has

no experience of what is going on inside, so if that was you, you would be talking to me, you would tell me about what you know intellectually, what you may have found out., but you don't actually know what's going on. If I'm talking to one of the other parts (the inside parts...EP's), the ANP won't know. But, what I know is, in 95% of cases, if I am talking to you as the ANP, all the other parts inside are listening. So I can talk to that part and I say 'well, I want you to know this, that part that I know you say is aggressive and I know you are frightened of, I know is vital. I am not frightened of that part, but I am respectful of that part's power. I would very, very much like to be able to talk to ', and this ANP part might say 'well you don't want to do that, or I can't do anything about that, and I just say don't worry, because I know that part is listening and I know that part has a lot of power, and I know that it is trying to protect you even though it may be doing it in a way that is not helpful from your point of view. I also know that without getting permission to know what the rules are I am not going to get anywhere.

It's a bit like, if you go to a dictatorship country and you want to be able to travel round the country, you go to the one at the top who has the power to give you permission, it's no use asking the guard who is controlling the border, they might say no or they might say yes, but you know if you haven't got that permission you are not going to get anywhere. Similarly if you have a problem with a purchase from a store, it's no use discussing or having an argument with the person at the till. The same on the phone, if you've got a problems with a call centre you request to speak to their manager, and if the manager doesn't get you what you want, you request to speak to their boss, until you get to the one with the authority and power to negotiate. The others are either going to follow a script or they will say these rules have to be adhered to. It's the same thing in an internal structure. Once you get through with respect to the aggressive/protective part, things change I have never been attacked, in twenty years. I may have that part be verbally aggressive initially: eg 'who the fuck hell do you think you are, why do you think I would want to talk to you,' but as soon as you have a verbal response, you know that you have made contact. And I know that once that happens, over time, that's what going to bring about change.

How important is it for patients to be reintegrated at the end of therapy?

Well it used to be so and in a lot of circles that is the ultimate goal. I feel differently, I follow the recognised three phases of therapy:

Stage One is you try to stabilise the symptoms, to stop the extreme threats to life, and to develop a good working alliance between you and your client which includes issues about boundaries etc. If you can negotiate with that protective part, you may have to accept some self harm, something to keep

and that is ok, and that can be tolerated, but you can negotiate, because what you are trying to do is change from things being done unilaterally with no thought of the consequences, to a space where the person starts to think before they react.. There is very little concept of thinking before decisions are made, and the concept I am trying to get across, is like....

lets try and get everybody round the board table, not everybody has got to like each other or agree.... a bit like conflict between countries, you often have to have pre-talks , but let's start with the dictator who has got control because without his permission or her permission, you can organise anything and it just won't happen. And that part may be all puffed up, because after all he/she often turns out to be a frightened child part, but when that part begins to feel unthreatened, they know they are going to be taken seriously, they start changing. Because you are trying, in partnership, you are not the one with the answer.

And the aim, within that first stage, is getting the communication going, so not only between the parts inside, but also to get the ANP involved round the table, even if it's only intellectually and through writing..... so I would encourage journaling at home, to make sure there is a bit of paper, and I know one person who has done that and they say 'my god I am a freak' because they have never seen the different handwritings...naturally it varies enormously how people present, I am just giving you a cross section. And that is the most important bit of the initial therapy

Stage two is working through the trauma history as experienced by each internal part and includes the developing of a time line between the parts.

Stage three is integration. A lot of people will say I don't want to get integrated, that's fine because then there is a system where if there's an important decision there is a dialogue about it at home in some ways, a bit like in a family if you have got to move locations because the job's elsewhere and the main earner is the father let's say, you get together and you discuss it as a family, now the crucial difference which is not understood sometimes is that you can discuss it but the ultimate decision is not made by the children, it's made by the adults.

So it's the ANP and there may be other adults internally, who make the decision, not because the child says she wants to do something, you listen to their point of view and then you try and see where it fit in. In a family, you won't ever let a child stop you moving because your survival depends on you getting a job elsewhere. You listen, and you think about the loss of friends here and you think about what we can do, maybe we can come back and get your friends to come over for holidays, but the bottom line is the two adults who are there working together, will make the final decision. Sometimes

families get it wrong now, sometimes children are given much too much power in my view, and there is confusion between listening and letting them dictate what is happening, so if someone gives them a sense that they are omnipotent, then they have to face the reality that the world isn't like that. And that can be as damaging in some ways as someone who is completely oblivious to any of the child's needs and only think of themselves. Both have consequences.

Some people might see DID as being better than normal life. I am thinking about Herschel Walker and in a recent talk he said he thought that DID was a gift from God...

Well in a way it has all that side to it, certainly in every day like people who are creative artists, use dissociation in some form, and people who are high functioning DID seem to have an amazing area for gifts and talents, an incredible ability when they put their minds to something. I suppose it's a bit like someone who is autistic and who may be incredible clever at numbers: there is a price to pay but somewhere there is concentration of ability and I think it has to do with how the mind gets divided.

Some people find that this changes. One of the fears and one of the losses of integration is that you may not be so good at doing those things, and you may not be so good at multi-tasking. But you can say it was a gift, but it was a curse why it was necessary in the first place. It's a gift because it allows you to survive and it's adaptive if you manage to work through it, and you've then got a gift because when people have managed to work with it, it can be a very satisfying and enriching life, after years of struggle. Of course that is not to say that with Herschel Walker it isn't very different and he has found a way, then who is to say he is wrong.

So if people don't decide to integrate, are DID clients one day able to turn around and converse with their alters even if before they have been unable to?

It can be very varied and that is why it is so difficult to generalise. At some level, the person on the outside, the ANP, is a sort of non person, it is a front that has been necessary in order to keep functioning. Some people describe it as, they can look around and they can see how people behave and they can take it in and they can repeat it, but there is no sense of depth to them, and often people on the outside feel meaninglessness about life and are often very suicidal. The energy for life, and the potential for life and the life-force that is carried through all the trauma (carried internally), if that is harnessed in some way, that curiosity, then that changes things.

In a way you could say that those on the inside are like the Japanese prisoner of war, they have got no engagement with real life, and the part on the outside has no engagement with the internal life and so you are trying to balance that up

Or what also happens is that internal parts of different ages have been stuck in their development, and they need time to catch up. They sort of join up as they go higher, so the four year old joins up with the six year old, and sometimes they are all adults at the end, with the ability that we all have to remembering how it is to be a child., For instance if you have children or friends or relatives who have kids, you can enjoy their enjoyment of Christmas or going on a funfair or something, you can engage with that.

If the outside part is going to remain, then that part will have to know some of the inside world and feel some of the pain, and process some of the emotional things, and once they do that then they are bringing more of that into their everyday world. But it is more important that there is that communication. For some people, that is enough, for others nothing short of just bringing it all together will be enough. Some people feel they will lose something through integration. I don't think so. Because it's all one body, one brain, you have to keep remembering that.. Ultimately you are just bringing it all together and neurologically, you are allowing new pathways so that all those experiences can now be linked.

Friend and family....

That's a very good question, because sometimes someone has got a partner who may have been oblivious to begin with and then it's started happening, and they have to deal with that and they may be the only ones dealing with it, and then they become the first person who starts recognising the different parts, and who starts learning about it and who starts relating to the different parts appropriate to their age, and so the person with DID may feel for the first time in a safe place. The problem is that often the partner will have to be partner, parent for their child if they have a child, and a carer for these different parts of their partner, and that's really difficult. It involves the loss of their adult partner, because it is all on hold in a sense.

And sometimes partners decide to become a carer rather than rely on professionals, often for very good reasons. This can lead at times to problems to do with co-dependence that is not always very helpful. And so here you are (the partner of someone with DID) trying to help them and getting used to being the 'parent' to there internal children. Then as therapy brings about change so that the person with DID starts taking more responsibility and this has an impact on their partner who may begin to feel threatened. So more

and more, I am more than happy, whenever the client wants to, to have their partner there, to see what the problems are and try to help or get independent help for the partner or career. It may be that the partner or career who fights to get help for the person with DID are in a sense in hyper arousal as well, in a war zone. Partners/careers also need to be part of the professional meetings otherwise an important 'attachment' is left out. So it is trying to see the bigger picture, that can be really difficult...I have one or two clients where the work comes to an impasse because their partner's sense of self is dependent on the person with DID remaining 'unwell.'

And there must be occasions where the partners estrange themselves from them because they find out the nature of the problem....

That does happen; you hear often of people who have gone through hell, fighting, getting justice to something tragic that has happened and then when it's all concluded they've got nothing to stay together for.. It's a bit like a relationship, if someone is in crisis, and they need to get help or get help for themselves, and change, is the partner going to also be able to adapt to change. There is never a certainty, nor can you make things stay the same.