Carer's and Loved One's of People with Dissociative Identity Disorder

Definitions

Part: An alternative identity state that an individual develops to manage trauma, typically in childhood. Previously known as "personalities" however this is no longer accurate.

System: A system is a collection of parts that exist together within a person. This FAQ will discuss individuals with DID as systems, for the sake of brevity.

System responsibility: Whatever a part does, their behaviours are the responsibility of the system as a whole and it's the system's job to figure out how to prevent maladaptive behaviours in the future, just as any other person is responsible to figure out how to not engage in unhelpful things, the way systems manage it might just look different.

Fronting: The part that the system is presenting as and feels like.

Co-conscious: Two or more parts fronting at the same time.

What types of dissociative disorders exist?

Based on the DSM 5, there are five dissociative disorders. The first is Dissociative Identity Disorder (DID) and you can check here for a description of the criteria, but essentially DID means that an individual has developed "alternative identity states" and has memory loss for events and/or trauma beyond regular forgetting.

The second disorder is Dissociative Amnesia, including an inability to recall information about their life, generally traumatic in nature. The forgetting is disturbing, not due to substance use, and is not better described by a different diagnosis. Interestingly, in the development of one of the leading structured questionnaires that assess for DID, the authors conducted research and could not identify individuals with Dissociative Amnesia and no identity states/DID, and amnesia seems to rarely appear on its own. This does not mean it is impossible, however more that some individuals may simply be yet to discover their parts due to "covert DID", explained at the end.

The third disorder is Depersonalisation/Derealisation Disorder.

Depersonalisation: "Experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body or actions."

Derealisation: "Experiences of unreality or detachment with respect to surroundings."

During the experiences above, reality testing remains intact, however, they are distressing, not due to substance use, and not better explained by another disorder.

Other Specified Dissociative Disorders are spoken about on the internet and in the literature quite a bit. There are, in some ways, two ways to categorise OSDD, one being the DSM 5 definition and the other being type 1a and 1b. For the purposes of this exercise, the 1a and 1b will be more helpful, as it is used a lot outside of the literature and are probably most helpful. As I noted

earlier, DID requires alternative identity states and amnesia. OSDD is simply those separated, so type 1a is only amnesia with no identity states and type 1b is only identity states with no amnesia.

Finally, Unspecified Dissociative Disorder includes symptoms that cause significant distress, however, the person does not meet the criteria for another disorder. Clinicians utilise this diagnosis when they choose not to, or cannot, disclose another dissociative disorder, such as insufficient information in an emergency department.

How does DID develop?
DID typically develops from early childhood trauma that is repetitive in nature and occurs prior to the age of 9. Often, caregivers or other close family members are perpetrators, meaning that the child cannot get away from the traumatic experiences and instead they shut down and put the memories of the experience into "another person" in their mind so that they can continue with their life without intrusive trauma symptoms. There are some exceptions to these examples, however, they are rare.

Additional to trauma, however, genetics, personality, and other supports play into the development of DID. A great website to read more about the causes is here.

How common is DID?
Research has shown the rates of DID in the general population as low as 1%, all the way up to 10%, however, the most commonly cited number is 2-3% of the general population. In the psychiatric outpatient population, research has shown rates of dissociative disorders as high as 29% and rates of DID at 6%. In comparison, the World Health Organisation has reported schizophrenia prevalence in the general population to be only 0.33%.

Is the person I know with DID more than one person?
Nope. They are one person, one human being, and one personality. A good example is a pizza or a pie, imagine that people without DID are a whole pizza or pie that has not been cut into slices, while those with DID have been cut into slices. While one slice is clearly pizza or pie, you still need all of the pieces to make up the whole pizza or pie, there is no original or core slice. Just like someone without DID may act a bit different to how they are at home or out with friends at a pub, someone with DID is a bit different in different scenarios as well, however, in DID if they have not had a lot of treatment they typically can't choose very easily what part they want to be and they can't be just a little bit like that or this, it's more all or nothing.

What types of parts exist?
Host: Often the host is simply the part that is "fronting" the most in the person's life. The host is not the "original" or "core", as these don't exist.

Child Parts (Littles): Child parts are typically trauma holders, but not always. All parts are made when an individual needs to fill a role, and a child part might include being a good kid around their perpetrator, going to school and learning, or experiencing the trauma so the other parts can do life how they need to. Even if child parts don't hold trauma, they are often very vulnerable due to their experienced age. Usually, carers and loved ones worry about whether they should

engage with child parts or not. The answer is an emphatic yes. Recognising for yourself that a different part is present and that their experience may be different to yours will be invaluable to them. What you can then do to help them, is introduce yourself, who you are, why you are there, and remind them that they are safe. If they manage that well you could ask what point in time they think it is and if they say a prior time you can softly begin reflecting that some things have changed and they are actually further forward in time than they might think but they are safe.

Gatekeepers: Having multiple parts in your mind and intrusive symptoms that can break through amnesia barriers if not kept in check and different situations needing different roles filled, keeping everything as seamless as possible to avoid detection, means that people often develop a gatekeeping part. The gatekeepers job is to make sure the correct parts are fronting at the correct time and the important amnesia barriers are not broken. They often present as pretty dry individuals that are just there to get a job done but they also rarely front, as their role is internal most of the time.

Protectors: Protectors can protect in a range of ways, some are caregivers for other parts, some are defensive, and some are downright aggressive. Protectors are there for a reason. Often they will have prevented trauma and stood up for themselves when other parts of them couldn't. Whilst protectors are confronting and can engage in behaviours that are not helpful for the system, their presence should be respected, as they will often be there because the person perceives some threat. The system, is, however, responsible for all behaviours and holding protective parts as accountable and not harming a carer or loved one is important. Communicating with the protector that you do not appreciate their behaviours as they are hurtful and then asking if there is another part they can try to communicate with to get a good understanding of the system's overall goals in relating to each other and other people. However, if the person does not have that level of communication or cohesion, know it is not your fault, it is the system's perpetrator's fault. Notify the protector that you are getting hurt and you are not comfortable with that, so you will be removing yourself for a period of time (tell them how long so they know you will be back) and will come back to it later to discuss it further. When either that part has calmed down or the person has switched and is no longer being aggressive, talk to them about how you can help them not respond in unhelpful ways so you can all work through it together.

Persecutors: These parts are often moulded off perpetrators and they can serve a range of purposes. Persecutors are often horrible to other parts and can re-enact trauma internally as intrusive thoughts. However, persecutors are not only horrible to parts internally, they can also harm the body with self-harm, drugs or alcohol, and ruining the person's interpersonal relationships, among others. Persecutors can appear very difficult to get along with, and often test boundaries, however, know they were developed for a reason and they have a role. How to help all parts includes finding out their role and their maladaptive behaviours, then finding new replacement behaviours to serve the same role in a healthier way.

Fictives/Factives: Fictives are parts that have been created based on a fictional character. For example, a child might see super man on TV and feels if they just had a super hero to protect them, they would be fine. Alternatively, factives are parts that have been developed off a real

person that has been in the system's life at some point, such as a football coach, close friend, or teacher.

Non-Human: Non-Human parts are quite common, as humans typically appear to kids as having limitations. Sometimes people develop dogs, wolves, monsters, and demons, among many others. These parts may struggle with communication and sheets of paper with basic needs on so they can point can be helpful. Do not discount these parts or any part. They are real and they exist and often there is significant stigma surrounding them.

Promiscuous Parts: Many people with DID will develop a sexual part, often when they grow older and realise they want intimacy in relationships or in their life but it is too triggering for any existing parts. These parts can become disruptive in relationships and may not show interest in their partner despite other parts and the system wants to be in a relationship. They can also cheat and be unfaithful, however, this is not the case for all parts and helping the person to learn what behaviours are positive and which are not will help this part to be affectionate toward the correct people.

How should I deal with switches?
If you notice a switch, you can ask if someone different is out and if they would like to just continue on as normal or is there something they need. Some parts get a bit funny about giving names, often names have been used against them in some way, and so asking for age can be helpful because that also helps you to know how to make things age-appropriate. If they are comfortable talking as themselves and haven't met you before, then you can introduce yourself, who you are, why you are there, and what you are both doing and give space to ask any questions in case they feel lost or scared.

Is switching a type of dissociation?
Switching is a type of dissociation. However, there are many types of dissociation and people with DID can dissociate without switching.

Dissociation is a broad term for disconnecting from an experience in some way. People may dissociate from pain and not feel anything when they get physically hurt, they may dissociate from emotions and almost switch them off, they might dissociate from memories where memories feel very distant. The meta (and sometimes confusing) thing is that parts can dissociate from their own experience so much that they later do not remember it despite not switching. One thing to bare in mind with DID and all dissociative disorders, is that typically they are looking to get away from their internal experience and so doing mindfulness like deep breathing or progressive muscle relaxation will freak them out, as they will be required to notice their body. If someone is dissociating and it's problematic (they need to go out somewhere and they are zoned completely out, or they aren't noticing pain and burning themselves in the kitchen) then you are best to get them to notice the outside world not inside. An example might be picking the part's favourite colour and asking them to name 3 things that colour in the room. Also, if they have switched, grounding techniques won't get the previous part back.

Can I ask for a different part to come back?

I mean, if you are wanting to make the part you are talking to feel invalidated, unwanted, disoriented, and stressed, sure. So, the answer is probably not. There are some caveats but if you are simply asking because you don't like that part much then that would be like someone asking you if you can be more like you are when you're at work cause you're more fun at work and you're just sad and depressed at home.

One caveat is if the system has agreed that you can request certain parts sit back a little bit and just watch on while another part takes the reigns in certain situations like doing the shopping or travelling on public transport or any places where, for example, a young part might be vulnerable or could end up putting the system at risk. If there is prior discussion and agreement on when, how, and who you can do this with, then doing it the way you agreed on makes sense. The other caveat is during self-harm incidents, which is below.

How can I help parts to communicate and is this a good thing?
Typically the end goal of therapy for someone with DID is integration. This word gets a bad rap because people think it automatically means what is called fusion but it can also mean what is called functional multiplicity. Functional multiplicity is where an individual still has parts, however, they communicate well enough and share the same goals that the disorder does not significantly impact on life or the person. To reach this point, the person needs to practice communicating with all parts when they are ready and this is something carers and loved ones can help with. If the person is struggling with a decision, you could ask if there is another part that might be good at making this decision to help the current part, or if you know the person's parts a bit you could suggest that a specific other part is good at this sort of thing and internal communication could be helpful. Additionally, getting the person to write notes on their phone or post-it notes. If the part says no, however, listen to that, as the part may have amnesia from another part due to trauma and it would open a heap up.

How does amnesia work? Will they always forget everything, or is there stuff they remember? There are often two types of amnesia, blackouts and grey-outs. Blackouts are the stereotypical "coming to" that you hear about where a person completely forgets and loses time or doesn't know where they are. Interestingly though, anecdotally they are not the most common type of amnesia, this is because DID is about hiding trauma. If someone was very clearly forgetting everything, people would go looking for why and may discover the trauma. So the brain often "confabulates" where the brain makes up small, inconsequential memories that tie things together to look less obvious to the person and those around them. Sometimes the memories are made up completely or they might be majority correct with some bits missing. Also, it's hard to know what you cannot remember.

What should I do if one part tells me something and says I can't tell other parts?
This depends heavily on the person's system. Some systems are extremely dissociated and separate, meaning they share very few memories and have blackouts quite a bit. These systems are probably hiding trauma that other parts really cannot cope with for one reason or another and breaching that amnesia, even if you had permission, could go very badly. If a system is better at communication and shares some trauma, things are a little different, however, you still need to ask yourself why you want to share this information. Unless you are seriously worried about the

person's safety, where they could very easily be in imminent danger if not shared (these situations are extremely rare), then sharing is not a good idea, as you lose the trust of the part.

Should I tell other parts trauma memories or stories a part has told me and not stipulated that I can't say anything?
If another part asks about something specifically, honesty is generally the best policy. If a part is asking specifically, they probably are ready on some level to hear the answer. However, if they don't ask then you have no reason to share the information and you might destroy very important amnesia barriers before the person is ready.

How can I help regarding self harm?
The other caveat is if the person is at risk of harm to themselves or someone else and you cannot control the part through any other means, that bit is important, then notifying the part that you are worried for their safety and they are really important to you and you care, so you don't want them to hurt themselves or anyone else because you know that's not what other parts want as well. Then ask because of that would they mind seeing if they can communicate with another part to help out, a caretaking protector maybe, and if you know a positive trigger for that part, sparingly using that to prompt their attention internally. You want to help the person to start developing their own communication so that when you are not available they can keep themselves safe. What is important to remember here is that lots of people without DID self-harm and there are ways to cope without switching, additionally, self-harm does not always need to be stopped, it just needs to be safe from the risk of infection, with no lethality involved, and other coping skills are being practised to replace the self-harm long term.

How do overt and covert DID work?
The are two broad types of DID in some ways. Overt DID typically involves fairly notable switches and blackouts that can't fit in any other context. Overt systems are anecdotally less common though and the more common system is a covert one where parts say they are the host and act as if no switch has happened despite feeling like themselves internally, this is called masking and is quite common.

What can I do to help people with a diagnosis of DID?
Be kind, understanding, and compassionate, but have your own boundaries that are clearly communicated. Most of all though, be honest and trust them, believe their description of their experience and ask them questions if you don't know. Ask them if it's ok to ask and if it's not how you can get the information. Know that they may not know the answers to your questions, they may not know much about themselves and their parts and that's ok.

Finally, get and use your own support!!

Source: Hunter Psychological Services