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Empathic Resonance: A Case Study of Dissociative Identity Disorder (DID)

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Abstract

Dissociative identity disorder (DID) also referred as multiple personality disorder can be accompanied by related alterations in affect, behavior and sensory-motor functioning. This article describes the case of a 33-year-old woman with a diagnostic of DID and who required intensive treatment, who suffered bullying at the age of 15 with a demon personality. Despite psychopharmacological treatment there was no improvement until the emphatic resonance therapy was carried out. Our case report shows the complexity of providing treatment for patient with DID.
Key words: dissociative identity disorder, medical therapy, emphatic resonance, case study.

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Novelty and Significance

What is already known about the topic?

- Dissociative Identity Disorder is a pathology with increasing prevalence.
- In addition to medical treatment psychological treatment is of special importance.
- There are not evidence-based treatment guidelines for Dissociative Identity Disorder.

What this paper adds?

- This paper describes a clinical case in which an approach focused on the empathic resonance process was applied.
- The therapeutic approach focused on the therapist's empathic resonance process can be an effective strategy for Dissociative Identity Disorder.

Dissociative identity disorder (DID) also referred as multiple personality disorder (Ashraf *et alia*, 2016) is a chronic post-traumatic condition (Dell, 2010). It is characterized according to DSM-5 by "disruption of identity characterized by two or more distinct personality states" (American Psychiatric Association, 2013), with "marked discontinuity in sense of self… accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning."

DID estimate prevalence in inpatient and outpatient settings generally ranging between 2%-11% (Dell, 2010), and over 1% in general population (Şar *et alia*, 2017). Despite these data, the validity of the diagnosis is often questioned due to the lack of reliable diagnostic measures (Reinder *et alia*, 2018; Vanijzendoorn & Schuengel, 1996; Weninger *et alia*, 2008). The lack of understanding in the etiopathogenesis makes the existence of this condition called into question (Brand et alia, 2009; Merckelbach *et alia*, 2016; Vissia *et alia*, 2016). There are no randomized controlled trials researching treatments for DID (Brand *et alia*, 2009; Duffy, 2010; Şar & Ross 2010).

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Method and Results

Case Descripcion

We present the case of a 33-year-old Caucasian female with no psychiatric history until 2 years ago. She suffered bullying at age 15. The patient is admitted to the Psychiatry Service due to worsening of her sudden movements of neck and arms, they were involuntary and associated anguish. These episodes began in 2019, after an esoteric experience lived by her sister, and the evolution has been fluctuating, although allowing a normalized life.

Treatment and Monitoring of Treatment Progress

During admission, consultations are made to the Neurology Service and the Neurophysiology Service, who request an electroencephalogram, an MRI and a brain scan, resulting in normality. The rest of the complementary tests did not present alterations. She was discharged with a diagnosis of conversion disorder with motor crises, under pharmacological and psychotherapeutic treatment.

After discharge, she returns home with her parents, and the crisis become more frequent and of longer duration. She acknowledges that during these periods she is dominated by her alternate personality, which she is unaware of until her family informs her. This personality is a demon, who verbally assaults and even physically threatens her surroundings, and can hardly be controlled by the prayers of her family. He has a male, threatening voice, who also uses tobacco abusively. Despite wearing a rosary and praying frequently, the other personality is gaining more presence, and when he takes control, gets rid of religious objects and blasphemes, being a totally opposite personality to that of the patient.

Currently, there are not evidence-based treatment guidelines (Huntjens *et alia*, 2019). The most common approach is individual psychodynamic psychotherapy (Bran *et alia*, 2009; Putnam & Loewenstein, 1993), according to practice-based guidelines initiated by the International Society for the Study of Trauma and Dissociation (2011).

Despite psychopharmacological treatment, with neuroleptics, anxiolytics and antidepressants, as well as the cognitive-behavioral therapy carried out by the patient for more than two years, there was no improvement. Once she comes to the consultation, it is decided to carry out a therapy guided by the central Rogerian attitudes, originating a process of empathic resonance of the therapist, which influences the experience of the patient (Vanaerschot, 2007). Three main interventions are carried out, the awareness of the disease, the regulation of the intensity of this experience, to maintain the attention and the exploration of what guides the change.

To handle the present case, we used a model with two pillars, the patient's commitment and the investigation of microprocesses within a process of experiential exploration, in which the therapist is a facilitator of reflective attention and experimental awareness (Vanaerschot 2007). The three main interventions performed during therapy are based on: (a) Awareness, experiencing it with a sufficient degree of conscious attention. Appropriate interventions can be attention to internal experience, bodily sensations, evocation of empathy, first-person reflections...; (b) Regulation of intensity to maintain reflective attention. A distinction is made between interventions that intensify or decrease the intensity of the experience; (c) Exploration to change, it is a constructive experiential process, in which a new meaning is created. The aspects of the experience

that are not clear and are not completely known, "on the unclear edge", are important (Gendlin, 1996).

During the interventions, the therapist's empathic resonance process influenced the patient's experimentation process, enhancing it. This action intervened in the areas that had not been adequately explored, promoting their improvement, and therefore helping her clinical improvement, currently allowing her to lead a normalized life.

After carrying out this intervention, the patient is currently asymptomatic, under treatment with Fluoxetine 20 mg and Asenapine 5mg, and a normalized life.

Discussion

Currently, the methods used in the diagnosis of DID are not standardized nor reliable (Elzinga, 2003). Those most used to aid in the diagnosis are the Structured Clinical Interview for Dissociative Disorders of the DSMIV (SCID-D), the Multidimensional Inventory of Dissociation (MID) and the Scale of Dissociative Experiences (DES); the three of them are symptom measurement scales.

The implications of the neuroanatomical basis of DID have recently been highlighted. Reinder *et alia* (2019) have shown that DID patients and healthy controls (HC) can potentially be discriminated using neuroimaging biomarker patterns. Chalavi et alia (2015) have found the great differences in the neuroanatomy of brains with DID compare to HC. Schlumpf *et alia* (2013) have previously reported differences in the activation and utilization of neural structure during facial recognition in the brains of patients with DID. The first meta-analysis of DID neuroanatomy corresponds to Blihar *et alia* (2021) who found that patients diagnosed with DID have smaller hippocampus, bilaterally, compared to healthy controls. This meta-analysis supports the potential of imaging biomarkers in DID patients, although more research is needed to determine the causal mechanisms. According to Lotfinia *et alia* (2020) sstructural MRI results indicate that reduced amygdala volume may be uniquely related to post-traumatic stress disorder, while alterations in the precentral gyri and temporal lobe are frequently reported in patients with a primary diagnosis of DID.

Several studies (Elzinga *et alia*, 2007; Reinders *et alia*, 2018, 2019; Schlumpf *et alia* 2013; Weniger et alia, 2013), studied functional magnetic resonance imaging (fMRI) alterations, finding differences with healthy subjects, but not significant enough.

These results suggest that morphological differences could help in the accurate and reliable diagnosis of DID, but reality is different, and there is no gold standard with high sensitivity and specificity (Blihar *et alia*, 2020).

In conclusion, in the described case the patient presented a dissociative identity disorder of several years of evolution. Her diagnosis was hampered at first by the lack of reliable diagnostic measures, and the normality in all neuroimaging tests performed. The torpid evolution suffered by the patient, with little clinical improvement to the interventions carried out, and the absence of evidence on the treatment, led to a therapeutic approach focused on the empathic resonance process of the therapist, with good results. Given the lack of both diagnostic and therapeutic measures for this disorder, it is necessary to carry out more research, expanding it to therapeutic fields not previously studied, such as the approach focused on the empathic resonance process.

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