A theoretical music therapy framework for working with people with dissociative identity disorder

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Abstract

Dissociative identity disorder (DID) is a debilitating disorder acquired due to severe ongoing neglect or abuse, characterised by the presence of two or more identities that frequently control the individual’s behaviour (American Psychiatric Association [APA], 2000). Literature pertaining to the wider spectrum of trauma outlines the benefits of various therapeutic interventions, including music therapy. With limited research into the field of DID and music therapy, the current authors identified a need for a systematic approach to the treatment of clients in music therapy programs. Through the use of Lev-Weisel’s (2008) suggested four therapeutic goals of treatment: symptom relief, de-stigmatisation, increase self-esteem, and prevention of future abuse; an accessible framework is provided for use with dissociative clients. With a session example of the use of song parody, a practical use of the four-goal framework is outlined. As there has been limited research in the field of DID and music therapy to date, along with the theoretical framework, the authors provide recommendations for future music therapy practice with DID clients.

Key words: Dissociative identity disorder, music therapy, trauma, cognitive behavioural therapy, song writing/parody

Introduction and background of dissociative identity disorder

Childhood abuse is a serious problem throughout the Australian population, with a reported one in three girls and one in six boys being sexually assaulted by the age of 18 years (Bravehearts Inc, 2008). Confirmed cases of abuse and neglect between 2007 and 2008 Australia-wide reached a total of 32,098 children (Australian Institute of Family Studies, 2009). Dissociative identity disorder (DID), formerly known as multiple personality disorder, is acquired in the childhood years due to severe ongoing neglect, physical, emotional, psychological and/or sexual abuse. DID is the presence of two or more distinct identities or personality states, known as alters, that
recurrently take control of an individual’s behaviour (APA, 2000). Prevalence rates of DID appear to be fairly homogenous across Australia, Europe and North America, with estimated rates between 1 and 3% of the general population (Briere & Elliott, 2003; Spitzer et al., 2006), however this statistic may be underestimated due to the lack of reported cases by child victims.

The complexity of difficulties encountered by people who are survivors of childhood abuse is widely acknowledged within the literature, with the most common DID co-morbidity being posttraumatic stress disorder (PTSD) (Brand, Armstrong, & Loewenstein, 2006; Reinders et al., 2006), alongside others ranging from depression, anxiety, suicidal ideation, somatisation and eating disorders, to re-victimisation, risk-taking behaviours, substance abuse disorders and interpersonal difficulties (Briere & Elliott, 2003; Jepsen, Svagaard, Thelle, McCullough, & Martinsen, 2009). More specifically however, Steinberg’s (2004) structured clinical interview for the diagnosis of DID identified the five core symptoms as amnesia, depersonalisation, derealisation, identity confusion and identity alteration. Literature suggests that when a child is abused, particularly sexually abused, the child no longer views the body as a “safe home” and escapism is often only possible in the mind, therefore dissociative behaviours are developed as a coping mechanism (Lev-Weisel, 2008). In several studies, children report abuse as though looking down on themselves and refer to the abused as if it were somebody else (Dale, Berg, Elden, Odegard, & Holte, 2009; Putnam, 1993). The severity of the disorder is dependent on numerous factors such as the age of the child at the onset of abuse, severity and duration of abuse, emotional attachment to the abuser, dysfunction of early social environment, and psychological factors (Gold, Hill, Swingle, & Elphant, 1999; Volkman, 1993). In order for these abused victims to function, dissociations are created, allowing the child to detach themselves from the experiences and emotions by associating certain traumatic memories with specific alter identities (Narang & Contreras, 2005; Reinders et al., 2006). This is an adaptive behaviour implemented to cope with the trauma and abuse, providing escape and protection, but ultimately resulting in a fragmentation of the mind (Lev-Weisel, 2008). This fragmentation is a maladaptive behaviour as the alter identities take on various emotions and roles within the system, and often act in opposition to each other, rather than working together for the benefit of the individual. Various therapies are hence required to manage this split of identities; to work together with the client in order to achieve cohesion and cooperation between alters.

**Psychological treatment of dissociative identity disorder**

The treatment of DID is often a long and challenging process, with possibility of “remission” scarce (Weber, 2007). Despite tentative steps in the
field to investigate the complexity of trauma related mental illnesses. 
progress is slow and often confounding, possibly as a result of the contention 
which remains in the field of psychiatry, with some clinicians and researchers 
questioning the veracity of DID (Hirakata, 2009; Piper & Merskey, 2004). 
Although a guideline for DID treatment has been issued from the 
International Society for the Study of Dissociation (ISSD, 2005), the 
American Psychological Association’s Evidence-Based Practice task force 
has recommended further investigation into a wider range of treatment 
interventions which encompass co-morbid DID patients (Brand et al., 2009). 
Common treatments for DID to date include individual, group, or family 
therapy, pharmacotherapy, creative arts therapies and clinical hypnosis, with 
in-patient hospital treatments often necessary (Pais, 2009). The majority of 
treatment modalities used in DID practice were developed for trauma victims 
suffering from PTSD (McDonagh et al., 2005). Although PTSD is a common 
dual diagnosis of DID (Lev-Weisel, 2008; Reinders et al., 2006), questions 
have begun to be raised in recent literature as to whether these two diagnoses 
are similar enough to warrant the same treatment interventions (Cohen & 
Hien, 2006; Hirakata, 2009). Hirakata (2009) has recently drawn attention to 
distinct neurobiological and physiological differences between PTSD and 
DID as reasoning to begin investigating different treatment approaches for 
these two distinct pathologies. Dominant frameworks of practice within these 
different treatment options include psychodynamic and psychoanalytical 
thories which focus on uncovering repressed and forgotten material (Loftus, 
1993), and cognitive behavioural approaches that focus on the events of the 
abuse and aim to change the client’s social adjustment and adaptive 
behaviours (Deblinger, McLeer, & Henry, 1990; Jepsen et al., 2009). 

Reported outcomes of in-patient treatment remain scarce, with Jepsen 
et al. (2009) only reporting seven articles located. In response to this, Jepsen 
et al. (2009) conducted a study on 34 adult survivors of child sexual assault 
(CSA) in a three-month in-patient facility. The study aimed to evaluate from 
pre to post treatment changes in levels of post-traumatic, depressive, and 
general psychiatric symptoms alongside interpersonal problems. Similar to 
the framework of the treatment program on which this article is based, Jepsen 
et al.’s (2009) program included individual and group therapy with a 
combination of psychodynamic and cognitive behaviour therapy (CBT) 
approaches utilised dependant on target areas of therapy. Improvements 
across most global scores from test instruments were found pre to post 
treatment. Most significant improvements were gained in the area of 
interpersonal problems, which was largely attributed to the inclusion of group 
therapy in the program (Jepsen et al., 2009). 

The treatment aims and goals for DID appear to have reached a 
consensus throughout the literature, which align to guidelines as outlined by 
the ISSD (2005). The ISSD lists integrated functioning as the primary and 
long-term goal of treatment; however, a number of phases should be
undertaken in order for such a goal to be reached, which as Pais (2009) cautions may require long-term therapy in order to work through each phase. A common structuring of treatment occurs in a three phase oriented treatment approach which consists of:

1) Safety, stabilisation, and symptom reduction
2) Working with traumatic memories
3) Identity integration and rehabilitation

Although such an overview of treatment is beneficial to the long-term treatment process of DID patients, the three phase model as presented by the ISSD (2005) remains problematic for clinicians who are engaged in short-term DID treatment, as can often be encountered in in-patient settings.

Lev-Weisel’s (2008) critical review of intervention and treatment modalities for CSA survivors provides an outline of four basic therapeutic goals in treatment. Although Lev-Weisel’s therapeutic goals could be interpreted for use in DID or PTSD settings, as has previously been discussed, the distinction between these two pathologies remains unclear, thus it could be argued that these goals are relevant in the current climate of DID group treatment. Goals were identified as; symptom relief, encouraging the client to alter their perceptions of the events, teaching the client to manage behaviours, facilitating expression, validating the experience and providing emotional support for the client; de-stigmatisation, through a supportive group environment and strong therapeutic alliance; increasing self-esteem, through cognitive and interpersonal exercises, role plays and games; and the prevention of future abuse, through changing the client’s environment and/or behaviours and awareness (Lev-Weisel, 2008). The use of Lev-Weisel’s basic therapeutic goals provides an attainable framework for both long and short-term treatment across a wide spectrum of different treatment modalities. As will be discussed further in the article, this flexibility is pertinent to the structure of music therapy programs, which although are not often a core modality of DID treatment, provide an adjunct therapy at certain points throughout the longer term therapy process.

**Music therapy and dissociative identity disorder**

Music therapy work from the broader trauma and abuse literature has shown the benefits of music therapy, as it can provide a voice to traumatic experiences (MacIntosh, 2003), increase social interaction (Holligan, 1995; Robarts, 2002; Orth, 2005; Volkman, 1993), improve interpersonal communication (MacIntosh, 2003), develop new coping skills (MacIntosh, 2003), reduce anxiety levels (MacIntosh, 2003), allow choice and control (MacIntosh, 2003; Orth, 2005), provide a release for emotions (Holligan, 1995; Robarts, 2002; Orth, 2005), build a healthy sense of self (Robarts, 2002), increase self-awareness (Orth, 2005) and provide validation (Orth, 2005).
Although current literature pertaining directly to music therapy and DID is stark, the ISSD (2005) outlines the benefits of expressive therapies, including music therapy, in the treatment of DID. Modalities such as music therapy provide a bridge for clients to safely communicate and externalise thoughts and feelings from their inner worlds (ISSD, 2005). Due to the lack of research and discourse in the field of DID and music therapy, it is proposed that Lev-Weisel’s (2008) outline of four common therapeutic goals in DID work provides a strong guideline for clinical practice and treatment goals for music therapists. The following is an expansion on each of Lev-Weisel’s goals, which also draws from a range of music therapy literature to provide further support for and highlight the possibilities music therapy offers in further treating and expanding on these therapeutic aims.

Symptom relief

Giles et al. (2007) highlight the importance of symptom management strategies for clients who have suffered abuse in providing alternatives to unsafe behaviours. With an emphasis on safety, reduced self-harm and affect regulation, clients are taught various coping strategies, including self-soothing and self-care, to assist in the management of trauma symptoms (Giles et al., 2007). Treatment emphasis for this goal should largely be centred on the acquisition of coping skills to help overcome destabilising factors of DID. CBT and psychoeducation are the primary treatment modalities in psychiatric facilities, and aim to provide knowledge and skills required to assist in the coping of a serious mental illness (Silverman, 2009; Giles et al., 2007; Jepsen et al., 2009). Abused clients often present using maladaptive behaviours, such as self-harming, suicidal ideation and dissociating, to cope with difficult thoughts and emotions (Briere & Elliott, 2003; Jepsen et al., 2009). Jepsen et al. (2009) describe the use of group psychoeducation within a multidisciplinary team to assist clients in developing coping skills and increasing self-esteem. and Pais (2009) reiterates the need for non-dissociative coping skills for these clients. Music therapy is able to provide alternatives to these maladaptive behaviours, by teaching clients to use music in various ways to assist them in coping. Clients can be taught to use song writing or parody, instrumental play, song listening and lyric analysis to assist in coping. A recent Australian study showed the use of music for coping with sexually abused clients (Day, 2006). Through interviews several years after the therapy program, participants reported a continued use of songs that were recorded in therapy to assist in coping, and to assist family and friends in understanding their experiences and emotions (Day, 2006).
De-stigmatisation

Trauma literature suggests the need for a supportive environment for therapy to be effective, with supportive group members or peers and therapist imperative for successful treatment outcomes (ISSD, 2005; Hirakata, 2009; Sachs-Ericsson, Cromer, Hernandez, & Kendall-Tackett, 2009). As traumatised clients may often have difficulty in establishing trusting and healthy interpersonal relationships due to histories of trauma, the process of building rapport within the group therapy setting is crucial in order to ensure the individual’s perception of safety. Although the process of developing rapport with this client group can be a somewhat challenging and lengthy process (ISSD, 2005), Hirakata (2009) emphasises the reparative experience of working towards reconnection in the treatment of DID, which encompasses self-connection, the development of relationships with others and the healthier ability to interact in the world. Sachs-Ericsson et al. (2009) argue that healthy supportive relationships provide the individual with more productive interpersonal skills and can assist the individual to develop effective coping skills. The aim of de-stigmatisation should be to build solid foundations for a supportive and encouraging therapeutic relationship, both with the therapist and within the group setting, to enable the individual to engage with others during interventions. By maintaining clear and safe boundaries, both for clients and therapists, music therapy can enable a safe and trusting environment in which clients feel able to discuss their experiences and to explore difficult topics with others. Group music therapy sessions have been shown to provide a supportive therapeutic environment. Silverman’s (2009) study found clients diagnosed with mental illnesses were more likely to discuss personal views during music therapy sessions rather than making general statements. Furthermore, clients were also more likely to engage in music therapy sessions, in turn leading to greater effectiveness of treatment (Silverman, 2009). Bensimon, Amir and Wolf (2008) suggest one of the main therapeutic aims of music therapy group work for men with PTSD is to develop interpersonal communication, group trust, familiarity and a sense of belonging, which in turn heightens the client’s engagement. Results suggested that after a four-month group drumming intervention, feelings of loneliness had shifted to togetherness as trust was developed amongst the group (Bensimon et al., 2008).

Increased self-esteem

Abused clients often present with low self-esteem, as well as guilt, self-blame, depression and suicidal or self-harming ideations (Loftus, 1993; Sachs-Ericsson et al., 2009; MacIntosh, 2003; Day, 2006). Group CBT is also utilised when working with survivors of CSA to reduce feelings of guilt, isolation and shame, and to develop the client’s self-esteem (Jepsen et al., 2009). Through the reconstruction of thoughts, cognitive-behavioural
approaches can be used to achieve self-acceptance and increased self-esteem (Austin, 2001). When addressing the client’s need for increased self-esteem, music therapy utilises task-oriented interventions, such as song writing, to attain and maintain a sense of control, empowerment and increased self-esteem (Day, 2006).

**Prevention of future abuse**

In the treatment of DID, the prevention of future abuse is centred on the client gaining a heightened sense of awareness and developing healthy coping strategies. This can be applied through the use of CBT techniques to enable the client to recognise unhealthy patterns and behaviours, and to adapt to life stresses and interpersonal problems (Hien, Cohen, Miele, Litt, & Capstick, 2004; ISSD, 2005). Treatment goals in this area are focused on eliminating maladaptive behaviours and introducing healthier strategies for coping, and on the client gaining a heightened sense of self-awareness. Music therapy, in particular song writing, supports the development of self-awareness for abused clients (Day, 2006). Sexually abused clients reported an increased awareness of self, and of their own feelings, following song writing interventions (Day, 2006). Hirakata (2009) shows music therapy to be beneficial in providing clients with an alternative to verbal discussion, allowing clients to release emotions and thoughts through an expressive and creative outlet. The use of group written song lyrics and song based interventions support the effectiveness of words and written expressions for dissociative clients. These word based interventions have been shown to have lasting effects for clients, as described by Chan and Horneffer (2006). The cognitive component of expressing thoughts and emotions in written dialogue has been hypothesised to create long lasting psychological benefits for clients (Chan & Horneffer, 2006).

As highlighted from the literature above, music therapy has the ability to be an adaptable and relevant treatment modality which can target broad-spectrum goals in DID treatment as outlined by Lev-Weisel (2008). Although it is beyond the extent of this paper to provide program evaluations to date (due to ethical considerations), a guide for the incorporation of the four therapeutic aims in a single music therapy session is provided in the following hypothetical session description.

**Therapeutic practice within the framework**

Many interventions have been successfully incorporated into the current authors’ music therapy practice in the area of trauma and dissociation, such as improvisation, song choice, lyric analysis and song listening/singing. However, the technique of song writing, or song parody, in group music therapy sessions was agreed by the authors to be one of the most successful interventions for targeting Lev-Weisel’s (2008) goal areas of symptom relief,
de-stigmatisation, self-esteem and prevention of future abuse in a single music therapy session. The following is an example of a music therapy session structure utilising song parody to target the four goal areas through the exploration of the topic of shame.

De-stigmatisation

Prior to the music therapy session, the music therapist chooses either a song or song options which deal with the topic of shame, for example Robbie Williams’ Better Man. The song is presented musically to the group, after which a short discussion or lyric analysis takes place in which the clients are encouraged to discuss either how they interpret the lyrics or relate to them in relation to the week’s theme of shame. This initial process of the therapy session already presents an opportunity for de-stigmatisation as clients begin to share or listen to relatable stories or experiences, either amongst themselves or with the song’s artist. The intervention of song parody for the session is then introduced to clients, in which they can either agree to re-write the song already presented or choose an alternative song.

Using a CBT framework within a song parody intervention, specific subtopics of shame can be created by the music therapist prior to the music therapy session, which allows focused discussion and group brainstorming to take place in the initial stage of the song parody process. Such a structured approach can be useful for sessions which are either time limited or are at risk of becoming “stuck” in negative or maladaptive self-talk. Subtopics which have been utilised by the current authors in a music therapy session on shame include:

1) How does shame currently present in your life?
2) How do you live/cope with shame? How do you manage it, without it swallowing you up?
3) What happens to shame over the course of therapy?
4) Seeing shame as a tool used against you, opposed to it being a part of your character

Clients should be encouraged to brainstorm and provide feedback of their own experiences of shame related to each subtopic. The clients are then given the opportunity to decide which subtopics will form the respective verses and chorus of the song which is then sequentially addressed to transform brainstorming ideas into song lines. This group interaction targets the goal of de-stigmatisation for the clients, as all group members are encouraged to provide their own ideas of how shame presents, even if it is only a one-word response. Through the vocalisation of ideas in the group, clients may often agree with another client’s response and elaborate on how they have had a similar experience or feeling. This process of group sharing can start to reduce feelings of isolation, allowing the clients to feel less stigmatised in their thoughts and beliefs around the topic. The establishment
of a supportive group and trusting environment furthermore allows clients the opportunity to speak more openly and honestly on the topic. This in turn, can enable greater self-awareness, which as discussed below, can be a factor in the prevention of future abuse.

**Prevention of future abuse**

Through a CBT approach, the songwriting structure aims to challenge client’s beliefs on topics such as shame, in order to provide an avenue in which DID clients can access and verbalise healthier beliefs about themselves, and to achieve a greater self-awareness on the topic. The ABC model that is used in CBT outlines the concept that our beliefs and thoughts influence feelings and behaviours:

1) is the activating event or situation,
2) is the beliefs or thoughts, and
3) is the consequent feelings and behaviours.

Through the use of this model during songwriting, clients are guided through a step-by-step approach, which allows them to acknowledge any negative self-beliefs, and then find alternatives for management and coping of shame. As can be seen in the example below, verse one provides opportunities for validation of self-beliefs around the topic, both positive and negative. The song continues to move sequentially through different stages, seeing shame as a process rather than a stagnant feeling and experience. Important to note is the use of repetition of the chorus throughout the song which reinforces the goal of prevention of future abuse by highlighting management techniques and coping skills to deal with shame.

**Original lyrics “Better Man”**

(Lyrics007, 2008)

**Subtopic structure for song parody**

**Verse 1**
Send someone to love me
I need to rest in arms……

How does shame currently present in your life?

**Chorus 1**
As my soul heals the shame
I will grow through this pain
Lord I’m doing all I can……

How to live with shame and how to manage shame without it swallowing you up

**Verse 2**
Go easy on my conscience
’Cause it’s not my fault……

What happens to shame over the course of therapy?

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1 Due to copyright laws only an excerpt of each verse/chorus is provided
Chorus 2
As my soul heals the shame...... Repeat chorus 1

Bridge
Once you've found that lover Seeing shame as a tool used
You're homeward bound against you, opposed to it
Love is all around...... being a part of your character

Repeat verse 1 and chorus 1 Repeat verse 1 and chorus 1

Although not presented to clients as a specific CBT technique, the therapist is able to guide the session so as clients are able to examine their thoughts and beliefs, and the consequences of these, in a non-confronting or judgemental environment. Through this exploration of self in the group setting, clients can be provided with an alternative view of awareness which aims to encourage them to change any maladaptive environments, thoughts and/or behaviours in order to prevent future abuse from occurring.

Self-esteem

Upon completion of the lyrics, the group collaboratively decides on a title for their song, rehearse singing their song and are given the option to record it. The clients are then provided with copies of their song on CD and in lyric form. This process targets Lev-Weisel’s (2008) goal of increasing self-esteem as clients are working on a group project and can gain a sense of mastery through recording their own song. The cognitive process of writing a song based on personal experiences can in itself increase a client’s self-esteem, however to record a group written song provides clients with a powerful sense of achievement and pride. The recording is then able to be shared with family and friends, or can be used in future therapy to further explore the topics discussed within the session.

Symptom relief

At the conclusion of the session, the use of song parody as an accessible technique to assist in coping outside therapy sessions can be discussed with clients. Although it could be argued the level of musical ability required to write songs outside music therapy sessions makes such an undertaking difficult, even the initial stages of song parody, accessing song lyrics and re-writing and changing the words, is often a manageable task for most clients. Encouragement can be given to re-write or create new songs to cope with challenging feelings and emotions, and to express these in a healthy, creative way to assist the client in symptom relief. Through the process of the group written song created in the session, clients are provided with an established method for song writing that can easily be replicated and
developed further outside of music therapy. This technique can be utilised by clients independently to manage behaviour and to facilitate expression.

Conclusions and recommendations

Due to a lack of research in DID and music therapy, this paper opens a potential discourse for therapeutic practice based on the current authors’ clinical experience in this treatment population. Through the process of establishing a clinical program in an in-patient treatment facility for DID, the authors saw the necessity to locate common treatment goals to give the program direction and containment. Lev-Weisel’s (2008) goals of symptom relief, de-stigmatisation, self-esteem and prevention of future abuse provided an attainable framework of practice which remained relevant to client needs. Although treatment goals as outlined in the ISSD (2005) are long-term processes, Lev-Weisel’s goals have the capacity to be targeted in single music therapy sessions as outlined in the song writing session description above. Future implementation of this framework for music therapy practice needs to take into consideration the overall framework of the multidisciplinary treatment program, session styles (closed vs. open group), session topics and group rules and boundaries.

In order to see an advancement of knowledge in music therapy practice and DID, more rigorous research needs to begin to be undertaken. To date what music therapy literature does exist in the broader field of trauma generally encompasses case vignettes or small sample sizes. There remains a gap in group based Australian research in this area. Group work is a growing trend in psychiatric care in Australia due to federal health funding, however, as Jepsen et al. (2009) point out, adult survivors of abuse often present with highly individualistic needs. In response to this, the current authors identify a future need to conduct program evaluations on a sizeable cohort to begin to establish common trends and provide an overarching view of group music therapy and DID treatment.

References


