

## Counseling Clients with Dissociative Identity Disorder: Experts Share their Experiences

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*Individuals with dissociative identity disorder (DID) are a challenging population for counselors to diagnose and treat (Brand, Loewenstein, & Spiegel, 2014). To more fully understand best practices for working clients with DID, the authors of this phenomenological study investigated the experiences of nine counselors who have expertise working with this population. Data were collected through focus group interviews with four counselors and individual interviews with an additional five counselors. Using content analysis, the authors identified eight themes that represent best practices for counseling clients diagnosed with DID: (a) matching goals and techniques to population characteristics, (b) contributing factors for therapeutic change, (c) counselor flexibility, (d) counselor investment, (e) diagnostic stigma, (f) ongoing formal and informal assessment, (g) counselor wellness, and (h) roadblocks to treatment success. Practice recommendations for counselors working with this population are provided.*

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Many clients who struggle with complex trauma related dissociative disorders (e.g., dissociative identity disorder [DID]) spend years in the mental healthcare system before the core dissociative problems are recognized and treated (Brand et al., 2012). High levels of comorbid psychiatric conditions (e.g., posttraumatic stress disorder [PTSD], depression, personality disorders, substance abuse, eating disorders, self-destructiveness, and

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suicidality; Brand et al., 2014) and high levels of impairment (Brand et al., 2013) make the identification process of this complex biopsychosocial disorder challenging. As a result, undiagnosed or misdiagnosed dissociative disorders including DID can be common in clinical settings (Brand et al., 2012; Brand et al., 2013; Brand, Loewenstein, & Spiegel, 2014). This is despite a prevalence rate of DID and dissociative disorders between 1% and 3% in the general population, approximately 2% in the clinical outpatient population, and approximately 5% in the clinical inpatient population (Foote, Smolin, Kaplin, Legatt, & Lipschitz, 2006; International Society for the Study of Trauma and Dissociation [ISSTD], 2011; Sar, 2017).

The accurate and timely diagnosis of individuals with DID can be problematic for counselors (Brand et al., 2013, Lloyd, 2016) with 5-12 years of unproductive treatment reported prior to correct diagnosis (Loewenstein, 1994) and lack of prior accurate diagnosis even within clinical population (Foote et al., 2006). The most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychological Association, 2013) outlines the following five criteria to diagnosis DID: (a) a discontinuity in both sense of self and agency that can be recognized by either the individual experiencing the change or observed by another person; (b) a loss of time or memory that is not accounted for by nonclinical forgetfulness; (c) the individual experiences significant distress in one or more areas of their life (e.g., family, work); (d) the symptoms must not be due to developmental, cultural, or religious practices (e.g., imaginary friend in childhood, communicating with spirits as an accepted cultural or religious norm); and (e) the symptoms must not be due to a medical condition or using psychoactive substances. Some researchers assert that the aforementioned diagnostic criteria are too abstract (e.g., Dell, 2001) whereas others posit that the criteria are sufficient (e.g., Spiegel, 2001). ISSTD (2011) acknowledges that some researchers have argued for re-categorizing dissociative disorders as part of a spectrum of trauma disorders due to their common base of developing from trauma histories.

Despite the difficulties in diagnosis and treatment the basic principle of DID treatment is clear: it is a treatment of the whole person not separate parts (Ross, 1997). Furthermore, Putnam (1997) recommended that therapists remember to treat each person with DID as a unique individual. Thus, counselors must remain sensitive to the specific circumstances of each individual client's life such as connections or lack of connections to family, comorbid disorders, availability of emotional resources, and economic resources, amongst others. Moreover, despite the chronicity, severity, and difficulties associated with treating individuals who are highly dissociative, current evidence indicates that clients with DID benefit from creative approaches to treatment, which include interventions focused on specifically working through trauma related dissociation (Chefet, 2008), step-by-step approaches to treatment (Brand et al., 2013; ISSTD, 2011; Ringrose, 2011;) and viewing treatment from a systemic perspective (Pais, 2009).

Across treatment approaches, experts have agreed upon several DID-specific treatment priorities to include: (a) establishing safety, initiating stabilization, and reducing symptoms; (b) working through, and then integrating traumatic memories; and (c)

integrating alters and rehabilitating into society as much as possible (ISSTD, 2011). Safety and stability may include suicide assessments or establishing a safety contract amongst others. Integrating traumatic memories is a process that may or may not involve co-consciousness between alters but certainly involves a sharing of memories. If co-consciousness is not achieved memory integration can be done through journaling of the alters or recording therapy sessions when the alters speak. Integrating alters is a process that involves memory sharing, co-consciousness, assignment alters roles, and then integrating the roles. These steps are just a guide; however, the description indicates that the priorities are meant to be accomplished in order beginning with safety and stability. However, a linear (1,2,3 and so on) sequence of treatment steps or clinical phases is only an outline of DID treatment according to Ross (1997). The actual therapy may include some forms of circularity within treatment that requires re-examination of previously addressed issues (Brand et al., 2013, Ducharme, 2017; Ross, 1997). The DID therapist must, therefore, be able to adapt to unpredictability and cope with potentially strong feelings of dislike within the therapeutic relationship (Ross, 1997) while making sure to interact with each alter equally, even the disliked ones (Ducharme, 2017).

While researchers have made general recommendations for counselors regarding the treatment of individuals with DID, systematic research that investigates DID treatment outcomes is still in its early stages (Brand et al., 2014). Furthermore, there is limited data that describes counselor characteristics that are necessary for successful counseling and treatment outcomes. Therefore, the purpose of this research study was to better understand the experiences and clinical recommendations of counselors treating clients with DID. Specifically, the authors were interested in identifying commonly used treatment interventions, specific techniques that are effective in both the beginning and later parts of treatment short- and long-term treatment goals, ways to develop a therapeutic alliance, and counselor characteristics that facilitate effective therapeutic alliances.

## Method

The researchers used a phenomenological framework to understand the clinical experiences of counselors working with clients diagnosed with DID. A phenomenological method was chosen to examine this phenomenon due to the scarcity of research focusing on the experiences of DID through the eyes of counselors and to allow the exploration of the depth of the experiences of counselors who treat clients with DID (Creswell, 2013; Hays & Wood, 2011). Treating a complex disorder such as DID involves complex and responsive treatment (Brand et al., 2013) and a phenomenological approach not only allows for that complexity to be explored but also for the participants to share the meaning they have created from their experiences (Hays & Wood, 2011).

### Sampling Strategies and Participants

The researchers utilized purposive sampling methods to recruit participants ( $n = 9$ ) for a

focus group who self-reported extensive experience providing counseling to individuals diagnosed with DID. Purposive sampling was chosen because of the specificity of the population (i.e., experienced counselors of clients with DID) and the small numbers of that particular population. The focus group was advertised and conducted during a national conference targeted to counselors of, and persons with, DID. Snowball sampling methods were then used by counselors to recruit additional participants for individual interviews. Specifically, facilitators of the focus group asked participants, after the conclusion of the focus group, to identify additional counselors who met inclusion criteria and who were believed to be able to provide a thick, rich description of their experiences. Following the focus group, identified counselors were contacted by email to invite them to participate in the study. Purposive sampling was also used to recruit participants for individual interviews who were currently working at treatment centers that provide clinical services to clients who have experienced trauma. Expertise was determined through experience working with the target population (i.e. clients with DID) and either attendance at a national DID conference or employment at a counseling center specializing in trauma. All participants were not only experienced with counseling clients with DID, they were also highly interested and knowledgeable about the DID population.

The focus group involved four participants who were attending the only national conference devoted to DID. The conference focus is divided between outreach to those with DID and professional development for those who help them. The researchers were known to the conference founder and organizer and had permission to conduct this research. All participants in the focus group were attendees at the conference and counselors who work with clients with DID. They volunteered to share their experience in the format of a focus group led by two researchers.

The individual interviews were conducted with counselors ( $n = 5$ ) found through recommendation of the focus group participants or through counseling centers that focus on treating survivors of trauma. All participants self-reported extensive experience treating clients with DID and each was asked for further information about their experience in the interview (see Interview Protocol in Appendix). The participants have been working as counselors between 6 years and 30 years. Three of them reported more than 15 years of experience as counselors and two, more than 25 years. Two have been working with DID clients since the disorder was known as multiple personality disorder (MPD). One participant with over 15 years in community mental health now works as a professor of counseling and researcher with those who have survived trauma. No further demographic information was connected to the interviewees to protect confidentiality of them and their practices.

### **Description of the Researchers and Subjectivity**

The full research team consisted of six members. Five dealt directly with the data through interviews, transcribing, coding, and analyzing data for themes. One member of the team, who also has the most experience counseling clients with DID, took the role of auditor

of the data analysis process. The research team involved in data collection and analysis consisted of five members all of whom identify as White. Two of the researchers conducted the focus group (one 31-year-old, heterosexual, atheist male doctoral student and one Jewish, heterosexual female doctoral candidate in her 30s). Two of the interviews were conducted by the researchers just described and three of the interviews were conducted by one other (a lesbian, female doctoral candidate in her mid-30s). The three researchers who conducted the focus group and interviews, and two others (a Jewish male doctoral student in his late 20s and a female master's student in her early 20s), coded all the data and developed themes through in-depth analysis of the participants words and multiple meetings to develop consensus.

The doctoral student researchers all had experience as counselors working with clients with histories of trauma. They also had research interest and experience with trauma as well. Three of the researchers had prior experience specifically with researching DID. Two with interviewing individuals with DID. One with interviewing daughters of women with DID. One of the researchers had experience with refugee survivors of trauma.

All researchers were from middle class backgrounds and spoke to the privilege that comes unasked for with being White. The majority of the team (4/5) are heterosexual. The team took the time to bracket their expectations about the research prior to beginning. Four of the researchers had little experience with DID prior to joining this research team and none would claim expertise. None of the team (with the exception of the auditor) had any experience counseling clients with DID. Their expectations came entirely from reading existing literature and the experiences of two researchers as part of a team researching therapeutic experiences of clients with DID. Expectations involved treatment delivered in stages, emphasis on counselor characteristics, and needing both short and long-term goals. The team put some of that into the research questions based on prior literature and made every attempt to bracket their expectations when coding the data.

## Data Collection

Consent was first obtained from all participants regarding audio recording their interviews and their participation in the research. All interviews were then recorded and transcribed verbatim by the research team. The research team took precautions to maintain the confidentiality of participants such as separating identifying information from the data. Focus group data were collected by two researchers. The focus group lasted an hour and half during one conference workshop time. One focus group ( $n = 4$ ) was conducted in-person, audio recorded, and transcribed. Five individual interviews were conducted via telephone by three researchers, audio recorded, and transcribed.

To guide the focus group and individual interviews, a semi-structured interview protocol of open-ended questions was developed. The protocol consisted of specific questions to capture (a) essential counselor characteristics, (b) efficacious techniques, (c) common treatment goals, and (d) construction of therapeutic relationships with survivors of DID. Utilization of a semi-structured interview protocol aligns with classical content

analysis (CCA; Hsieh & Shannon, 2005), which is the method of data analysis that was used by creating opportunities for participants to reconstruct their experiences within the context of a phenomenon, which in this research was their experiences counseling individuals with DID. CCA is discussed further in the Data Analysis section.

Data saturation for this study was reached when consecutive interviewees provided no additional information not already captured. Patton (2002) noted that there “are no rules for sample size in qualitative inquiry” (p. 244) and that sample size depends on what the researcher aims to understand. Lincoln and Guba (1985) recommended sample selection to the point of “redundancy” (also known as data saturation) because if “the purpose is to maximize information, the sampling is terminated when no new information is forthcoming from new sampled units” (p. 202). In this study, data saturation resulted in five individual interviews after the focus group for a total of nine participants. The data collected from the focus group and interviews had a high degree of overlap and overall agreement between participants.

### **Data Analysis**

The researchers utilized CCA for data analysis (Hsieh & Shannon, 2005; Leech & Onwuegbuzie, 2007). CCA is a form of phenomenological research practices and can be utilized to understand and describe a phenomenon (Hsieh & Shannon, 2005). In this research, the phenomenon being researched for understanding is the perspectives of counselors who counsel clients with DID in order to start to establish best practices in treatment for individuals with DID. Common among many qualitative data analysis procedures, CCA includes a six-step data analysis process that includes: (a) identifying key concepts, (b) constructing preliminary codes, (c) compiling a list of preliminary codes, (d) identifying and adding codes throughout data, (e) evaluating all codes within the context of the data, and (f) developing a final code list (Creswell, 2013; Hsieh & Shannon, 2005). Following the CCA steps of analyses, the researchers first coded the key concepts in the data, and then grouped identified key concepts into broader preliminary themes. The initial coding was done independently by each of the five members of the research team. Secondly the team met to discuss the initial codes and develop a common code list. After reviewing codes as a research group, adding as needed, refining, and grouping, the team met to consensually develop themes from the codes. The codes were grouped into eight themes that will be discussed in the findings section.

### **Validity and Verification Strategies**

To promote trustworthiness the researchers utilized peer triangulation, the six-step data analysis process of CCA (Glesne, 2015; Leech & Onwuegbuzie, 2007), and an internal auditor who had no participation in data collection or analysis. The internal auditor has professional experience counseling clients with DID and researching DID, in addition to background knowledge of and experience with qualitative methodologies. The internal

auditor reviewed the raw data, codes, and themes to provide feedback to the initial researchers. Investigator triangulation served to ensure inter-rater reliability during the coding process (Leech & Onwuegbuzie, 2007). Consistent with CCA, individual researchers did their own coding and provided their own interpretation of the data prior to coming together as a group. Reaching consensus was a priority and required multiple meetings with much discussion to achieve.

## Findings

Data analysis resulted in eight overarching themes, which included multiple subthemes. The eight themes were: (a) matching goals and techniques to population characteristics, (b) contributing factors for therapeutic change, (c) counselor flexibility, (d) counselor investment, (e) diagnostic stigma, (f) ongoing formal and informal assessment, (g) counselor wellness, and (h) roadblocks to treatment success. Each theme is further discussed in the sections below. No potentially identifying information was retained with the transcribed interviews and no quotes will be shared that contain potentially identifying details.

### Matching Goals and Techniques to Population Characteristics

Participants reported four counseling goals common to all individuals with DID. The subthemes reflecting these goals include: (a) ensuring safety and stabilization, (b) fostering resiliency, (c) engaging in trauma work, and (d) working with alters. Each subtheme is discussed with the participants words to add clarity and meaning.

***Ensuring safety and stabilization.*** Participants stressed the importance of ensuring safety and stabilization above all other counseling goals. One participant mentioned:

I really would want to make sure that I stress the importance of [safety contracts]. When you are dealing with a DID client and you really truly know that's what you're dealing with, it's really important you have that contract, have that signed, you sign it, whoever is present and all the other parts that are present and not present to sign it.

Another participant stated, "Safety is the number one thing you have to always assess for, making sure they are really safe." Additionally, a participant highlighted that, safety and stabilization can last for years...Don't forget that for some people that you see, even if you see them for years, safety and stabilization is all you will ever do."

***Fostering resiliency.*** Participants mentioned that conceptualizing the development of alters as a way to handle trauma is a powerful form of resiliency for clients. One participant mentioned, "It is such a powerful coping mechanism that folks acquire in an

unfortunate set of circumstances...it is a survival technique that without it I am sure that several of these folks would not be with us today.” Acknowledging and working with alters assists in establishing a therapeutic alliance with them. One participant said, “I think it's getting to know them, being interested in them and all of them.” Another participant suggested, “Think of yourself in the therapy relationship with 10 to 15 people all at the same time.” In addition, participants mentioned that clients with DID are creative. For example, one participant shared, “When you think about DID, a person has to be extremely creative...it is just mind boggling to people that somebody can actually function in this world as a multiple.” The innate creativity of clients with DID lends itself to the incorporation of expressive art therapies, as one participant encapsulated, “DID people are creative...so I've used a lot of different kinds of adjunctive type of therapies, art, music, play, sandtray.” Utilizing the inherent resiliency and creativity of clients with DID in counseling is a starting point for ongoing growth in other areas, as summarized by one participant, “When you think of somebody who has developed DID in order to survive horrific situations and then turn it into such a positive, it's really truly amazing.” When safety is established and clients with DID, as well as their counselor, are able to conceptualize DID as an aspect of resiliency, the counseling work can begin to address the trauma and the client's alters.

***Engaging in trauma work.*** Participants mentioned several therapeutic approaches for reducing trauma symptomology, including hypnosis, eye movement desensitization and reprocessing (EMDR; Shapiro, 1989), dialectical behavior therapy (DBT; Linehan, Suarez, Allmon, Heard, & Armstrong, 1991), and mindfulness techniques. In addition, participants stressed that it is not only the host personality who needs to process the trauma, but also each part of the internal system of alters who are connected in some way with the trauma. Several participants mentioned that trauma work supersedes integrating the alters. In fact, integration may not ever be included if that is not a goal of the client.

***Working with alters.*** In working with alters, participants reported that some clients view integration as a loss (i.e., of the alters) and do not want to integrate, preferring to find ways to operate as a system that includes the presence of all of their alters. For clients who do not want to integrate, participants emphasized that co-consciousness among alters and working as a system may be the goal. One participant summarized, “I personally haven't paid as much attention to integration as I have to trauma recovery. Now what I found within the context in working through trauma recovery issues with people, is that some spontaneous integration occurs.” Another participant mentioned, “Long-term, common long-term goals are typically integration. Not everyone chooses to integrate.” The participant went on to state, “I mean I have had situations where that's really been resisted, um, but overall I would say the majority of folks I have worked with have wanted to work towards having co-consciousness but ultimately integration.” Participants stressed that clients with DID have the right to determine what long-term goals best fit their situation. Client empowerment, as demonstrated by involving clients in the goal-

setting process, is also an example of the next theme, contributing factors for therapeutic change.

### **Contributing Factors for Therapeutic Change**

When prompted in the interview by a question about essential counselor characteristics, participants verbalized aspects of therapeutic common factors evidenced by one participant's remark, "Well I think it's the same counselor characteristics that a counselor needs working with anyone." Participants spoke about empathy, authenticity, compassion, genuineness, unconditional positive regard, and humility as essential for providing counseling to clients with DID. Participants spoke about genuineness and transparency by saying, "I think [counselors] need to be real people. . . . Genuine, yes, genuine. Straight shooters, yeah, no pretense, no BS." And another participant stated, "just to be clear making things as transparent as possible in that way." Participants further spoke about therapeutic common factors through unconditional positive regard saying, "[Counselors need to have] unconditional positive regard, regardless of how manipulative or how aggressive or... how inappropriate the [client's] behavior is." Participants further stated that, compassion is important, and that though, "Counselors in general have compassion, but you really need to have that compassion." Accountability was also seen as important, "I also think you have to be accountable as a therapist . . . you're role modeling what you're hoping for them too." Taken together, these identified common factors to forging and then maintaining a therapeutic relationship with clients with DID were deemed as essential.

### **Counselor Flexibility**

The theme of counselor flexibility encapsulates flexibility with subthemes of (a) goals, (b) techniques, and (c) theoretical frameworks. Participants stressed that counseling clients with DID requires counselors who are willing and able to be flexible and adaptable while maintaining some structure. For example, one participant stated, "There has to be some flexibility within the structure [of counseling]" and though "there's a lot of flexibility . . . at the same time you allow them to drive while you maintain the safety."

**Goals.** According to participants, the goals of therapy may change as needed but your role as the counselor in maintaining safety does not. One participant stated, "For me the first one is some kind of stabilization . . . to me the goal is really for a DID client to have a better life in the here-and-now. For others, some of the goals are integration or they're this or that. . . . obviously, the abuse and history gets in the way then there's room to deal with that but we have to help them get coping strategies so they can [deal with that]."

**Techniques.** According to one participant, flexibility in techniques often involves using techniques that seem developmentally inappropriate as with a client who "could be 60 years old but they have little ones [alters] who are two and three, so with those two

and three-year-olds we may do play therapy.” Another participant summed this up with,

I think certainly play therapy has been good with some of the younger ones and just giving the opportunity to play because they haven't been allowed a lot of times have been really constricted so being able to find their playful parts, um, and a lot of times you know DID people are creative, they've you know created this way to survive and they're creative in other ways as well so I've used a lot of different kind of adjunctive type of therapies, art, music, play, sandtray, things that you know kind of grasp different parts.

Further, another participant reflects this saying,

play therapy is always a really good technique to use . . . play therapy, art, my goodness gracious, art therapy is huge with DID. Get anything, a drawing, crayon, maker, you always need to have paper around because you are going to find drawing to be very helpful, very revealing.

***Theoretical frameworks.*** In addition to techniques, participants described theoretical frameworks that they utilize including, cognitive behavioral theory (CBT), dialectical behavior theory (DBT), attachment theory, psychoeducation, systems approach, humanistic, flexibility with theoretical orientation, sequential frameworks, play therapy, and art therapy. One participant described their use of theory, stating that,

I use my CBT. I come from the perspective, I believe in doing a lot of education with my patients, really teaching them a lot about what's going on giving them a lot of insight into themselves. So, you know, ok, some more cognitive behavioral. I also use DBT, I've been trained in that and am a consultant there, so I do integrate that to teach them more self-awareness things like that, you know, from the trauma perspective . . . it's a good starting point. A lot of supportive therapy from the beginning. . . . Teaching them to stay present-focused. Integrate EMDR, but that's further down the road.”

Participants also highlighted that there is no singular correct method or process for providing counseling to clients with DID; they stressed the importance of being knowledgeable about many theories and able to use many techniques. As one participant summarized, “I think we use many things and we look at them as a toolbox. . . . I think it's really eclectic to me.”

## Counselor Investment

It became clear in the interviews that counselors working with clients with DID need to be invested in their clients. Subthemes of counselor investment were, (a) motivation, (b) passion, and (c) ongoing education and supervision. Participants verbalized the importance of counselors being invested in their work and in their clients. Participants mentioned clients with DID are best treated by counselors with professional and personal motivation, coupled with continuing education about DID.

**Motivation.** Professional and personal motivation for working with clients with DID can come from many places. Those can be personal such as the participant who had a personal history of trauma and also wants to give back to clients.

Some of it is my own, my own personal experiences, I do have some history of some abuse and some dissociative issues that I have worked through in therapy so some of it was just personal wanting to give back at this point.

In addition, clients with DID are best served by counselors who have flexible schedules as one participant forewarned:

If you take on a DID client just know that it is going to take a lot of your clinical hours. It's not only the sessions, and typically you have to extend your sessions, possibly close to two hours. You need to be available off-hours for emergencies. It's really time consuming.

That requires not only motivation but a time commitment as well.

**Passion.** Participants also highlighted that their initial exposure to DID triggered their interest and subsequent passion. One participant summed this up:

But when you actually see it, um, right in front of your face and then that experience, it is life changing and I've had, um, had an interest working with trauma anyway and was kind of leaning toward, kind of that path in my own clinical experience and when I had exposure to folks struggling with DID, that just sparked so much of an interest in me, I just really, I don't know, it changed me, I don't know how else to say it, it really just changed me.

Another participant simply stated, "I have a passion for trauma and for folks who suffer from trauma. So that [counseling clients with DID] just seemed like the natural progression."

**Ongoing education and supervision.** Part of being invested in clients with DID involves pursuing continuing education about DID in order to be able to utilize more techniques (i.e., having a more comprehensive toolbox). Participants related how initial experiences with treating clients with DID spurred on-going investment, such as seeking supervision, consultation, and continuing education. For instance, one participant related that after her first experience with a client with DID, “I knew that I needed supervision beyond what I could get at my agency.” Therefore, she and a colleague “formed a study group” to provide “peer supervision.” Counselor investment was also demonstrated by participants’ continuing education efforts, such as:

we rely on education and we learn things all the time and we acquire this model, and... it works for these kinds of people but it doesn’t work for everybody. The next thing you learn...you have an expanded way at looking at something else.

Therefore, counselor investment through continuing education assists practitioners in maintaining a broad scope of awareness and knowledge. Participants also pointed to having passion for the population as necessary in providing best practices for clients with DID. That passion helps counselors to keep going despite frustrations and the length of treatment necessary to help those with DID. This type of investment of both personal time and professional development requires a lot of motivation, passion, and commitment from counselors who work with DID clients.

### **Diagnostic Stigma**

Participants reported an awareness of stigma surrounding living with DID, and further noted that stigma was a concern from both society in general *and* other counselors. Additionally, participants reported that pop culture and the media perpetuate the image of individuals with DID as being dramatically unstable. According to one participant,

I guess that is another thing the stigma you know a lot of, and I think that's an important piece for us to do as therapists you know to really help people with DID to know that they don't have to hide and to make it safe for them because if you have these full blown out images of Jekyll Hyde, Sybil, United States of Tara, you know that kind of stuff, you know in general, it's much less dramatic and yet, and very painful.

Therefore, being aware of the damage that can be caused due to the stigma associated with a DID diagnosis, participants found it particularly important that clients feel that the counseling environment is a safe place, void of harmful, stigmatized views. Because of

stigma, participants voiced that a diagnosis of DID could be seen as “a demonized diagnostic category,” which they thought was particularly damaging due to the vulnerable nature of the particular client population.

Stemming from the overwhelming perception of stigma associated with DID, participants also verbalized that stigmatized beliefs about diagnosis can often lead to difficulties in the process of diagnosis, or even misdiagnoses. One participant spoke to this, “Therapy is never successful for them because people refuse to even look at this diagnostic category as a possibility. So, they’ve had many therapeutic failures, they’re expecting when they come to see me, they are expecting one more therapeutic failure.” Another said, “Once you actually see someone with DID there is no doubt of the actual validity of the disorder, and it is as I’m sure you know, a controversial diagnosis and is misdiagnosed quite often.” This disconnect about diagnosis occurs because clients view a diagnosis of DID as stigmatized, and therefore, may resist that label for themselves. Participants warned that “clients don’t come to us going, oh, I think I’m dissociative”, instead the participants found it more likely that dissociative clients would seek treatment for relationship problems, profound emotional difficulties, or some sort of crisis (e.g., arrest, failing out of school, hurting someone or themselves). This could be due to fear of the diagnosis, lack of awareness about their dissociation, or lack of awareness that the voices they hear inside their head are due to other personalities (i.e., alters).

Aside from not recognizing a DID diagnosis, due to exaggerated messages in the media, the perceived stigma of DID may leave clients distancing themselves from a diagnosis, even after it is made. “There’s so many times with clients with DID who will want to say well, I don’t really have DID.” The stigma of the diagnosis, and therefore the potential fear of such a label, requires counselors to work with clients in coming to terms with the DID diagnosis as a part of their treatment. Accepting their diagnosis may be one step in working past their dissociation. One participant stated, “that’s another thing to be able to help them acknowledge, yes I do [dissociate] and it was helpful at the time, and now there are other ways to cope.”

### **Ongoing Formal and Informal Assessment**

The assessment theme emerged from participants sharing of the need to assess client progress and severity of symptoms through both formal and informal assessments. The use of formal assessments (e.g., the Dissociative Events Scale [DES; Bernstein & Putnam, 1986], the Symptom Checklist-90-Revised [SCL-90-R; Derogatis, 1994]) were recommended as a way to better understand a client’s symptoms when beginning a counseling relationship. In addition to the aforementioned formal assessments, participants also thought it important to assess clients’ somatic symptoms, since they are rarely accounted for in formal dissociation assessments yet clients frequently experience them.

In addition to using assessment as a way to identify how to begin initial treatment, participants also noted that assessment should be used to better understand client goals in counseling. Rather than a stagnant process, client assessment was also referred to as a

continuous process, with participants frequently re-assessing client goals and needs throughout counseling. One participant stated this by saying, “sometimes the goals shift and change, and the first goal might just be make life less chaotic and more stabilized, and that might be enough”. Likewise, some clients who initially may be opposed to the concept of integration may later decide it no longer seems as scary, “so the goals shift and change as you work”.

One participant noted that client improvement can be seen “when they develop more self-awareness...they’re not afraid to share symptoms of what they’re experiencing”. This informal assessment (i.e. the noted increase in self-awareness) allows the counselor to assess therapeutic progress. Additionally, the client’s ability to communicate more directly about symptoms has therapeutic benefits of allowing the counselor to address unwanted or uncomfortable symptoms.

Finally, participants reported that they saw client progress through improvement in a client’s relationships. As one participant shared, “I mean, it’s a long process, but their relationships are better, they have more stable relationships, they feel more comfortable navigating throughout their own life.” This same participant went so far as to say that observing relationship improvement (i.e., “trying to get some semblance of cohesive relationships in their life, better support systems that they can seek out themselves”) was this participant’s ultimate end goal for clients with DID, and therefore the final way to assess client progress.

### **Counselor Wellness**

The theme of counselor wellness became apparent throughout the interviews but was most often evident when participants were asked about essential counselor characteristics for treating clients with DID. What became apparent is the necessity of the counselor’s strength to be able to be present for clients and to engage in self-care. Individuals with DID have experienced trauma and their counselor should convey, “That I’m not afraid to hear their story; I can hear whatever horrible abuse happened to them.” Furthermore, building trust and a therapeutic alliance is dependent on the counselor “having a lot of strength that [clients] can rely that their therapist is there for them.” It is equally important to communicate this to the client:

Convey yourself as a strong person, confident person, honest, not arrogant, empathetic. I think you need a lot of integrity, need to have good boundaries, need to know your own limits as a therapist, meaning, “How far can I go with this? Can I deal with some of the issues that are coming up?”

Despite that internal strength, listening to the trauma that clients have experienced can take its toll: “To sit there and listen to some of the things that we hear, um, it takes a lot.” Counselors’ strength must also be balanced with their ability to take care of themselves.

Self-care is a critical aspect of working with clients with DID. Participants have lengthy sessions with clients because “you have to extend your sessions, possibly close to two hours” and “You need to be available off-hours for emergencies.” Even with doing that participants hear from their clients with DID between sessions getting “inundated with 10, 12, 15 page emails, 2, 3, 5 in between sessions...and it’s overwhelming.” This is why participants say that self-care is critical because, “You have to be able to let go of it at the end of the day.” Participants make this a priority, “You have to be very, very mindful of how to take care of yourself. So, when I say boundaries I mean you really need to leave work at work and have a life.”

Counselor wellness, as demonstrated by counselor strength and counselor self-care, is a crucial component of providing appropriate treatment for individuals with DID. Given the complexity of the disorder, and the trauma history of the clients, participants recognize the necessity to be well themselves so that they can be present for and effective with clients. Counselor wellness helped participants cope with the long hours and frequent communications with clients between sessions as well.

### **Roadblocks to Treatment Success**

In any counseling situation, there can be roadblocks to treatment success. According to participants, roadblocks to treatment are prevalent when treating individuals with DID due to the complicated nature of the disorder. As one participant stated, some of the challenges can be related to the number of alters, noting:

It really depends on how many personalities you are dealing with and the willingness to do the work because sometimes you might have a session where everything seems to be going fine and everyone is on board with cooperating and doing some work and the next session, people are shut down or there has been some kind of a crisis that happened with someone. I mean, you just never know. Think of yourself in the therapy relationship with 10 to 15 people all at the same time, and everyone is clamoring to get their little 10 to 15 minutes and you have one who is monopolizing the session.

That participant explained that this can certainly take a considerable amount of time and may take “a while [for the client] to settle in and get feeling comfortable to start dealing with stuff.” Furthermore, “the first 20 minutes is just a matter of them settling in and figuring out who is going to do the talking, who is going to do the watching.” Therefore, even the time needed for a session to get to a point of doing work can be a therapeutic roadblock that can be ameliorated or complicated by the treatment setting and the availability of time and space for longer sessions.

An additional roadblock for counselors in treating clients with DID is clients with a comorbidity of diagnoses, dual diagnoses, previous misdiagnoses, or previous counselors

being unable to diagnose due to other factors (i.e., lack of knowledge, counselor stigma). Many individuals who are subsequently diagnosed with DID may currently be or previously have been self-medicating and/or have substance abuse issues so severe that, “[the client’s] life was absolutely in total chaos and they weren’t diagnosed until they were clean and sober.” Another participant stated:

That’s why we have to rely a lot on resources because our rate for dual diagnosis for substance addiction is so high a lot of times people come in and you have to say in [one] shape or another is that we have to deal with your alcohol and your OxyContin addiction and then we will move from there.

Patients may not come in until there is a crisis such as “You forget to pick your kids up or you’re self-medicated.”

Additionally, clients may come in to treatment for their trauma history and have incorrect diagnoses, such as schizophrenia. One participant reported exactly that happening, clients were arriving, “diagnosed as schizophrenic, and they would say, ‘You know I am diagnosed as schizophrenic because they really don’t know where else to put me.’” Misdiagnoses are a roadblock to counseling due to inappropriate past or present treatment based on the incorrect diagnosis rather than addressing the salient concern.

Comorbidity further complicates treatment and treatment outcomes. Other diagnoses that individuals with DID are dealing with include “eating disorders” and “complex PTSD” due to prior trauma history. Clients come into treatment for a variety of reasons but rarely come in specifically for DID. This can lead to a disconnect between client goals and counselor goals because, “It’s in part why they’re coming in; what symptoms they’re presenting, what their goals are, what we see. What we see and what they see may be different.” One participant continued that “a client may be coming in thinking they don’t have a problem but we hear them talking about suicide the whole time. So, my attention is going to go there.”

Differences in goals between the counselor and the client, in addition to the complicated nature of DID, can result in ruptures in the therapeutic relationship for which the participants may not be able to prepare. Ruptures were reported as so commonplace that

It seems to me like you’re on the edge of a rupture every session. You know it could go uphill or downhill depending on some nuance. My tone of voice might not be quite right for a particular alter who is out right now and that could send things downhill.

This could be due to client concerns and, “there’s always the potential that the person is going to just get angry and never come back.” This could be due to lack of rapport or “because they felt that you have betrayed them in some way or there just is no connection.”

Ruptures in treatment can lead to client's carrying a fear, such as a prior negative experience in counseling, forward into future therapy. According to one participant, a client's negative experience in prior counseling, "led to a suicide attempt [by the client]." The participant added "I didn't start seeing her [the client] until years later but it still even affects [treatment] now because she's expecting me at any point to say you're wasting my time and you're not working hard enough." Other fears that can cause a roadblock are a "phobia of feelings" or even a fear of their own alters. As one participant communicates to clients:

I can hear from all of them [alters] because a lot of times they're afraid of what they might perceive as the angry ones who are often angry because they've been hurt or they're trying to protect everyone and they are sabotaging things when the truth is they're scared too... a lot of times clients get to know somebody that they were really afraid of and then that person becomes their best ally.

Another participant clarifies that for treatment to progress "you have to work through the various conflicts and fears." One counselor expressed the importance of honesty in the process of correcting a rupture in the therapeutic relationship by saying,

I think that if I mess up, I have to say I messed up. There's times that I'm not perfect and I may say something that, you know, upsets somebody or whatever, then it's important that I acknowledge, you know, and say that I messed up and that may not have been the best thing to say at that point or I have to look at myself and see, oh wait a minute, I was coming from another place and you know whatever the issue was. Another strategy to repair a rupture in the therapeutic alliance is to have a conference with all the alters, due to a rupture being more complex because you're dealing with a part of an entire system so if you have one part that is kind of distancing themselves because they feel betrayed or hurt... if I did I would probably call some kind of a conference in the mind with all the part[s] and we would have a collective discussion about what's going on with this one particular part and could everybody just kind of get on board with trying to pull that person back in.

Roadblocks to treatment seem to be common for counselors working with individuals with DID. Some of the most common roadblocks are client challenges unique to DID such as clients having many alters, comorbidity of diagnoses or misdiagnoses, differences between clients and counselors regarding goals, client's fears, and ruptures in the therapeutic alliance. Yet for each one, particularly when discussing therapeutic ruptures, there are strategies that participants utilized to address each roadblock. Repairing ruptures

in the therapeutic alliance will be discussed further within clinical implications.

## Discussion

### Clinical Implications

Counselors who are working with individuals living with DID must ethically provide effective treatment for their clients (American Counseling Association [ACA], 2014; ISSTD, 2011). Best practices in treating DID have not been fully agreed upon (Brand et al. 2013; Brand et al. 2014; ISSTD, 2011; Ringrose, 2011) but this research provides some guidelines from expert counselors interviewed. According to themes from the participants interviewed, some of the most important considerations in treating clients with DID include (a) matching goals and techniques to population characteristics, (b) contributing factors for therapeutic change, (c) counselor flexibility, (d) counselor investment, (e) diagnostic stigma, (f) ongoing formal and informal assessment, (g) counselor wellness, and (h) roadblocks to treatment success. Some of the implications overlap themes but all are encapsulated below.

*Matching goals and techniques to population characteristics.* Individuals with DID are a unique population with unique needs. According to interviewees, it is important to match the goals of counseling with each individual client with DID's specific needs. This can be accomplished in particular ways within each subtheme: (a) ensuring safety and stabilization, (b) fostering resiliency, (c) engaging in trauma work, and (d) working with alters.

Ensuring the safety and initial stability of clients with DID is critically important according to interviewees and prior research. Participants all referenced safety in their interviews and one stated that it was the number one priority. Therefore, the establishment of and continual assessment of safety is paramount to any other counseling goals with clients with DID. When safety is established, additional counseling goals can be addressed, including the promotion of resiliency. Establishing safety for most participants started with a safety contract with all alters to ensure the safety of the shared body to allow counseling to continue. Ongoing safety required frequent check-ins about things such as substance use and risk-taking behaviors. Clients who had previously been physically safe may still be at risk for STDs with an alter who is promiscuous and impulsive. Due to comorbidity with substance abuse, that is a concern to continually assess for. Prior to co-consciousness, alters who take more risks may put the client in unsafe situations. For some clients, it was helpful for involve their support network to help with safety but for others, who have fewer supports, making sure that they had access to emergency services is critical.

The counselors interviewed indicated that DID, is a powerful sign of resilience in clients that have overcome incredibly traumatic histories. Participants also referred to the creativity of DID clients as an aspect of their resiliency. Fostering that creativity within clients and acknowledging client resilience is important for counselors of DID clients.

Fostering creativity can take the form of play therapy for younger alters, expressive arts techniques (i.e. drawing, painting, sculpting, crafting), creative writing (i.e. journaling, poetry, play writing), sandtray, amongst others.

A defining commonality of all clients with DID is profound trauma history, therefore counselors must be comfortable and competent in trauma work. Though it is not always necessary to investigate each trauma (Ducharme, 2017), knowing when and how to intervene is critical. EMDR can be a helpful tool for counselors with appropriate training. Expressive techniques such as art therapy can also be very helpful in addressing trauma.

Building a therapeutic relationship involves everyone involved in that relationship including alters. It is critical to include all alters including those that are disliked (Ducharme, 2017) in the therapy and in goal setting. According to participants, knowing who is communicating and being willing to step in for the safety of all is important.

***Common factors within treatment and roadblocks.*** Treating clients with DID, according to the expert counselors interviewed, involves a focus on the therapeutic relationship (i.e., common factors and repairing therapeutic ruptures), a phased treatment approach (i.e., that starts with safety and moves towards co-consciousness with alters working together) with assessments throughout, and advocating for clients through reducing the social stigma associated with DID. Common factors of therapeutic change show up throughout the interviews and additionally have strong research background (Grencavage & Norcross, 1990; Leibert, 2011; Norcross, 1986). In fact, thirty percent of therapeutic change is due to a strong therapeutic alliance, the largest factor besides extra-therapeutic factors that counselors have no control over (Norcross, 1986).

Building a therapeutic alliance, and overcoming ruptures in the relationship, is critical according to the interviewees and prior research. A roadblock to treatment in the form of a rupture in the therapeutic relationship can be addressed by counselors in a variety of ways. One that were mentioned by a participant are honesty in acknowledging the rupture and even acknowledging if they (the counselor) has made a mistake. Another participant suggested having a conference with all the alters since the counselor is working with a system within one client. Some other suggested by participants are to have a safe place in the office for a client to retreat to if necessary and have previously worked on relaxation skills to calm down. Another technique, to prevent and possibly repair a rupture, is to model appropriate boundary setting to avoid confusion and misinterpretation. There are other ways to repair ruptures but the participants agree on the importance of the therapeutic alliance and the need to repair any ruptures that may occur.

***Counselor flexibility, investment, and wellness.*** Counselor flexibility is important when working with clients' with DID, as noted by participants. Clients with DID are complex and can present differently at each session, and even within sessions, depending on which alter(s) is/are present., necessitating longer sessions and more frequent communication between sessions. Counselors who treat individuals with DID can and should focus on being flexible with treatment considerations within and between sessions. The

complications inherent in DID can result in a need for changing the treatment plan, having longer and/or more frequent sessions, and possible communication with clients between sessions.

The treatment needs of clients with DID necessitate that counselors are invested in treatment. Though counselor investment in client care is important for all clients, it is critical with clients with DID, due to the complicated nature of the symptoms and treatment. The investment of counselors who are effective with clients with DID can be honed through counselor preparation programs, ongoing training (e.g., workshops, conferences), and ongoing supervision.

Additionally, counselor wellness can influence client outcomes and is a part of practicing as an ethical counselor (ACA, 2014). This is especially true when counselors are working with traumatized clients such as individuals with DID. Thusly, counselors who treat clients with DID are urged to focus on their own wellness. Making a wellness plan could be an important aspect of counselor self-care, as could having a support group, consulting, and even seeking personal counseling. Each counselor's wellness needs are different and a plan for wellness should be individualized for each counselor. Some counselors use physical movement such as exercise or yoga. Others rely on social outlets while still others need alone time. Wellness is critical and incumbent upon each counselor to self-assess for their own wellness.

**Diagnostic stigma.** The stigma associated with diagnosis of DID and prior misdiagnoses were mentioned by participants. Additionally, stigma associated with a diagnosis of mental illness, particularly DID, is acknowledged in the field (Hallett, 2015). It is critical that counselors not only reduce stigma for their clients but within the field. If clients are misdiagnosed due to either stigma or lack of information, clients do not get the treatment that is most efficacious. It is up to counselors to advocate for clients within our profession and beyond the borders of our professional identity. There are some organizations that help with advocacy for clients with DID. For example, "An Infinite Mind" hosts an annual conference for survivors with all dissociative disorders, particularly those with DID, their supporters and loved ones, and mental health professionals who treat them (<http://www.aninfinitemind.com/healing-together.html>). The National Alliance on Mental Illness (NAMI) provides information and advocacy for many with mental illness including DID. Support information specifically for those with DID is provided through NAMI (<https://www.nami.org/Learn-More/Mental-Health-Conditions/Dissociative-Disorders/Support>). For clients to receive treatment and live fulfilling lives, they must not only be educated about this diagnosis, the world must also be safer for those with it. Counselors can get involved with local mental health organizations to advocate for policy and legislation that impacts those with mental illness. Additionally, counselors should remain aware of inaccurate, negative portrayals in the media and counteract those in their own sphere of influence.

**Formal and informal assessment.** Formal assessment of DID has not changed recently with the DES (Bernstein & Putnam, 1986) and the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1994) named as the main formal diagnostic tools. Participants warned, however, that having a client fill out their own assessment about symptoms they are experiencing can be “overwhelming” for the client, and therefore, it is important to conduct initial assessments slowly and respectfully.

In addition to formal assessments, the use of informal assessments is also essential to the counseling process when working with clients with DID. These informal assessments, which may even include counselor observations of the client’s behavioral changes, allow the counselor and client to identify client growth and achievement. One participant recognized that therapeutic growth was indicated by in clients’ growing ability to be self-aware and therefore able to communicate more which allows the counselor to address symptoms more directly. This increased self-awareness also could allow clients to have therapeutic insight when that is helpful. In addition, a participant noted that client growth was assessed through clients’ feeling comfortable to take more risks, such as reaching out in social relationships (e.g., seeing a medical doctor or initiating social interactions). In addition to relying on client observations as a means of assessment, participants relied on client feedback as a way of determining how the client was progressing in the treatment process. One participant reported that their client has shared “I’m aware that part of me is no longer there”, and therefore, appeared to be more integrated overall. Additionally, as trauma work progresses, there is a need to assess re-traumatization and adjust techniques as needed.

### **Limitations and Directions for Future Research**

There is much work to be done with research in the area of treating individuals with DID. Although this research has important implications for counseling practice, there are a few noteworthy limitations worthy of mention. Due to the nature of focus groups and interviews, the participants may have answered questions to portray themselves in a positive light or in a way that they thought desirable to the interviewers. Social desirability could have been particularly true in the focus group due to the presence of other counselors. Further limitations include a lack of follow up regarding the self-reported expertise of participants. Although participants were either referred through colleagues or found through their work, that does not guarantee the expertise they espoused. An additional questionnaire about DID would have created more reliability about the level of expertise of participants.

Further research is needed for clients with DID, especially given the diagnostic stigma that the participants referenced. Additional research on reducing stigma and accuracy in diagnosis would benefit the DID population. Prevalence rates, though interesting, may be skewed by that stigma. Research on prevalence rates should be redone with a focus on diagnostic stigma and its effects. Future qualitative research should focus on the therapeutic relationship between clients with DID in comparison to the counselors who treat

them. Furthermore, research should also include measures of the therapeutic relationship from both the counselor and client perspectives. The therapeutic relationship from the perspective of each alter would not only be interesting, it may be therapeutically beneficial as well. Future projects should continue to explore this area, while also gaining perspectives from clients with DID on what is deemed effective treatment. Research that could quantify these findings would also be meaningful to the field, as there is a dearth of outcome research surrounding treatment approaches for this particular client population.

### Conclusion

The researchers of this phenomenological study identified eight themes during this research investigation: (a) matching goals and techniques to population characteristics, (b) contributing factors for therapeutic change, (c) counselor flexibility, (d) counselor investment, (e) diagnostic stigma, (f) ongoing formal and informal assessment, (g) counselor wellness, and (h) roadblocks to treatment success. Together, these themes provide necessary, new knowledge for the treatment of DID. Specifically, findings from this investigation add to previous research on effective counseling techniques and counselor traits, such as those illuminated through the research on therapeutic common factors (Grencavage & Norcross, 1990; Leibert, 2011; Norcross, 1986). Similar to themes identified in previous research on counseling outcomes, qualities such as empathy, safety, and congruence seem pivotal to this study's participants' treatment of clients with DID. Additionally, the importance staged interventions (i.e., moving from safety to trauma work and then to co-consciousness or integration) was highlighted when working with the DID population. Furthermore, the present study brings focus to the clinical needs of those living with DID from the perspective of counselors treating that population; an area with little prior research in the counseling literature. The limited research that exists in this area has focused on individuals with limited or restricted functioning, including clients who live in residential treatment facilities. The findings from this investigation call attention to the specific treatment needs of individuals diagnosed as having DID in conjunction with maintaining levels of independence and meaningful relationships in an outpatient treatment setting. The findings identified in this research study also help to establish the importance of specific and attainable counselor characteristics (e.g., flexibility, authenticity, investment) while reminding counselors of the importance of self-care and the effectiveness of formal and informal assessment when working with this population.

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## Appendix

**Interview Protocol**

1. Can you please tell me a little bit about yourself and your experience working with DID clients?
2. What led you to start working with DID clients?
3. Do you follow a suggested model for working with DID clients? If so which one? (probe for explanation)
4. What are some of the common short-term goals for clients with DID? (probe for specific examples)
5. What are some of the common long-term goals for clients with DID? (probe for specific examples)
6. (If needed) Describe the process of arriving at those goals.
7. What counselor characteristics are essential for working with DID clients?
8. What techniques have you found to be effective in working with DID clients?
9. How do you form a therapeutic relationship with clients with DID?
10. How do you repair ruptures in the therapeutic relationship with clients with DID?
11. Is there anything that you would want to add to this?