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Therapists' experiences treating clients with dissociative identity disorder

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Alexandra E. Paull
Therapists' Experiences
Treating Clients with
Dissociative Identity Disorder

ABSTRACT

The purpose of this exploratory study was to collect qualitative data to examine what social workers describe as their experience working with clients who fit the diagnosis of Dissociative Identity Disorder (DID). This study interviewed twelve licensed therapists through in person, phone, and skype interviews. These interviews explored the experience of their clinical work and its impact on them personally. Seven major themes were identified from coding the narrative data: *the challenges and rewards of treatment, characteristics of the population, characteristics of the clinicians, treatment structure, what treating their first client with this disorder was like, misconceptions, and places current research is missing*. The findings of this study highlighted current and evolving treatment perspectives, the general misconceptions about the disorder, and the importance of training all mental health professionals how to screen for and treat clients with this disorder. While the sample was limited in size and scope, the study results added to the current limited body of research on Dissociative Identity Disorder and provided some direction for future research.

Running Head: THERAPISTS' EXPERIENCES TREATING CLIENTS WITH DISSOCIATIVE IDENTITY DISORDER

**THERAPISTS' EXPERIENCES TREATING CLIENTS WITH DISSOCIATIVE
IDENTITY DISORDER**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2014

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This thesis is the result of nearly a year of incredible support, love, and caring, without which it would have never become a reality. This paper is a result of the therapists who endeavor to treat a population incredibly dear to my heart, and I thank them for sharing their experiences with me.

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CHAPTER I

Introduction

The purpose of this exploratory study was to collect qualitative data to examine what social workers describe as their experience working with clients who fit the diagnosis of Dissociative Identity Disorder (DID). Sampling was expanded to include other mental health disciplines due to the inability to recruit a large enough sample pool of social workers who wanted to participate. Particular attention was paid in the analysis of the data to any apparent thematic differences in the data provided by social work and non-social work participants. The *Diagnostic and Statistical Manual of Mental Disorders*, (American Psychiatric Association, 2013) states the “defining feature” of DID as “the presence of two or more distinct personality states.” Known national prevalence rates for this disorder range from 0.01 percent (National Alliance on Mental Illness, 2015), to 1.5 percent (American Psychiatric Association, 2013). However, DID appears to be frequently misdiagnosed due to the frequent intense trauma basis and comorbidity pervasiveness of the disorder (Gast, Rodewald, Hofmann, Mattheß, Nijenhuis, Reddemann, & Emrich, 2006; Slogar, 2011). Because of this, prevalence may be even higher within the population than first thought. It is therefore likely that, at some point in a career, a therapist will encounter a client with DID. Despite this, it seems little training goes into preparing mental health workers for treating clients with DID (Colin, 2015). Those with this disorder may not accrue the essential care necessary to treat them. Because of this, additional research may contribute to the improved treatment of clients who suffer from this disorder.

DID is one of the most controversial diagnoses in the history of the mental health field (Sousa-Ferreira, Ferreira, Ferreira, Amaral, & Cabral, 2015). Despite its inclusion from the

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DSM-II onward (under its previous names of Hysterical Neurosis, Dissociative Type (American
Psychiatric Association, 1968) and Multiple Personality Disorder (American Psychiatric
Association, 1980; Putnam, 1989)), the validity of the disorder continues to be questioned
(Boysen & VanBergen, 2014; Cohen, Elin, & Berzoff, 1995). The purpose of this study was not
to prove or disprove the existence of this disorder but to explore the experiences of therapists
who work with clients who meet the diagnostic criteria for DID. Nevertheless, it was expected
that the narrative data of the study would reflect issues related to the validity of the diagnosis.

It was expected that the narrative data would likely focus on theoretical and practice
approaches used by study participants, treatment issues related to transference and
countertransference, supervision, and the lack of guiding literature. This study was guided by a
review of the literature on mental health practice with DID. It is noteworthy that there is very
little research related to the treatment of DID, and even less research on social workers treating
DID, especially when compared to the literature for other disorders. Following a qualitative
approach to the methodology, narrative data were examined and organized into thematic
categories.

The following chapters explore theoretical and empirical literature on DID, the
methodology used to explore the research question, the findings of this research, and finally a
section of discussion to explore the meaning of these findings.

CHAPTER II

Literature Review

Introduction

This chapter provides a review of several major themes that appear in the literature about what clinicians may experience when working with a client with Dissociative Identity Disorder. It is divided into three major areas: describing the disorder itself, the controversy surrounding the disorder, and treatment for the disorder.

Describing the disorder

Diagnostic history of the disorder. The diagnostic perception of DID has evolved over the past few decades. One of the first formal attempts to include the symptoms of DID was via the diagnosis “hysterical neurosis, dissociative type” in the Diagnostic and Statistical Manual of Mental Disorders, second edition (American Psychiatric Association, 1968). This disorder was characterized by “involuntary psychogenic loss or disorder of function” along with alterations that “occur in the patient’s state of consciousness or in his identity, to produce such symptoms as amnesia, somnambulism, fugue, and multiple personality” (p.39-40).

It wasn’t until the DSM-III, however, that the disorder received its more familiar name of Multiple Personality Disorder (American Psychiatric Association, 1980). The DSM-III listed three main criterion: the existence of two or more distinct personalities (each dominant at a particular time), the dominant personality determining an individual’s behavior during the time it is dominant, and that each individual personality must be complex and have its own unique behavioral patterns (p. 259).

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The DSM-IV gave DID the name it currently holds (American Psychiatric Association, 1994). The DSM-IV divided the criterion for DID into four separate criteria: that the individual has two or more personality states (each with particular ways of perceiving and relating to its environment and self), that these personality states recurrently take control of behavior, that there is significant amnesia between states, and that these states are not caused by substances or medical conditions (p.484).

Current description of the disorder. There is a significant body of literature, both quantitative and qualitative, that attempts to describe the various aspects of DID. The DSM-5 (American Psychiatric Association, 2013) stated that the “defining feature” of DID was “the presence of two or more distinct personality states,” coupled with amnesia between these states (p.292). The DSM-5 also indicated that these personality states must cause significant distress or impairment, are not part of a cultural practice, religion, or imaginary play of children, and are not due to substances (p.292). Although not a requirement for the disorder, the DSM-5 noted that those with DID often have extensive trauma histories and comorbid disorders (American Psychiatric Association, 2013). The DSM-5 indicated that these personality states differ from auditory hallucinations in that the person must identify a feeling of loss of self and the absence of a sense of personal ownership or control (p.293). The DSM-5 additionally detailed that the dissociative amnesia must present in three primary ways: gaps in memory of life events, gaps in “dependable memory” (e.g., daily skills used previously, what happened during the day, etc.), and discovery of evidence of actions they do not recall (e.g., shopping receipts, etc.) (p.293). Finally, the DSM-5 noted that DID is associated with traumatic experiences, especially that of abuse early on in life (p.294).

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The trauma-basis of DID has been studied on the neurological level. An example of this is Reinders et al.'s (2014) study which examined the neural network patterns of clients with DID. This study was comprised of 11 clients with DID and 16 healthy control subjects who attempted to simulate DID symptoms. The study reported two major findings. The first was that DID patients showed activation patterns consistent with patterns associated with clients with Post-Traumatic Stress Disorder (PTSD), while the control group did not. The second finding was that there were additional areas activated in clients with DID that were not activated in clients with PTSD (as reported in the literature (Reinders et al., 2014), including the posterior association areas, parahippocampal gyri, and dorsal striatum. The study concluded that these areas may “play a pivotal role in suppression of trauma-related autobiographical memories” and may “be crucial in the regulation of memory access by modulating the presence of different identity states” (p.242).

Similarly, neurological studies have been done on the variance within the states of DID (Reinders et al., 2006). Reinders et al. (2006) studied the difference between different dissociative identity states. The study separated states into two different categories: “neutral identity states” (NIS) and “traumatic identity states” (TIS) via subjective reports, cardiovascular responses, and neuroimaging (p.730-731). This study, comprised of 11 clients with DID, found that there were differences between the way NIS and TIS reacted to trauma-related stimulus on all three types of report (p.737-738). The study concluded that the areas affected in the neuroimaging scans (including the visual association cortex, middle temporal gyrus, inferior and superior parietal lobule, and superior frontal gyrus) were involved in the “establishment of functioning as two dissociative identity states” (p.738). This meant that clients with DID

THERAPISTS' EXPERIENCES TREATING CLIENTS WITH DISSOCIATIVE IDENTITY DISORDER encompass at least two different dissociative identity states. These identities involve different subjective reactions, cardiovascular responses and cerebral activation patterns to a trauma-related memory script.

Despite the refinements in diagnostic description and advances in neurological research on DID, there is still a dearth of research on this disorder. A recent meta-analysis by Dorahy, Brand, Şar, Krüger, Stavropoulos, Martínez-Taboas, Lewis-Fernández, and Middleton (2014) set out to elaborate on this deficit. This analysis found five areas in which research for DID is lacking: *diagnostic concerns*, *cultural issues*, *post-traumatic avoidance*, *cost-benefit issues*, and *conceptual challenges*. The first of these, *diagnostic concerns*, involved the high rate of “polysymptomatic” individuals, a lack of inclusion of dissociative testing in most major research tools, and the general under-researched nature of the disorder (p.403). The second, *cultural issues*, concerned the lack of cross-cultural research with the disorder (p.403). The third, *post-traumatic avoidance*, involved the conditioning of patients with severe trauma histories who do not tell of their abuse by their abusers, and the possible influence this may have on reporting within research that currently exists (p.404). The fourth, *cost-benefit issues*, cited the lack of funding for current research and treatment given the often intensive care needed to effectively treat these clients (p.404). Finally, *conceptual challenges* detailed the lack of consistent validity across the board in research, assessment, and treatment tools alike (including content validity, criterion validity, and construct validity) (p.404-407).

Consequently, describing the prevalence of the disorder can be difficult. The known national prevalence rates for DID range currently from 0.01 percent (National Alliance on Mental Illness, 2015) to 1.5 percent (American Psychiatric Association, 2013). According to a

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meta-analysis by Gast et al. (2006), this rate variance may be due to the nature of the disorder

itself. The report suggested that the disorder may be difficult to diagnose for two reasons:

memory loss and shame. As one of the requirements for a diagnosis of DID is listed as amnesia
between personality states (American Psychiatric Association, 2013), clients often may have

disrupted functioning in areas of “memory, perception, and self-experience” (p.4). Because of
this amnesia, patients may not be able to report to clinicians the sense of the “other” (p.4-5).

Instead, the literature suggested that first clinical contact may only involve “secondary or
consecutive problems” including depression, self-harm, etc. (p.4). Secondly, the analysis found

that many patients appear to resist reporting dissociative symptoms due to feelings of shame
(p.4-5). Because of this, it appears this disorder may be frequently misdiagnosed and true

prevalence within the population may be higher than recorded.

Controversy

DID has been under speculation throughout its development as a diagnosis, gaining
particular movement from the early 1900's onward (Putnam, 1989, p.341-350). Sensationalized
in the media by books such as *Sybil* (Shreiber, 1973) and movies such as *The Three Faces of Eve*
(Johnson, 1957), there has been much controversy about the existence of the disorder itself.

Cohen, Berzoff, & Elin's (1995) book detailed in length the various theoretical and treatment
controversies surrounding the disorder. The book presented various articles both criticizing and
supporting the diagnosis. In summary, the arguments presented against the diagnosis of DID
included the lack of isolated and uninfluenced by culture setting in which DID could be found,
the high prevalence of DID in developed countries, and the possible influence of the media
creating the disorder (p.58). Those in favor of the diagnosis included arguments such as the lack

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of any disorder (dissociative or otherwise) existing outside of culture and society, the possible influence of the media's representation of other disorders, and the existence of cases of DID that are found outside of developed countries (p.59-60). Overall, the book reinforced the idea that other more widely-accepted disorders could receive the same questions (and, in some cases, have in the past), but have no empirical basis to receive this particular skepticism. Instead, they argued that this skepticism was due to media influences and a lack of review of the literature (p.62).

An overview of empirical literature surrounding this controversy was presented in Elzinga, van Dyck, & Spinhoven's (1998) article. This study presented three main controversies about DID: the possible *iatrogenic influences* on this disorder, the accuracy of the *diagnostic criteria*, and the possibility of *false memories* induced by therapists. The article detailed that the first of these, *iatrogenic influences*, was supported by a study that had students role-play and respond to a hypnotic interview (Spanos, 1994). Spanos's (1994) study resulted in the report of amnesia and the presence of alters. However, it was found that this simulated enactment did not hold up under diagnostic interview (p.18). Elzinga, van Dyck, & Spinhoven instead suggested that the only possible influence of iatrogenic components would be on the number of personalities, but more study on this possibility would be needed before any conclusion could be made (p. 15). The second controversy in the study, *diagnostic criteria*, involved the issue of possible over-diagnosis of DID (p.16). The study found that most of the confusion in past years appeared due to vagueness by the DSM-III, DSM-III-R, and DSM-IV in the criteria for DID (p.16). The study posited that despite this, instruments such as the SCID-D (Steinberg et al., 1993) had been both tested for reliability and validity, and had also served as adequate diagnostic tools to make a proper diagnosis (p.16). It was found through an overview of literature that it

THERAPISTS' EXPERIENCES TREATING CLIENTS WITH DISSOCIATIVE IDENTITY DISORDER appeared possible to create false memories for the final controversy, *false memories* (p.17-20); but moreover, it was possible that traumatic memories may be repressed and dissociation may rise in their place (p.20).

As previously postulated (Cohen, Berzoff, & Elin, 1995; Elzinga, vanDyck, & Spinhoven, 1998), skepticism towards DID may be due to a lack of knowledge about the disorder. Hayes & Mitchell's (1994) study examined the role of knowledge and skepticism towards DID. This study consisted of 207 mental health workers nationwide who were surveyed for their knowledge of and level of skepticism towards DID. Overall, the study found two significant correlations: the first that those with more knowledge about the disorder were less skeptical towards it (p.411), and those more skeptical towards it had higher rates of misdiagnosing it (p.413). Although the results were broken up into categories of social workers, psychologists, and psychiatrists, all three had the same significant correlations and differed only in their specific correlation strength (p.411).

Although it is unclear as to exactly how attitudes towards the disorder have changed, it appears that this relationship between skepticism and misdiagnosis has held true. Perniciaro's recent (2014) quantitative study, for instance, mirrored the conclusions of Hayes's & Mitchell's (1994) previous findings. This study examined the possible influence of skepticism towards the disorder on the detection rates of clinicians. This study consisted of 91 masters or doctorate level clinicians with varying degrees of experience treating the disorder. The study found three significant correlations within their sample: that those who had treated a client with DID were significantly more likely to correctly diagnosis the disorder, those who were more skeptical towards the disorder were more likely to give an incorrect diagnosis, and that those who had

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previously treated a client with the disorder were less likely to be skeptical towards it. The study concluded by recommending more training for clinicians in order to provide more accurate diagnoses.

Despite this possibility, it seems little training goes into preparing mental health workers for treating clients with DID (Colin, 2015), which may negatively affect treatment. A study by Myrick, Gasson, Lanius, Leventhal, and Brand (2015) tested the effects of a therapist's experience level and the effectiveness of their treatment. The study specifically examined the interventions used by a sample of international outpatient therapists and a sample of dissociative disorder experts treating clients in the first or second stages of treatment. Although there were some similarities of treatment, it was found that those with more training for dissociative disorders had significantly better treatment outcomes.

Treatment

Research for treatment for dissociative disorders, including DID, has been slowly accumulating over the past three decades (Dalenberg et al., 2007). A study by Brand et al. (2012) detailed the most common practices and recommended treatment interventions for therapists treating patients with this disorder as well as Dissociative Disorder Not Otherwise Specified. This study of 36 international experts found a theme of a three or five-stage intervention plan for clients. The first and second of these stages involved assessment for safety strategies, daily functioning skills, psychoeducation, and cognitive-behavioral therapy focused on changing distorted cognitions (p.493). The third stage involved similar steps, but additionally integrated trauma-focused work based on the current models of trauma treatment (p.494). Although treatment interventions varied more significantly during stages four and five, a goal of

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“stabilizing the patient after intrusions from reported perpetrators” was a constant for these stages (p.494). Overall, it was found that the recommendations from these clinicians were consistent with the staged treatment outlined in treatment guidelines (e.g., ISSD (2006), and all seemed to target modulation of affect, crisis stabilizations, and improving interpersonal skills (p.496).

Kluft's (1999a) study on the various forms of psychotherapy for clients with DID echoed the stage model by Brand et al. (2011). Kluft indicated that though there were multiple staged models (varying from three-stage models to nine-stage models (p.295)), the stages could be summed up into three: safety, remembrance and mourning, and reconnection (p.295). Kluft additionally detailed the use of other techniques in combination with this stage-model format: Eye Movement Desensitization and Reprocessing (EMDR) therapy, Hypnosis, Psychopharmacology, Group therapy, Family therapy, and Creative Art therapies. Although Kluft found that a few of these may pose potential hazards such as encountering potential abusers through family therapy, or the controversy of hypnosis potentially creating alters, when used properly, Kluft reported that they acted as great additional supports to psychotherapy (p.301-304).

Translating these theoretical models into actual practice can be difficult. MacIntosh's (2014) qualitative article on treating a client with DID identified the current trauma models and, through a single case study, demonstrated the struggle of integrating these trauma models into treatment. In the article, MacIntosh reported finding two main types of treatment: stage-model treatment and relational psychoanalytic model-treatment (p.520-522). MacIntosh identified the first main difference between the two models as to how the models choose to explain the origins

THERAPISTS' EXPERIENCES TREATING CLIENTS WITH DISSOCIATIVE IDENTITY DISORDER of DID. MacIntosh described stage-model treatment as defining DID as “a failure of normative integration” due to “impacts of chronic, early, and severe abuse” (p.520). The relational psychoanalytic model, on the other hand, described DID as “the degree to which parts of the self are fluidly overlapping versus sequestered, separated by permeable versus rigid boundaries, experienced simultaneously versus amnesic and unknown to each other,” and is formed as a protection from “painful affects and memories they may hold” (p.521). MacIntosh then identified the second difference between the two models: the approach to treatment. MacIntosh reported the stage model as having three main stages: stabilization, processing trauma, and reconciliation and integration with the self and outside world (p.520). Alternatively, the relational psychoanalytic model does not recommend a linear process, but instead emphasizes safety and the role of the therapeutic relationship in the treatment process (p.521). MacIntosh then used a combination of the two with her client. MacIntosh reported finding that stage-model treatment was used primarily for the early stages of treatment (crisis stabilization and the processing of trauma), but did not appear as effective with the case in the later stages of treatment (p.527-528). Once the sessions became stable, MacIntosh reported that looking at the therapeutic relationship for enactments of the traumatic roles in this particular client’s life was much more effective (p.531-534).

Research on the clients’ perspective of treatment has also been approached in recent years. Jacobsen, Fox, Bell, Zeligman, & Graham’s (2015) qualitative study examined the perspectives of the counseling process for 13 individuals with DID—specifically, what clients found to be effective or ineffective. Their findings revealed four main themes: *effective approaches and techniques, effective relationship-building techniques, ineffective approaches*

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and techniques, and negative and positive counselor qualities and characteristics (p. 311). The first, *effective approaches and techniques*, involved many issues related to safety and support—creating a secure structure, grounding techniques, providing good pacing of sessions, group support, the teaching of coping skills, etc. (p.311-312). Techniques outside of safety and support involved identifying and assigning alter roles, but not engaging those roles in traumatic flashbacks (p.312-313). The second, *effective relationship-building techniques*, involved self-disclosed insight, being client-centered, and modeling appropriate emotions (e.g., showing the client enthusiasm for accomplishments even if the client cannot feel a sense of satisfaction) (p.314). *Ineffective Approaches and Techniques* involved inadequate termination (terminating without due process), relying solely on technique (instead of simultaneously creating a relationship along with using technique), a lack of safety (e.g., being hospitalized without due process), inappropriate confrontation, and lacking a therapeutic plan (p.314-315). Finally, *counselor qualities* were split up into two categories: *positive* and *negative*. *Positive* counselor qualities were listed as empathy, being engaged, validating, unconditional positive regard, genuineness, transparency, flexibility, experience, analytic abilities, motivation to learn about DID, stability, safety, and advocating professional boundaries. *Negative qualities* were generally listed as the opposite of these (lacking empathy, lacking unconditional positive regard, etc.). However, they also included not believing in the disorder, not being available, and not adequate focus on the client (p.316-320).

There has been some controversy as to whether treatment for clients with DID is helpful or harmful. An empirical review by Brand, Loewenstein, & Spiegel (2014) provided an overview of support for both arguments. This analysis involved the treatment outcome of 160 studies from

THERAPISTS' EXPERIENCES TREATING CLIENTS WITH DISSOCIATIVE IDENTITY DISORDER 1989-2014. The study found that a very low percentage of studies (a total of four) showed that clients with the highest level of dissociation were not responsive towards treatment, and "sustained worsening" only occurred in 1.1% of clients (p.176). Of all treatments, it was found that the stage trauma model for DID treatment was "beneficial across a wide variety of outcomes, treatment settings, researchers, and cultures" (p.178). This trauma stage-model form of treatment involves three primary stages: stabilizing and managing response, processing and grieving traumatic memories, and reconnecting with the world (p. 169-171). The analysis then presented the themes that were identified as harmful in treatment: failure to review scientific literature and reliance on opinion pieces, reliance on non-peer-reviewed anecdotes, inaccurate assumptions about the nature of DID treatment, strained logic and lack of parsimony in interpretations of data, misunderstanding awareness of self-states, and unsubstantiated claims that treatment makes clients more dissociative (p.179-183).

Part of the issue of treating DID comes from the little written about what therapists actually experience when treating a client with DID. Some research comes close to describing what therapists encounter in treatment. For instance, Pearlman and Saakvitne's (1995) book on the theoretical considerations of therapists working with sexually abused clients addressed issues that arise when treating dissociated clients. Issues that appeared in treatment include vicarious trauma that may arise when dealing with severe abuse, the roles of transference and countertransference, the different support systems therapists utilize during treatment.

Through texts like these, we may see glimmers of what it may be like to treat clients with DID. However, to date, there has been very little research on what therapists experience when treating this disorder. In order to best prepare therapists for the likelihood of treating a client with

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DID, it might be helpful to examine what therapists describe as their experience working with clients who have DID.

Summary

Dissociative Identity Disorder has entered the focus of the mental health field primarily during the last few decades. Currently, the disorder is defined as one that involves distinct personality states with periods of amnesia between these states (American Psychiatric Association, 2013), potentially caused by intense trauma during childhood. Controversy has surrounded the disorder since its inception due to questions of therapists implanting false memories and the creation of sensationalized media around the disorder (Cohen, Berzoff, & Elin 1995; Elzinga, van Dyck, & Spinhoven, 1998). Because of this, much of the research literature on DID has been dedicated to the investigation of its legitimacy. Additionally, it has been found that skepticism around the disorder may greatly negatively impact the detection rate of DID as well as treatment (Hayes & Mitchell, 1994; Perniciaro, 2014). Guidelines for DID treatment primarily recommend utilizing trauma stage-model treatment (Brand, et al., 2011; Kluft, 1999a; MacIntosh, 2014), potentially in combination with Hypnosis, modified EMDR, and other therapies (Kluft, 1999a). Although it appears very little has been researched into the therapist experience when treating clients with this disorder, issues that may arise during treatment include vicarious trauma, the roles of transference and countertransference, and the different support systems utilized in treatment (Pearlman and Saakvitne, 1995).

This study might contribute to the literature by helping fill in the gap surrounding the research on the experiences of therapists who treat clients with this disorder. The following chapter on methodology will contain descriptions of the research design, sample, data collection,

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analysis, limitations of the study, and implications for practice and future research.

CHAPTER III

Methodology

Research Purpose and Question

To date, there has been limited research on therapists and Dissociative Identity Disorder. For this reason, the purpose of this exploratory study was to gain a deeper understanding of therapists' experiences with clients who have DID. In addition to providing insight into the theoretical and practice issues in providing services, it was expected that the narrative data of the study would reflect issues related to the validity of the diagnosis.

Research Type, Method, and Design

This study was designed as a qualitative, exploratory study that used open-ended questions to gather narrative data. The inductive nature of this approach allows for deeper understanding of a phenomenon without assumptions behind it—that is, the study did not hypothesize the themes that would emerge from interviews with study participants, allowing them to discuss their experiences openly. The choice for this inductive form of study had multiple reasoning behind it. Firstly, an open-ended interview allows for the possibility of participants discussing controversy related to the validity of the disorder (Elzinga, van Dyck, & Spinhoven, 1998; Sousa-Ferreira et al., 2015), and participants could identify the most useful theories, the “best practice approaches,” and suggestions for additional research. Secondly, as the disorder has limited research when compared to other disorders (Slogar, 2011), especially when

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focused on the role of therapists treating this disorder, this design allowed respondents to richly explore their experiences and opinions in more freeform ways. The following sections outline the methodology of this study, including sampling, data collection, data analysis, and possible limitations of the study.

Sample

The sample pool for this study was initially social workers who self-identified as having some expertise treating clients with DID in the New England area. Due to the inability to recruit a large enough sample pool of social workers, research was expanded into other disciplines. Recruitment involved purposeful snowball sampling of self-selected participants. A group of agencies that are likely to have clients with this diagnosis was asked permission to distribute recruitment e-mails (see Appendix A) to obtain participants or referrals for possible participants. Inclusion criteria included mental health professionals who have self-identified as having some expertise in treating those with DID, the ability to speak English, locality (as the sample consisted of those in the New England area), and licensure (all participants were licensed therapists). Initial contact with possible participants included a listserve-distributed e-mail stating inclusion criteria requirements and how to contact the researcher (see Appendix B). Once participants learned about the study, they contacted the researcher through an e-mail address. Once this e-mail was received, participants were sent two copies of the informed consent form (see Appendix C) by e-mail or mail. If by mail, a self-addressed stamped envelope was additionally sent to participants in order to return one signed copy of the informed consent. Once the informed consent was received back, participants were called and an interview time was scheduled. Additionally, this study was reviewed by Smith College School of Social Work's

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Human Subjects committee and ensured for appropriate protection for participants in this study

(see Appendix E).

Data Collection

Using open-ended questions, data were obtained through interviews, lasting between 40 and 120 minutes in length. Interviews were conducted either in-person, by phone, or by Skype. If in person, interviews were conducted in confidential spaces, (e.g., in a single-person office, home, etc.) of the participants' choosing. These interviews were audio recorded for transcription and qualitative analysis.

During this interview, several demographic questions were asked, including age, gender, and years of professional practice (see Appendix D). After demographic data were collected, all participants were asked the same initial question: "what has it been like to treat clients with DID?" Additional follow-up questions, based on the participants' responses, were then asked. Examples of follow-up questions included "how did you learn about that treatment?"; "how well do you feel that treatment worked?"; "did you talk to a supervisor or peer about that experience?" After the interview, recorded data were then transcribed into written text for the purpose of analysis.

Data Analysis

Transcribed interviews were examined for common and divergent themes. Demographic data were then examined for possible association with these themes. Particular attention was paid to the analysis of the data to any apparent thematic differences between social workers and non-social workers.

Limitations

This study is limited in that it relies on a small sample size taken from a limited geographic area, and is therefore restricted in its generalizability to the mental health field as a whole. An additional limitation was the inclusion of non-social workers due to low recruitment for this population. Because of this, it is unlikely that this sample was indicative of all possible social workers' perspectives regarding DID.

Implications for Practice and Future Research

As previously stated, there is very little research regarding the experiences of therapists who treat clients with DID. Because of this, the influence of theoretical orientations, treatment perspectives, and all other facets that influence how therapists may approach treatment with clients with DID have gone largely unrecognized and unexamined. Data from this exploratory study, even with its methodological limitations, may suggest useful practice suggestions as well as pathways into future research.

CHAPTER IV

Findings

The purpose of this research project was to explore the experiences of therapists who treat clients with Dissociative Identity Disorder. This chapter outlines the findings of this exploratory, qualitative study based on 12 interviews with therapists who identify as having some expertise treating clients with DID.

The data presented in this chapter were collected through phone, Skype, and in-person open-ended interviews which were transcribed and then analyzed. In addition to the open-ended interview questions, several demographic questions were asked, including age, gender, and years of professional practice. Seven main themes emerged from the data, each theme encompassing several subthemes. This section will present the seven main themes and their respective subthemes using examples from the interviews, thereby maintaining fidelity to the participants' voices. The seven main themes this section describes are: *the challenges and rewards of treatment, characteristics of the population, characteristics of the clinicians, treatment structure, what treating their first client with this disorder was like, misconceptions, and places the research is missing*. Demographic data (including professional identification) will be examined for potential associations with narrative thematic data. This chapter begins with a presentation

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of the demographic findings.

Demographic Data

A total of 12 individuals participated in telephone, in-person, and Skype interviews and answered all demographic questions. Of the 12 participants, nine identified their gender as female, and three identified as male. The participants' ages ranged from 43 to 74 years old, with the average being 62.3 years, with a median age of 66 years old. The participants' years of experience ranged from 12 to 50 years, with the average being 32.0 years, and the median being 32.5 years. Five of the participants were social workers, five were psychologists, and two were mental health counselors. Finally, the number of clients with DID reportedly treated ranged from 4-100 clients, with the median being 19.9 clients. It is noteworthy that all therapists caveated this last demographic question that it was difficult to determine the actual number of clients due to the nature of the disorder. When broken up by profession, the demographics show some additional variance. Social workers averaged an age of 57.2 years old, whereas other mental health professionals were on average ten years older (67.6 years old). Similarly, social workers had ten years less of practice experience (24.0 years versus 34.6 years of experience). Finally, social workers on average had 10.4 clients with DID, while other mental health professionals had an average of 25 clients with the disorder.

The following sections outline the seven main themes and their respective subthemes that emerged during the qualitative data analysis. In the following sections, all participants are given pseudonyms to protect confidentiality.

Themes

The challenges and rewards of treatment. The first theme encountered was the

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response to the initial question all participants were asked: "What has it been like to treat clients with DID?" Nearly all participants gave a list of varying adjectives as a response. Of these adjectives, two in particular were used by nine out of the twelve participants: *challenging* and *rewarding*.

Participants cited a range of similar reasons that working with this population was particularly challenging. The most common challenging feature was that of the "angry, destructive parts" of personality that sometimes arose in therapy. Samantha, a 50-year-old social worker who has treated 10 clients with the disorder, explained what working with these "parts" entails:

The ones that turn on the others in the system are the ones I have a hard time with. It's kind of what we might see in a Borderline patient... irritable and grumpy, or nasty hostile... Just really angry. Internally, they can often times be hurting others. You know, it's really hard to get them to cooperate because they want no part of it. They're really upset that this person is bringing them to therapy; it's almost as if you've got a parent driving in an adolescent girl that's hitting people. You know you can intervene in certain ways but, because it's in an internal system, it's really frustrating.

Nathan, a 70-year-old social worker who has treated 10 clients with the disorder and currently facilitates trainings for clinicians working with this population, described how destructive alters can sometimes halt therapy altogether:

The most floridly dissociative client I've ever treated took about three months to create safety in my office. With some frequency, an alter would drive the car a hundred miles an hour... and she would come to just before crashing into another car... There was a huge

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step forward when she could experience safety in my office, but one day she came in and said “it’s been destroyed. I can’t be here anymore.” The persecutor interject, the alter, had destroyed her sense of safety. Nothing physically had happened—it’s just that they were not going to allow treatment to happen... The hostile interjects are incorporated personifications and messengers of abusers.

Notably, only one participant described these angry parts as “frightening.” Maria, a 43-year-old social worker who has treated eight clients with the disorder, explained:

There has been times when it can be a little bit frightening. That’s a misunderstanding—the idea that people think [those with the disorder are] obvious to the word that the person has [this disorder], but most of the time it’s not so dramatic... I had one that got kind of frightening, a part that was aggressive towards me... But just like for any client, that if you feel they’ve been triggered, they’re not seeing things clearly and they’re paranoid, angry, bitter. So sometimes it’s a little nerve-wracking, but other times it’s just like no different than working with any client.

These angry, destructive parts were consistently described as the most challenging to therapy overall. However, they were not the only challenging piece to this work, as seven of the participants noted that the complexity of the disorder was also quite challenging to work with.

Nathan explained:

For me, what’s most challenging is just the profound complexity of the disorder. Compared to other disorders, the journey can take so long with these clients. Tools like EMDR and structural dissociation really speeds up the process due to the clarity of understanding clients [with DID] can achieve, but it’s really just amazingly complex.

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Finally, it is notable that a minority of participants (n=2) mentioned vicarious trauma, despite the strong emphasis on it in the DID literature (Pearlman and Saakvitne, 1995).

The second consistently used adjective used when describing the experience of working with clients with this disorder is “rewarding.” When asked why it was so rewarding, clinicians consistently cited two reasons that made working with these clients particularly rewarding: seeing how dramatically people with DID can change and the feeling of being “invited” into the complex and frequently secretive inner world of individuals with this disorder. Referring to change, Karen, a 55-year-old therapist who had treated 20 clients with the disorder, explained:

People start out from such a low point. It's very exciting and rewarding to me when the behaviors the client comes in with go down and they're managing their rage or self-destruction or some addictive pattern. ...Like this one woman's marriage who was going to be ending soon because of her rageful behaviors, she was able to really turn it around and hang onto her family in a way that was very impressive. That's very rewarding. I think because they start out from such an incredibly hard place, seeing them turn it around is amazing.

Participants gave an additional reason why working with these clients was so rewarding. Because clients with this disorder often have to utilize a level of secrecy, participants reported that being trusted enough to be let into the clients' world as also particularly rewarding. Nathan explained:

It's an extraordinary privilege. They invite us into their dissociative fog, and so it's often very confusing because there are often multiple alters running interference and interrupting therapy. At the start of therapy, they feel people can't be trusted because it's too dangerous to go near the memories... And so when you can create the space for them

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to start to let you in, it's just... What a journey.

In addition to being particularly rewarding, five clinicians interviewed stated that working with these clients was “the most rewarding work” out of all disorders, in part due to these feelings of “being let in” and how much clients can change. Louise, a 74-year-old therapist who had treated nine clients with the disorder, described why working with clients with this disorder was most rewarding:

I love working [with clients with DID]. It's the type of work that I like the best. It's challenging, it's fascinating, it's incredibly rewarding. ... You know it's a very good relationship because you're the first person who has fully understood their experience and these are people who have not grown up with good attendance with their caregivers. These are people who have been through some of the most painful and unhappy childhood experiences of anybody that I've seen. So the therapeutic relationship ... it's deeply meaningful. I also have tremendous respect for these people. It's exciting, and really the most rewarding work I've found.

Participants largely seemed to feel that, despite the challenging nature of working with clients with DID, the simultaneously rewarding nature made them want to continue this work.

Characteristics of the population. The second theme that arose in the study is that of clinicians describing characteristics that those with the disorder have. When considering what it was like to work with the disorder, two characteristics of clients regularly appeared in the data: secretive (n=8) and intelligent (n=5). As mentioned in the previous theme, a majority of participants found that their clients with this disorder were often masters at keeping their symptoms secret. Maria explained that when discussing advice she would give:

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...It's important to educate people on why it's such a hidden diagnosis. You don't just really want to tell someone, like, hey! You have DID. You know? That's not exactly great news. There are reasons why someone doesn't walk into the door and tell you that they have different parts. They either don't know it, or they kind of know it, and they really are good at convincing themselves and not knowing it and they don't want to put any tension on it. Yeah, there's a reason that it's not flaming showing up.

In terms of intelligence, participants often remarked on the amount of mental effort managing DID takes. Samantha explained how she often lets clients know this:

A lot of folks with DID are very high-functioning, you know, they're raising kids, they're going to work... We all have aspects of our own personalities where "this is how I am at work" and "this is how I am at home" but... they don't have the memories. That's what introduces the need for treatment: the behaving differently, not remembering things that they've said and done. You go around the world asking "what's going on with you?" So it's a really ingenious way because if they didn't have the systems they are suffering too much and probably doing even more maladaptive behaviors. I spend time educating the patient as to what's going on... They're almost relieved. ...It's a method of coping with things that no one should have to cope with. If you hadn't developed this ingenious way and we just wouldn't know where you would be.

Participants also suggested that these traits of intelligence and secretiveness may go hand in hand. As Nathan explained:

I worked with a woman who... originally pretended that she was getting consultation and guidance from me for her partner... She was going to go onto graduate school to get a

doctorate in psychology and she wanted me as a reference, and the whole thing was such a crock... And like most of my DID clients she was brilliant, and constantly putting me in binds... It takes a lot of mental energy to have this defense and be able to manage to hide and function with [their symptoms].

Overall, the majority of participants cited that intelligence and secrecy as two traits which their clients typically needed in order to manage their lives when having this disorder.

Characteristics of the clinician. A number of participants (n=6) remarked on different characteristics that could be considered desirable in clinicians who work with clients who have DID. Most commonly, participants mentioned that therapists who work with clients with this disorder had to have a love for the work. Andrew, a 64-year-old who has treated 14 clients with the disorder and currently runs a consultation group for clinicians, explained:

The big advice is don't feel obliged to work with this population. If you're not comfortable with this population, don't feel like you have to. Know how to refer. Some people work with children, some don't. Some with couples, some don't. Some with adolescents, some don't... Nobody ever questions if someone doesn't want to work with teenagers... This is just another population that either you have a feel for working with or you don't.

Additional characteristics that therapists who work with this population might have varied.

Karen, for instance, mentioned that she thought therapists would need a love of puzzles:

“People with DID provide you lots of puzzles... I have always found it exciting and intriguing. I have a new dissociative client and I've only seen her three times and we just figured out that she has very little tolerance for positive affect. So that's going to be our

first goal—rounding any up any parts of self that have tolerance for feeling happy,

feeling good, feeling protected, whatever those good feelings might be. I find that I like puzzles like that.”

In general, participants seemed to feel that therapists who treated clients with this disorder would benefit from possessing certain personal characteristics.

Treatment structure. All participants in the study discussed the different aspects of treatment. Several sub-themes were reported consistently, the most frequent of which will be mentioned.

Therapeutic relationship. The first of these sub-themes involves four different aspects of the therapeutic relationship with the client: the importance of discussing goals, the importance of getting consent at every step of treatment, the importance of boundaries, and the importance of language. Karen explored why goals (n=5) were so important:

Well, with somebody who has a dissociative disorder, I talk to them really specifically about what my goals are for them, and then I try to figure out what their personal goals are, [like] if they want to have fewer yelling episodes with their partner, if they want to have more of a sense of unity of their different parts of self... So I think that one thing that helps for people to get comfortable is to know what your thoughts are about how the treatment ideally should go.

This idea of establishing this comfortability in the therapeutic relationship through different means included client consent (n=6). Andrew noted why consent was vital to the relationship with the client:

Every time you want to do something, you have to ask consent. “Would it be okay if we

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did this?" ...When working with the parts, you ask even more consent than [with a client who does not have DID]. ...You ask all the time. You give the person more sense of control of what's going on over something that can be very frightening for them. So you don't even take little steps without asking. Then they get the feeling of trust that you're always going to ask them and more sense of control. It's going to be more likely they'll stick with therapy. I think its huge mistake that people don't do that.

Participants reported that consistently asking for consent helped establish trust in the relationship and that it continuously re-established the treatment alliance. The importance of boundaries (n=7) was also emphasized by participants. As Karen explained:

You have to have a good personal boundary because there's usually a secondary personality disorder diagnosis that goes along with it, so you have to have a rock-solid sense of self to preserve when mud is slung in your direction... With vicarious trauma, keeping boundaries definitely does help. You have to leave this work at the office—you can't bring these peoples' trauma with you, or you're sunk. You have to leave it at the office... I always tell people that they can call me and leave a message between sessions ...because when they get home another part of self might have reactions to the work that we did... I don't feel like that's bending the boundaries, I feel like that's just allowing myself to be the receptacle for the holding between sessions.

Finally, the importance of language (n=5) was frequently presented. Specifically, using a language that was inclusive of dissociated parts of the client acted as an additional method to develop and maintain the relationship, as Samantha explained:

I start with just telling the patients the fact that I'm speaking to [all of the parts] that

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would like to listen. I always make sure that my language is inclusive. Either from speaking to one body in front of me or if I'm talking to them all. A lot of the first phase of treatment is making sure that they know that they're not going to be annihilated. That's what makes them avoid going to therapy—all these parts are thinking “she's going to get rid of me” or “I'm going to have to let it go and cease to exist.” I let the whole system onto the fact that they're sharing one body which they're also not aware of.

Language was additionally important when referring to the clients themselves. Nathan, for instance, remarked that when accidentally referring to a client he treated as a “DID client,” he corrected: “A client with DID, not a DID client. I hate that objectification of the disorder.”

Overall, participants remarked that the therapeutic relationship, once a treatment alliance is established, becomes extremely important for clients with this disorder.

Clinical modalities. Another important sub-theme is the range of clinical modalities participants mentioned as being particularly helpful. A majority (n=7) of participants mentioned using an eclectic approach. Of this approach, several commonalities included the use of EMDR and Trauma Stage-Model therapy. Maria explained how useful she finds EMDR in working with clients with DID:

“I specialize in trauma. I thought if I'm a trauma therapist, I need to learn EMDR. So I went to get trained and then I was very disappointed to find that if [clients] are dissociative when you screen them, you're not supposed to [do EMDR]. Because you need to be grounded in order to do so... I thought “are you kidding me?” Everyone I had in mind to do EMDR had complex trauma. That's how I found my consultant group that does a modified version of EMDR. What you do is you're taking this big protocol and

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basically breaking it down into tiny bite-size pieces. You do a tiny bit at a time and you make sure all parts of the system are on board and okay with doing a little bit of work. It's sort of like little modified adaptations of EMDR.

... [The client's] insight mind is not answering the same as their trauma mind that carries the emotions. We all have some level of dissociation where our deepest wounds are separated from our intellectual mind. That's what I love about EMDR: it really helps to take that insight and help it spread into those pockets that are split off so that the full mind can benefit from the insight. So it makes so much sense that it's a wonderful tool for dissociation... It breaks down the barriers of the mind. People with dissociation are split off for a reason, so you don't want someone to be breaking down those barriers that are there for self-protection and have the person get flooded and overwhelmed. That's why the modified EMDR is for tiny little pieces like little bite-size pieces and you monitor the person carefully and you make sure that they're in their window of tolerance. It's been a wonderful tool.

Andrew echoed the usefulness of a modified EMDR:

When you're using EMDR... The adaptation for working with the parts is that you ask more permission. Again, it goes back to constant consent. You know, "Is it okay to do another set? And then is it okay to do the next step?" So that's really important.

Participants who mentioned EMDR (n=6) consistently mentioned both the usefulness as well as the need for modifying it to use with clients with this disorder.

When discussing stage-model treatment, participants typically discussed it in terms of how they actually staged their treatment. Andrew, for instance, described it as:

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I basically do it in three stages. The first days are your normal evaluation of this person and their problems, where they're coming from and so forth, and there are certain signs that start to pop up that make you think maybe this person has a dissociative disorder. The second phase is to give them one or more screenings to see if we can verify two things: one, do they have repetitive traumas starting in early life, and two, are they showing symptoms of dissociation on one or more screening instruments... If it comes up with yeah, they have trauma, repetitive and family-based... Well, then they have trauma-related dissociation disorder. The next thing you do is to share that with the client and try to give them whatever support or comfort they need to deal with what you're telling them. Sometimes [the client] becomes very depressed, or very relieved... or they get scared, different reactions. Moving on to the third stage would be treatment with their permission. We explore dissociation, how it works... the roles and functions of the personality, things like that. That's ongoing even as you're undertaking the treatment. You continue trying to understand how they work.

That first phase of treatment of diagnosis might be anywhere from one to three or four sessions, the second phase one, two, three, or four sessions and the third phase is maybe years ... As you're doing treatment you're constantly trying to assess and further and deepen your understanding what's going on. A lot of the time, parts of personality don't emerge right away, maybe not even for years. You have layers of parts of personality. The parts can be in kind of a hibernation, and because therapy itself or life circumstances has changed, the parts are prepared to reveal themselves.

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Markedly, a number of participants (n=5) mentioned that a background in psychoanalysis was helpful, but could not be the sole model of treatment with clients with this disorder. As Maria explained:

...[When trying to be] a better therapist, I used to find that with a psychodynamic training there was all sort of transference things playing out, and from early on I thought... I need to get better at psychodynamic skills. But then I found that, though I love psychodynamic work, insight doesn't it really bring change. And I find it really frustrating that when you and your client figure something out [the client says] "yeah, great, but I still need help."

Participants who mentioned psychotherapy consistently reported the need for additional types of therapy to supplement treatment with clients with this disorder.

Notably, despite the large history of hypnosis being used with the disorder, only two participants used it in practice. Andrew spoke about how, after his first two clients, he wanted to further his technique:

[With the first two clients] I was just following my nose... I did not have any theory about how to be helpful other than providing a place to be safe and explore. I developed [a theory] subsequently. I went back to graduate school to study hypnosis. I didn't think of it originally as a tool for working with that, but as I came out of graduate school we learned that hypnosis is a very good tool for working with dissociation.

Other participants mentioned that they thought hypnosis would be a useful tool for treating clients with this disorder. Nathan, for instance, said:

I'm not a hypnotherapist and that's certainly been the way that clients with DID have been treated over the last hundred years. It would be very helpful to become sophisticated

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in that mentality, but I postponed that because of all the teaching that I do.

Additional therapies participants discovered during the course of treating clients with this disorder included structural dissociation (n=5) and accelerated experiential dynamic psychotherapy (n=2), often used in combination with the other therapies.

Goals of treatment. A portion of the participants (n=5) had mixed views in regards to what the “end goal” of treatment was. For instance, Samantha mentioned that contrary to past treatment suggestions of the target goal as being integration, she did not find this helpful to treatment:

I don't know if integration is what people shoot for anymore... You know everything that I read [when I was treating clients with the disorder] said that was the final stage. I don't know what people are really attached to that anymore. It's more about the overall health of the person in the system. You know, we all have parts, so why is it all that harmful to have one part do grocery shopping and all that. Does it really matter? I think it's the parts that are abusive the angry parts the parts that need some work.

Maria similarly had clients who did not find integration was a goal that they wanted in treatment:

My first client had parts that spoke to me and were very open about it. I didn't know a lot about [the disorder] at the time. She had parts where trauma-related material would come out... But for her, we probably didn't get deep enough into the treatment because she wasn't aware of any negative parts. It wasn't even something that she wanted to fix, it was just something where she says “I have a built-in side of me that helps me.” ...So it wasn't very dramatic or eventful with my first one, and it not always is. You know a lot of the time you're working with a regular person that just has an issue that can speak in its own

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words.

Andrew, conversely, mentioned how integration can be part of EMDR:

...During the whole length of therapy you're ...trying to primarily build up the person's level of mental functioning... Because only when the person gets to higher mental levels can they then begin to integrate information. So when you get them to an appropriate level, you can start working on integration. That starts with offloading the pains that various parts of their personality carry. EMDR can be used for that.

Regardless of whether integration was mentioned or not mentioned, the participants' main goal appeared to be the reduction of trauma held in the various parts.

Treatment support. A majority of participants (n=7) stressed the importance of supervision and training throughout treating clients with this disorder. Nathan stressed that this was important for some clients more than others:

My advice is to get advanced training, get consultation, and don't pretend that you can do it without that. The complexity of their minds with dissociation that enables them to survive in childhood... It's astounding. I have a client in particular who disclosed about ritual abuse, and I have a peer consult who when I told him about this immediately sent me a reference for someone. Ritual abuse is a factor of ten above quote-unquote "normal" DID, and you can't pretend to understand it without specific supervision... I think that's where probably fragmented people with hundreds and hundreds of alters probably stem from or are most likely to stem from.

Additionally, participants mentioned that as they began to treat clients with this disorder regularly, being able to talk with other counselors through supervision and training provided a

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sense of relief. Maria expressed:

It's always nice to be able to talk to those who understand the language and the difficulties and rewarding parts of treating these clients. Especially in the consultation group I go to—sometimes especially when you're like “wow, this happened,” and you can share and get feedback on the experience in a meaningful way. So many clinicians miss the disorder, so it's always relieving in a way to find others that really know how to talk about it.

First client. All participants mentioned the first client they treated who had this disorder. When talking about their client, several sub-themes arose, including the little they knew about DID at the time and the different methods of education they sought.

Little known about the disorder. In terms of what they knew about the disorder at the time, no participant specifically reported that they knew much or a sufficient amount about the disorder. In fact, a majority of the participants (n=8) explicitly mentioned that they felt they knew very little about DID when they first treated a client with it. As Karen noted when discussing her first client:

[My first client] was a little girl... who had been sexually abused by her father... I knew nothing about [DID] or dissociative disorders at the time. When her behavior at school and at home would shift again and again so rapidly, she would turn into this other part of self... it was these night and day switches that would happen and I realized what the diagnosis was. That's when I read the [International Society for the Study of Trauma and Dissociation (ISST-D)] treatment guidelines and sought consultation.

Methods for learning about the disorder. Participants indicated three main ways they

THERAPISTS' EXPERIENCES TREATING CLIENTS WITH DISSOCIATIVE IDENTITY DISORDER pursued further education about the disorder: consultation and supervision (n=7), trainings (n=7) and research (n=8). The effectiveness of these methods appeared to vary from participant to participant. A number of participants (n=5) mentioned getting bad supervision. Rachel, a 67-year-old therapist who estimated treating 100 clients with the disorder, discussed bad supervision during the treatment of her first client with the disorder:

I was an intern. I didn't know what I was doing, and I was getting terrible supervision from my supervisor. Bad supervision was like bad therapy. If a therapist is narcissistic themselves or hasn't done their own deep work... it will undermine your work... I would encourage early therapists to never stop reading, learning, never stop doing your own work. It's really going to be important for you to do the work from your heart and soul.

For one participant, this bad supervision appeared to come up as a result of the controversy surrounding the disorder. Janice, a 66-year-old psychologist who treated around 20 clients with the disorder, described her supervision when treating one of her first clients:

I did my internship at a psychoanalytically oriented placement, so we had an acute unit for adolescents. There was a 14-year-old girl who I was supposed to see on the unit and three times a week. She was classically DID. She was not remembering from the beginning to the end of the session sometimes, she would bring her head up and stare blankly, and really... Switching was happening. In my office which really doesn't happen with DID. So... my coworker, a fellow intern, mentioned that it could be DID. I mentioned it to my supervisor and my supervisor who had been at that time very supportive of me became very irritated that I was suggesting this.

I became really frustrated with that because my supervisor was saying "you been reading

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too much Sybil.” The funny thing was that I had lived in Israel for all of the seventies and I didn't know what Sybil was. At the time, I was in my grad school classes in the late seventies I don't even remember the word dissociation being used in my graduate school. It was kind of interesting. I mean, PTSD wasn't even really used, and when it was used, it was only to describe veterans.

Participants noted how this bad supervision or lack of knowledge about the disorder seemed to fuel their interest in it. As Janice explained:

For me I really felt like these kids had PTSD, and the reaction was they can't have PTSD [because] they're too young. And that bothered me. I started to read a little bit on dissociation, and at the time, there were about 400 items of literature total. The reason I know this was because I got so angry by the time this was done with the internship I did grand rounds on the under-diagnosis of dissociation.

Conversely, Samantha, who had positive supervision during the treatment of her first client with DID, was able to quickly gain experience and become involved with the disorder:

I had fun. I was in grad school and had done my research paper on DID, so I had the awareness of what it was. My supervisor in my field placement was a DID specialist. She and I actually went on to do trainings for the other therapists working with clients with this disorder. So I think it was surprising, to kind of exciting, to “this is really cool.” I just learned to be in the moment with it because you can see it happening on the face when they're switching and... You just want to know who that is and talk to them and figure out what's going on with them but also to give back research and be an ally with them.

In terms of what was the most effective tool to understand the disorder, participants advocated

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for a mix of all three approaches (consultation and supervision (n=7), trainings (n=7) and

research (n=8). Karen, for instance, discussed how trainings affirmed her treatment:

It's hard to say [whether reading, consultation, or trainings are best]. I would have to say that I really believe in taking the trainings. I actually put many hours this past year into trainings... I'd recommend people for people to get ratings as soon as they can. By the time I took my training already been treating clients for a few years... and it was like "oh, good, I'm doing the right thing." I know it's sometimes hard to afford... because you don't make a lot of money in this field, but I feel like if you're able to, you should do it.

Many participants reported using a combination of supervision, research, and trainings after their first client in order to learn more about the disorder.

For some participants, the largest change came via their clients (n=4). For instance, when speaking about how he felt his method of treating clients with the disorder changed since his first client, Nathan stated:

The way that I've learned [how to treat clients with DID] is that I've been a student of my clients. You know, as all the masters say, my patients have taught me more than anything else or anyone else.

Misconceptions. Nearly all participants (n=10) mentioned misconceptions regarding DID and its treatment. The most common misconceptions included perceptions clinicians may have about their efficacy in treating the disorder, the observability of symptoms, issues obtaining support, and issues of how dissociation is perceived as a whole.

In terms of efficacy, seven participants mentioned that many clinicians who have little or no experience treating clients with this disorder often worry if they're going to be effective.

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Maria, despite being one of the few clinicians who felt fear due to an angry alter, still noted this misconception:

I have a lot of colleagues who feel once they realize [DID] is there, they think "I don't have the skills for that." But I feel like their relationship is the most important thing. I think if you already have a relationship with that person you are a wonderful person to deal with this... I know it can get a little scary, but so many times it not that much different than treating anybody else. It's just that [the client's] defenses have a life of their own. Sometimes it's easier because you're speaking right to the defense.

George echoed a similar surprise, given his expectation about the disorder:

[Before treating a client with this disorder] I sort of looked at it as the most difficult and complicated situation there is, that's probably way above my pay grade inability to deal with. What I find is that once you got the sort of logic of things it's actually quite pleasant to work with, and easy to develop a sense that you know something about what you're doing. The biggest surprise for me that I can really do this work.

A second misconception mentioned by the majority of participants (n=7) is that, although clinicians can be effective in treating clients with this disorder, they do need extra support through readings, trainings, and consultations. Louise echoed that, while anyone could treat clients with this disorder, the additional education ensured that they would be treated effectively:

There are some people who don't want the intensity or get scared. You hear people get scared. But for those of us who have learned about it and got involved in it... I think there are therapists who love the work once they figured out what it's like. My advice would be to get training, and read lots and lots of books. Don't think that you can just wing it and

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get a lot of good results.

Janice additionally emphasized that, although anyone could treat clients with this disorder, extra help would be necessary:

Treating DID isn't rocket science. Part of what happens is that therapist can be scared, and because they're afraid, they then make certain choices in the treatment that would be different. ...For instance, clients that cut themselves, the supervisor could ask "well, did you ask to talk to the part that cut themselves?" They say, "no, I don't want to bring that part out." If people are in supervision, they could talk through how to do that safely... ...So I think what really has to happen for people who are treating their first couple of cases is that they need just to have a supervisor consultant on the case.

The final misconception often mentioned (n=7) is that those with DID have easily observable symptoms. As Maria explained:

...It's important to educate people on why it's such a hidden diagnosis. You don't just really want to tell someone like "hey! I have DID." That's not exactly great news—there are reasons why someone doesn't walk into the door and tell you that they have different parts. They either don't know it, or they kind of know it, and they really are good at convincing themselves [they don't have it].

Echoing the earlier theme of secrecy, participants felt that the "hidden" nature of the disorder, combined with a lack of knowledge about the disorder, often leads to under-diagnosis. Maria, for instance, explained:

I really wish more therapists knew how to see it... I wish people would screen for it because you might think that you're addressing the whole person but only one part of a

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person is showing up in the office... You need to learn to develop the radar to see this.

Louise echoed this statement:

The biggest misconception is that it's rare. There was a study in northern New York, and they're were checking for DID and they found one and a half percent [had the disorder].

It's amazing. Among the therapeutic populations, it would be many more. [Therapists] think they'll be able to recognize it, and without training, that's very unlikely.

In general, it seemed that a majority of participants felt that DID is both hidden as well as underdiagnosed.

Remarkably, only a minority of participants (n=3) identified a misconception as disbelief as to whether the disorder it exists. Additionally, a minority of participants (n=3) mentioned the controversy. Gerard, a 66-year-old therapist who had treated four clients with DID who discussed the controversy, said:

The controversy comes from a horrible eight or nine-year stretch where people's lives were ruined by being accused of doing things to people that they had not done. Academic psychologists in particular started this whole who-ha of belittling the whole notion of repressed memories. Like other controversies, I think people are going to be naysayers for a long time. Some of the people I know [who have treated clients with the disorder], physicians and all, say that they would never have believed it until they treated them.

Generally, participants did not bring up concerns of whether the disorder was accepted or the controversy surrounding the disorder.

Places the research is missing. A final theme that arose for participants was mentioning where research around DID was missing. In particular, three areas were mentioned: family work,

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addictions, and EMDR. Debora, a 68-year-old social worker who had treated four clients with
the disorder, explained why there needed to be more research on how to work with the family
when treating clients with this disorder:

I believe that mental illness is a family illness. So that's my bias. If you don't work with
the family, the work is half done. [The clients I treated with DID] were labor-intensive,
and the dedicated parts of the family have to be brought out of the theatrics in order to be
stable and supportive. The patients need to understand the family's respected as well that
people have a limit. So it's part of the equation that often gets overlooked and
underserved.

Karen similarly felt that research regarding the role of addiction with this disorder was
overlooked:

I haven't seen much about addictions and dissociative disorders. I've had clients over the
years who've had very risky behaviors—sexual addictions, illegal activities, prostituting
themselves, and I haven't found very much stuff on treating co-morbid addictions with
Dissociative Disorders together because a lot of times those things do seem to show up
together. It's unfortunate because it's so incredibly prevalent for clients with these issues.

Finally, a number of participants (n=4) mentioned that there needed to be more research
regarding EMDR and DID. As Andrew explained:

EMDR is such a wonderful tool, but I don't think it's been researched enough, certainly. I
don't think our tools are up to that level of research. You know, [right now] it's sort of
interesting and dazzling disorder, and brain waves change when you're in parts so that
kind of stuff [interests the field] ... But there's nothing that I find particularly useful at

this point as a tool for understanding [DID]. I just don't think it's useful clinically yet.

We're still a level where clinical description and theories based on observations and inductive theory is really where it's at right now, and the most powerful [information] is from the 19th-century psychiatry. It's a shame that things like [the controversy] have taken away from researching what we can do to really help these clients.

Participants who mentioned research (n=5) regularly described it in terms of what was missing. These participants expressed that there was much more to learn about this disorder that researchers have not yet tackled.

Correlation between demographics and thematic data. Special attention was paid to potential correlations between demographics and thematic data. However, no apparent association between demographic variables and thematic data were found.

Summary

The seven main themes that emerged from the qualitative data in this study are *the challenges and rewards of treatment, the characteristics of the population, the characteristics of the clinician, treatment structure, what treating their first client with this disorder was like, misconceptions, and the need for additional research*. The data suggest that therapists who treat clients with this disorder often begin treatment knowing very little about the disorder, and find that guidance through research, consultation, and training to be crucial to effective treatment. They use a variety of tools and methods in their treatment, feel that there are many misconceptions and a lack of research on the disorder, and although treatment is challenging, find clients with this disorder rewarding to work with. The implications of these findings for social work practice follows in the next chapter. The following chapter also contains a further

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discussion of the interconnectivity of the seven themes and an outline of study bias and

limitations.

CHAPTER V

Discussion

The purpose of this research study was to explore the experience of therapists who treat clients with Dissociative Identity Disorder. The framework outlined in this discussion arose through analysis of qualitative data collected during semi-structured in person, telephone, and Skype interviews with 12 mental health professionals who self-identified as having some expertise treating clients with this disorder. Many of the emergent themes in this study support prior research on mental health workers who treat clients with dissociative disorder, although some themes differ.

The major findings of this research project are that most mental health workers who work with clients with Dissociative Identity Disorder find the work both challenging and rewarding, that clients with the disorder are often both intelligent and secretive, that treatment often involves an eclectic approach including trauma-stage model treatment and modified EMDR, that consent, boundaries, discussing goals, and language are vital to the relationship with clients with this disorder, that consultation, training, and reading research is key to effectively treating the disorder, that there are many misconceptions about treating clients with this disorder, and that there is considerable research still to be done. Most of these main findings are generally supported in the literature. However, some contradictions to the literature also appeared, including little discussion of hypnosis as a treatment modality and of the controversy

THERAPISTS' EXPERIENCES TREATING CLIENTS WITH DISSOCIATIVE IDENTITY DISORDER surrounding the disorder. The following sections highlight how the seven themes from this study compared with the existing literature on the experiences of therapists who treat clients with Dissociative Identity Disorder. Following the comparison with the existing literature, the study's strengths and limitations and recommendation for treatment and for further research will be presented.

The Challenges and Rewards of Treatment. One narrative theme in the data was that nearly all participants described their experience treating clients with Dissociative Identity Disorder as both challenging and rewarding. In their descriptions of what made working with clients with this disorder challenging and rewarding, several sub-themes arose. Participants stated that angry or destructive parts of personality as well as the complexity of the disorder made the work challenging, whereas being allowed into the often secretive lives of the clients and witnessing the positive changes they accomplished made it rewarding (and, for some participants, the “most rewarding”).

In the literature, research supporting these experiences is mixed. As for the challenging aspects, guidelines for treatment such as the International Society for the Study of Trauma and Dissociation (ISST-D; 2011) manual on the treatment of Dissociative Identity Disorder mentions the mediation of these alters being listed as one of the main treatment goals for therapists, (p.132) but does not go into great detail on what causes an aggressive alter or how a therapist should achieve this goal. Although the existence and difficulty of managing these alters are acknowledged in the literature, it appears that there is not much in the research literature about how to do so. In regards to the rewarding aspects, data in the literature about the rewards of

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working with this population are largely anecdotal (e.g., Howell, 2011; Krakauer, 2001) despite its regularity in the narrative data.

A divergent theme that appeared in the narrative data was that of vicarious trauma. In the literature, the potential for vicarious trauma when treating clients with Dissociative Identity Disorder is thought of as quite high (Cohen, Elin, & Berzoff, 1995; Saakvitne, Gamble, Pearlman, & Lev, 2000; Sinason, 2002). However, only one participant endorsed any form of vicarious trauma.

Characteristics of the population. A second theme that arose was that of clinicians describing the characteristics of their clients with Dissociative Identity Disorder as secretive (n=8) and intelligent (n=5). Participants often noted that, contrary to many portrayals of the disorder in the media, those with the disorder were experts at hiding their symptoms. Participants seemed to feel secrecy was a trait that clients needed in order to maintain daily functioning. In terms of intelligence, participants also felt that those with the disorder were typically “highly intelligent” individuals. Although participants gave varying answers as to why this may be, the majority stated that the complexity of having the defense of alters to manage their histories of trauma required tremendous mental energy and skill.

There appears to be very little research literature on an association between the intelligent and secretive nature of clients with Dissociative Identity Disorder. One such instance of an exploration of the secretive nature is in Howell's (2011) book on understanding Dissociative Identity Disorder, for instance. He remarks that “often, they are afraid that they will be considered crazy and will be put [into a mental institution] if they are found out” and that this level of secrecy might be seen as one of the reasons for the under-diagnosis of the disorder.

Characteristics of the clinician. A number of participants (n=6) remarked on different characteristics that clinicians might have when working with clients who have Dissociative Identity Disorder. Most commonly, participants mentioned that therapists who work with clients with this disorder would benefit from having a love for the work or had to have a love of puzzles. There appears to be no direct link of these characteristics, and would greatly benefit from further research.

Treatment. In this fourth theme, participants discussed various aspects of treatment. This was broken up into two separate sub-themes: the therapeutic relationship and the different treatment approaches.

The therapeutic relationship. Participants spoke of four different aspects of the therapeutic relationship, including the importance of boundaries, the importance of language, the importance of getting consent at every step of treatment, and the importance of discussing goals.

In the literature, the importance of boundaries is stressed more than any other parameter in treatment for establishing a therapeutic relationship with clients with this disorder (Behrs, 1994; Kluft, 1999b; International Society for the Study of Trauma and Dissociation, 2011). In fact, the International Society for the Study of Trauma and Dissociation's (2011) recommendations for treatment of clients with this disorder states that "even the properly conducted treatment of DID can cause temporary regressions while patients grapple with understanding their... limits and boundaries in treatment." As the literature and narrative data suggest, maintaining boundaries benefits both parties in the relationship, limiting the possibility of vicarious trauma for the therapist as well as helping the client appreciate the importance of boundaries in the management of the therapeutic relationship.

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The importance of language in the therapeutic relationship is a less common theme in current literature, though still present. A sizeable portion of the participants (n=5) discussed how language—specifically ensuring that language was inclusive of all alters—was critical in developing the relationship. Current literature does not seem to fully make this connection. For instance, the ISST-D (2011) does recommend that “clinicians should attend to the unique, personal language with which DID patients characterize their alternate identities” due to concerns that “certain terms would reinforce a belief that the alternate identities are separate people or persons rather than a single human being with subjectively divided self-aspects” (p. 121). However, it does not reflect on the impact this would have on the relationship. The narrative data, however, seem to take this a step further in noting that a therapist’s inclusive language additionally allows all parts to feel less threatened and more included in the therapy. Additional considerations of language that appeared in the narrative data include how clients are referred to. A notable number of participants (n=5) mentioned that they disliked referring to their clients as “DID clients” and felt it important to refer to them as “clients with DID.”

A third important aspect of the therapeutic relationship for clients with this disorder was that of consent. Half of the participants (n=6) indicated that consent needs to be repeatedly obtained throughout the course of treatment. Despite appearing frequently in the narrative data, the importance of consent in the therapeutic relationship does not seem to be prevalent in the literature. For instance, the ISST-D (2011) guidelines only discuss consent in terms of informed consent for medication (p. 150), when conducting additional treatment practices such as hypnosis and EMDR (p. 158-159), and in reference to ethical issues with informed consent (p. 163-164). Again, the narrative data appears to take this a step forward in noting that repeatedly asking for

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consent may foster the therapeutic relationship by ensuring that all parts of the personality are in alliance with the treatment.

The importance of goal-setting in the therapeutic relationship appeared just as vital in both the research and the narrative data. In each, goals unified the therapist and alters by offering a concrete objective. This is reflected in the ISST-D (2011) guidelines that state that goals must involve a “harmony among alternate identities” (p.133). However, the narrative data seems to take this a step further in inferring that allowing the client to set goals allows clients to feel more in control and strengthens the therapeutic relationship.

Treatment approach. The next sub-theme within treatment was that of treatment approach. A majority of participants (n=7) described using an eclectic approach, including EMDR (n=6) and trauma stage-model treatment (n=6). Both of these themes are consistent with the current literature (Brand et al., 2011; ISST-D, 2011; Lazrove & Fine, 1996; MacIntosh, 2014) guidelines and recommendations for research. In terms of EMDR, ISST-D’s (2011) guidelines, as well as this study’s narrative data, discuss a modified version of EMDR (p. 158-160) aimed at integrating the complex traumatic memories often occurring for clients with this disorder. This modified version primarily involves structuring smaller procedures in order to reduce the intensity of treatment and not overwhelm clients with their traumatic memories (ISST-D, 2011; Lazrove & Fine, 1996). Similarly, stage-model treatment recommends structuring practice into carefully thought-out sections in order to not overwhelm the client in treatment both in the narrative data as well as in current literature (Brand et al., 2011; ISST-D, 2011; MacIntosh, 2014).

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A divergent theme that appeared in the narrative data regarded psychoanalytically-oriented therapy. In MacIntosh's (2014) article, the use of stage-model treatment was recommended for the earlier half of treatment, followed by the use of a psychoanalytic model. However, the narrative data suggested that psychoanalytic treatment, while being a "good background" for treating clients with this disorder, did not appear to be efficacious. While recommendations such as the ISST-D's (2014) or Brand et al.'s (2011) guidelines on the treatment of clients with Dissociative Identity Disorder do not strictly recommend against psychoanalytic models of treatment, it seems they also favor the trauma stage-model form of treatment as do the majority of participants.

A second divergent theme in the data about treatment modality is that of most participants (n=10) not utilizing hypnosis as a form of treatment, unlike what is largely recommended in the current literature (Boyd, 1997; Fine & Berkowitz, 2001; ISST-D, 2011). Although these participants did note that hypnosis may be a useful tool, they often remarked feeling "too busy" to get additional training in this practice. Of the two participants who did use hypnosis, only one reported using it often in treatment.

A final divergent theme in regards to treatment was that of the "end goal" of treatment. The literature often describes the overall goal of treatment as the integration of all alters into a single personality (Fine, 1999; Kluft, 1999b). However, nearly half of the participants (n=5) felt that having a main goal of integration had not been helpful to clients, nor was it always a goal that the client wanted. Instead, the narrative data seemed to present that therapists and clients were more concerned with keeping the entire system healthy and functioning regardless of

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whether alters were present or not. Some research (Gillig, 2009), including the most recent set of ISST-D (2011) guidelines, supports this theme but it is an area that clearly needs more research.

First client. Notably, all participants mentioned their first client with Dissociative Identity Disorder and seemed to feel that sharing this information was an integral part of explaining their experience treating clients with this disorder. Most participants (n=8) discussed how they knew very little about Dissociative Identity Disorder when treating their first client. The literature often suggests that, because of the lack of training and awareness around the disorder, clinicians often fail to screen, recognize, or know how to treat the disorder (Colin, 2015; Putnam, Guroff, Silberman, Barban, & Post, 1989; Ross, Norton, & Wozney, 1989).

In order to learn more after this initial client experience, participants reported using three main methods to discover more about the disorder: consultation and supervision (n=7), trainings (n=7), and research (n=8). A number of participants (n=5) noted that they received “bad supervision” regarding how to treat the disorder—either due to their supervisor not knowing much about the disorder or due to their supervisor not believing the disorder existed. Most of these participants with negative supervision experiences found they had to seek out experts in the field in order to obtain what they felt was “good” supervision. Of the three methods, participants seemed to feel that therapists needed all three in order to fully round out their experience. Although the research on the different effects these methods may have on the professional development of therapists treating this disorder, as demonstrated by Colin’s (2015) study on the lack of knowledge a majority of therapists seem to have on how to screen and treat the disorder, any method to learn more appears to be greatly needed in this field.

Misconceptions. Nearly all participants (n=10) mentioned misconceptions regarding Dissociative Identity Disorder and its treatment. The most common misconceptions included perceptions clinicians may have about their efficacy treating the disorder as well as the perceived observability of symptoms.

In terms of efficacy, the majority of participants (n=7) reported that their colleagues who did not treat clients with the disorder often falsely worried that they were not going to be effective. All seven clinicians additionally caveated that, while “any therapist could do this work,” education (in the form of trainings, consultation, etc.) would be needed to ensure that the work was being done as effectively as possible. This idea is present in the literature, as exemplified in Myrick et al.’s (2014) study that found that therapists with more training for dissociative disorders had significantly better treatment outcomes.

A second misconception is that of the perceived observability of symptoms that those with Dissociative Identity Disorder display. A majority of participants (n=7) reported that both non-clinicians, as well as clinicians, thought that the symptoms of the disorder would be easily noticed, “flamboyant,” and be easily diagnosable. The narrative data consistently noted that those with the disorder were actually quite secretive (as mentioned in a previous theme) and their symptoms were often hidden as much as possible. The clinicians believed this was part of the reason why the disorder is often under-diagnosed. Studies such as Coons, Bowman, & Milstein (1988) and Braun’s (1988) book details the hidden nature of the symptoms of this disorder as well as the prevalence of this misconception.

Divergent themes include the minority of participants (n=3) who identified a misconception as disbelief as to whether the disorder exists. Considering the amount of literature

THERAPISTS' EXPERIENCES TREATING CLIENTS WITH DISSOCIATIVE IDENTITY DISORDER devoted to the controversy (e.g., Cohen, Berzoff, & Elin, 1995; Elzinga, van Dyck, &

Spinhoven, 1998; Gillig, 2009; Perniciaro, 2014; Piper & Merskey, 2004), it was expected that a much larger portion of the participants would discuss this topic. Additionally, when the controversy was mentioned, it was often referred to as something “no longer relevant.” Considering this, therapists who treat this disorder may feel that the mental health field as a whole has begun to move away from the controversy and questions regarding the legitimacy of the disorder.

Places the research is missing. A final theme that arose for participants was mentioning where research around dissociative identity disorder was missing. In particular, three areas were mentioned: EMDR, family work, and addictions. Although EMDR has been mentioned in the ISST-D's (2011) guidelines, participants felt that there is still much to be explored for the applications of EMDR for clients with Dissociative Identity Disorder. Similarly, participants felt that family work and the intersection of addiction and the disorder were areas missing from the current literature. This is consistent with known deficits of existing literature, as displayed in Dorahy et al.'s (2014) meta-analysis on the current research regarding Dissociative Identity Disorder.

Differences between social workers and other mental health professionals. The original purpose of this study was to examine the experiences of social workers who treated clients with DID. However, despite thorough outreach, an adequate sample of social workers could not be obtained, and the sample pool had to be widened to that of other mental health professionals. When examining the narrative data, special attention was paid to possible differences between social workers and the other mental health professionals interviewed.

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Although nearly all thematic categories were evenly split between the two, some did differ. Only non-social workers, for instance, felt that working with clients with this disorder was “the most rewarding” population to work with, and that in order to work with the population, you needed to love it. Social workers, on the other hand, were the only ones to discuss areas of future research, and social workers utilized EMDR much more than other mental health professionals.

Strengths and Limitations of the Study

This study demonstrated the perspectives of what it is like as a therapist to work with clients with Dissociative Identity Disorder. The themes identified areas of clinical importance such as the challenging and rewarding nature of the work, the secretive and intelligent nature of the clients, the dedicated nature of the therapists who work with the clients, the way treatment for clients with this disorder is changing, and revealing the misconceptions often associated with this disorder. The second strength of this study is that it adds to the literature on therapist education and training. These exploratory interviews provided data about the lack of training and knowledge many mental health professionals have regarding this disorder. It additionally provided insight into the way mental health professionals sought out how to effectively work with this population, despite the controversy, disbelief, and lack of research on the disorder.

The major limitations of this study are related to the sample bias, including a small sample size, self-selection, and lack of sample diversity. There are a number of sample biases in this study, which can indicate problems with validity and reliability. The generalizability of the study is limited by the nature of the sample such that it may be particular to the sample and not reflective of all mental health professionals. All participants live within the New England area, potentially further influencing the content of the data by not including the perspective of

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clinicians of other geographic areas. Examining treatment from the perspective of the client is a critical area for future research. Finally, there is some potentiality for researcher bias. This includes the social location of the researcher as well as the use of personal connections for part of the recruitment.

Implications for Clinical Practice

The findings in this study suggest that there is a significant dearth in training therapists how to recognize, screen for, and treat DID. Additionally, the data emphasize that there are a number of critical misconceptions regarding the disorder that may add to this lack of screening and treatment knowledge. The data in this study also suggest that therapists who treat clients with this disorder need a number of supports, including consultation, trainings, and current research in order to conduct treatment effectively. Finally, the data suggest that there are rising forms of treatment (especially that of modified EMDR) that therapists feel to be especially effective with this population, and need further research.

Due to these issues, it is clear that mental health professionals must actively further their education regarding this disorder. Ideally, this could be done by assessing where education on the disorder is lacking in the training of mental health professionals as well as providing additional and more accessible trainings on this disorder for those in practice. Finally, it is clear that research must be continued in order to ascertain the most comprehensive understanding and best treatment practices for this disorder.

Areas for Further Research

As mentioned previously, there are many areas for further research that could provide wider knowledge about the research question. Further research should be conducted with different populations than the sample in this study and in different regions to discover whether the themes identified in this study can be replicated. Additionally, as mentioned by the participants in this study, there are multiple areas within the realm of Dissociative Identity Disorder that require further research as treatment evolves, including that of the interplay between family work and clients with the disorder, addiction, and modified EMDR.

Conclusions

This present study investigated the experiences of therapists who work with clients diagnosed with Dissociative Identity Disorder. The study interviewed twelve licensed therapists, five of which who were social workers and seven of which who were other mental health professionals, who work with this population and explored their experience of the clinical work and its impact on them personally. Seven themes were identified from coding the narrative data. These themes were: *the challenges and rewards of treatment, characteristics of the population, characteristics of the clinicians, treatment structure, what treating their first client with this disorder was like, misconceptions, and places the research is missing*. The themes that emerged highlighted the importance of training all mental health professionals how to screen for and treat clients with this disorder, the sense of reward as well as the challenges of working with these clients, current and evolving treatment perspectives, and the general misconceptions about the disorder. While the sample was limited in size and scope, the study results provided some

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direction for future research. Future studies might research exploring the most effective modes of
treatment, including issues regarding family work, addiction, and modified EMDR.

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Appendix A: Agency Email Permission for Recruitment

From: Paull, Alexandra **Sent:** Thursday, February 03, 2016 9:12 AM **To:** Drury, Laura **Subject:** Potential Study?

Hello!

My name is Alexandra Paull, and I am a graduate student at Smith College's School of Social Work. I was wondering if it would be possible for me to send out a recruitment e-mail for a study I am conducting as part of my degree. The study is a qualitative survey of social workers' experiences treating Dissociative Identity Disorder. Attached to this e-mail is the recruitment letter I would use if permitted to contact your social workers.

If you have any questions, please feel free to e-mail me back at this e-mail address (_____) or contact me by phone at _____.

Thank you so much,
Alexandra Paull

From: Drury, Laura **Sent:** Thursday, February 04, 2016 10:33 AM **To:** Paull, Alexandra
Subject: RE: Potential Study?

Hi Ali,

Yes, you may recruit, I like your letter. If you have something for folks to complete re: their experience, one way students have accomplished this is by coming to a social work meeting & explaining your study & handing out your form. Or you could come & explain your study & then arrange to meet folks. This is a good way of capturing the most social workers for the N of you study.

Let me know how I can help you,
Laura Drury, MSW, LICSW

Director of Clinical Social Services
Butler Hospital
Providence, R.I. 02906
Senior Clinical Teaching Associate
The Warren Alpert Medical School
Brown University

From: Paull, Alexandra **Sent:** Thursday, February 04, 2016 10:34 AM **To:** Paull, Nancy
Subject: Recruitment Letter

THERAPISTS' EXPERIENCES TREATING CLIENTS WITH DISSOCIATIVE IDENTITY DISORDER

Hello!

My name is Alexandra Paull, and I am a graduate student at Smith College's School of Social Work. I was wondering if it would be possible for me to send out a recruitment e-mail for a study I am conducting as part of my degree. The study is a qualitative survey of social workers' experiences treating Dissociative Identity Disorder. Attached to this e-mail is the recruitment letter I would use if permitted to contact your social workers.

If you have any questions, please feel free to e-mail me back at this e-mail address (_____) or contact me by phone at _____.

Thank you so much,
Alexandra Paull
Smith College School of Social Work

From: Paull, Nancy **Sent:** Thursday, February 04, 2016 11:07 AM **To:** Paull, Alexandra
Subject: RE: Recruitment Letter

Dear Ms Paull,

Yes, we would be delighted to have your study here at SSTAR. Please email me times you are available to meet to discuss implementation.

Sincerely,
Nancy E Paull MS
CEO of SSTAR (Stanley Street Treatment and Resources)

Appendix B: Recruitment Letter

Greetings!

My name is Alexandra Paull, and I am a graduate student at Smith College School for Social Work. I am currently conducting a research study to fulfill the thesis requirement of my graduate program. This study, titled: ***Social Workers' experiences treating DID*** will explore social workers' experience with treating clients who have DID. Participation in this study is confidential.

As part of the study, you would be asked to participate in a 45 to 90-minute interview in-person, over the phone, or via Skype that will be audio recorded. In order to be part of the study you must:

- be a licensed social worker
- identify as having some expertise treating clients with DID
- be able to complete the interview in English
- be willing to participate in the study

Your participation in this study will be kept confidential. You will not be monetarily compensated for participating in this study. Some study participants find they benefit from talking about their experiences. Participation in this study also carries the risk of causing psychological distress due to talking about difficult experiences. Before the interview I will mail to you a mental health resource sheet that describes how to access mental health resources in your area. These resources are available should you experience psychological distress as a result of participation in this study. The results of this study may be published or used in presentations, though individual identities will be disguised. Participants have the right to withdraw from the study at any time.

If you are interested in participating in this study you may contact me by email at ____ . If someone you know would be interested in being interviewed for this study, please forward this message to them.

Thank you for your time and consideration and I look forward to hearing from you!

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Appendix C: Informed Consent Form



2015-2016

**Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA**

.....

Title of Study: Social Workers' Experiences Treating DID

Investigator(s):

Paull, Alexandra
Smith School for Social Work MSW candidate
xxx-xxx-xxxx

.....

Introduction

- You are being asked to be in a research study exploring social workers' experience with treating clients who have DID.
- You were selected as a possible participant because you are a licensed social worker **who identifies as having some expertise treating clients with DID**
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to collect qualitative data to examine what social workers describe as their experience working with clients who fit the diagnosis of DID.
- This study is being conducted as a research requirement for my masters in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: attend one 45-90 minute audiotaped interview about your experiences treating clients with DID

Risks/Discomforts of Being in this Study

- There are no reasonable foreseeable (or expected) risks.

THERAPISTS' EXPERIENCES TREATING CLIENTS WITH DISSOCIATIVE IDENTITY DISORDER

Benefits of Being in the Study

- There are no expected personal benefits to this study.

The benefits to social work/society are: this research may allow the field of social work to better understand how DID is perceived and treated.

Confidentiality

- Your participation will be kept confidential. The interview will be conducted in a secure area of the participant's choice (e.g., an office with no other persons in it), or over the phone. Names will be omitted and substituted via numerical labels. In addition, the records of this study will be kept strictly confidential. The audio recording of the interview will be destroyed immediately following transcription.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift

- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by [add a date]. After that date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Alexandra Paull at . If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

THERAPISTS' EXPERIENCES TREATING CLIENTS WITH DISSOCIATIVE IDENTITY DISORDER

.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....

[if using audio or video recording, use next section for signatures:]

1. I agree to be audio taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Appendix D: Interview Guide

Demographic Questions:

1. Age?
2. Gender?
3. Years of professional practice?
4. Number of sessions with clients with DID (approximate)?

Interview Question:

1. What has it been like to treat clients with DID?

Potential Follow-Up Question Examples

1. Have you found that your comfort working with patients with DID increased over time?
2. What has been most helpful in building a treatment alliance with these patients in general?
3. Is there a theoretical framework that you rely on?
4. Has this framework changed over time?
5. Have you been able to find helpful supervision?
6. Has it made sense to you to avoid or to grapple with the disagreements about how DID should be conceptualized?
7. Is work with this patient population demanding? How so?
8. Is it rewarding? How so?
9. Did you make the diagnosis of DID for most patients, or did you find they had already been diagnosed when coming into treatment?
10. Have you found much helpful research on DID?
11. What was your first experience treating with someone with DID like?

THERAPISTS' EXPERIENCES TREATING CLIENTS WITH DISSOCIATIVE IDENTITY DISORDER
Appendix E: HSR Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

February 5, 2016

Alexandra Paull

Dear Ali,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Bruce Thompson, Research Advisor

Appendix F: Protocol Change Request

**2015-2016
RESEARCH PROJECT PROTOCOL CHANGE FORM
Smith College School for Social Work**

You are presently the researcher on the following *approved* research project by the Human Subjects Committee (HSR) of Smith College School for Social Work:

« Social Workers' Experiences Treating DID »
Alexandra Paul
Bruce Thompson

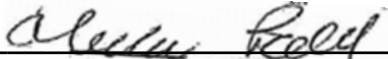
.....
Please complete the following:

I am requesting changes to the study protocols, as they were originally approved by the HSR Committee of Smith College School for Social Work. These changes are as follows:

1. I would like to expand my population beyond social workers. Since the time my HSR has been approved, I have made due diligence in attempting to find social workers who identify as having some expertise treating DID for my study. Although I do have a number of additional willing participants, they hold other positions in the field of mental health (mental health counselors, psychologists, psychiatrists, etc.).
2. I would like to change the title of my Thesis to correspond to this change. The new title would be: *Therapists' Experiences Treating DID*.

.....
 I understand that these proposed changes in protocol will be reviewed by the Committee.
 I also understand that any proposed changes in protocol being requested in this form cannot be implemented until they have been fully approved by the HSR Committee.
 I have discussed these changes with my Research Advisor and he/she has approved them.

Your signature below indicates that you have read and understood the information provided above.

Signature of Researcher: _____ 

Name of Researcher (PLEASE PRINT): Alexandra Paul **Date:** 3/6/16

PLEASE RETURN THIS SIGNED & COMPLETED FORM TO Laura Wyman at LWyman@smith.edu or to Lilly Hall Room 115.

*****Include your Research Advisor/Doctoral Committee Chair in the 'cc'. Once the Advisor/Chair writes acknowledging and approving this change, the Committee review will be initiated.**

Appendix G: Protocol Change Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 7, 2016

Alexandra Paull

Dear Ali:

I have reviewed your amendments and they look fine. The amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Bruce Thompson, Research Advisor