Meeting the Needs of Clients with Dissociative Identity Disorder: Considerations for Psychotherapy

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6439 Words

**Keywords:** Counselling, dissociative identity disorder, multiple personality disorder, psychotherapy, trauma, treatment.

**Abstract**

Therapy with a client with DID will be different to working with any other client because these clients are multiple and have multiple needs. This raises questions for the practitioner in respect of who is the main focus of therapy? There appears to have been a shift of focus from practitioners working with both the ‘parts’ and the ‘host’, to more recently focussing on working solely with the ‘host’ and hearing from the ‘parts’ through them. Reasons and implications for this altered practice are evaluated. Lastly, therapy with clients with a diagnosis of DID will differ because there are specific issues that these clients need to address, in order to be able to live successfully either as a multiple, or as an integrated person. The main components of therapy with this group of clients: strengthening the ‘host’;
increasing the ‘host’s’ understanding of the ‘parts’; and encouraging communication, co-operation and collaboration between the ‘host’ and the ‘parts’ through psycho-education and teaching are outlined. The BASK model is introduced as a method of working through the client’s trauma with those who wish to take this final step.
Introduction

My practice has taken me to a variety of settings, a college and forensic services, working with both in-patients on a low secure ward and at an out-patient clinic, as well as in private practice. My initial training was in client-centred therapy and as such I was trained to trust that clients know what they need and will act accordingly. Also, I was taught to adopt a non-directive approach, one in which the therapist follows the client. This approach has served me well and in respect to working with clients with DID has its strengths but, as with all approaches, I argue there are exceptions to the rules and potential pitfalls to following approaches too closely. A poignant example arose whilst I was working with one of my first clients with dissociative identity disorder (DID).

I had been seeing this client privately for about 18 months. She came to session and spoke about a trauma incident. We processed this and the client left grounded and, as far as I was aware, stable. The next day she was waiting for me outside my therapy centre having just come from hospital. She had been admitted after cutting her throat. A ‘male part’ thought this would silence her and keep him alive. Allowing the ‘host’ to talk, he felt, would lead to his father killing him and he would do anything to try and prevent this. Suffice to say this was a wake up call for me to adapt my therapy with this group of clients.
What is Dissociative Identity Disorder?

Dissociative Identity Disorder (DID);

“Is characterized by the presence of two or more distinct identities or personality states that recurrently take control of the individual’s behaviour, accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness. It is a disorder characterized by identity fragmentation, rather than proliferation of separate personalities” (p.519, American Psychiatric Association, 2000).

Frankly, I find this definition is insufficient to adequately explain the concept of DID. I therefore offer the following vignette explaining how DID develops.

The Development of DID

Vignette

At five years old Kerry was molested by her stepfather. During the molestation she got through it by imagining it was happening to ‘someone else’. The next time it happened ‘someone else’ just came and took the abuse and left Kerry to get on with her life. After a while Kerry forgot about ‘someone else’ but she found that sometimes when she was alone with her stepfather she would become scared, she didn’t know why, ‘someone else’ did.
When Kerry was eleven, her step father brought a friend to her house, he raped her. She pretended it was happening to ‘anyone but her’. She saw ‘anyone but her’ from the ceiling of her bedroom. She looked nothing like Kerry. Kerry left for a while.

‘Anyone but her’ began drinking and smoking cannabis. ‘Anyone but her’ was not like Kerry, where Kerry let her curly hair run loose and liked pretty dresses, ‘anyone but her’ wore her hair tied back, always wore jeans and let no-one come close. Other people viewed ‘anyone but her’ as a bully. ‘Anyone but her’ knew about ‘someone else’ and berated her for whingeing and getting upset. She called her a baby and told her to shut up whenever ‘someone else’ spoke.

At fourteen Kerry was invited to a friend’s party. Kerry had to buy a dress, all she could find in the wardrobe were jeans and T shirts. She put on her new dress, wore her hair loose and said goodbye to her mother. Her mother said she had the old Kerry back. Kerry did not know what she meant. At the party, one minute Kerry was talking with friends, the next thing she remembered was coming to, slumped in her friend’s hall with her friend’s parents shouting at her. She couldn’t understand it. She never got drunk, she did not even like drink, she said someone must have spiked her drink but her friend said she had left soon after arriving and came back with a bottle of vodka.
On the way home, when Kerry was trying to explain things to her mother, ‘anyone but her’ told Kerry to shut up, she called her a useless bag of s**t and told her she would shut her up if she did not shut up of her own accord. Kerry went quiet. She began to lose time, with no memory of what happened for long spells of the day. On one occasion she came to having overdosed on sleeping pills. She had no idea why she had taken them, she had no memory of it at all.

When her step father picked her up from the hospital he told her she was a liar and of course she must know what happened. Being called a liar and making excuses for behaviour she had no recollection of performing were becoming commonplace. Other strange things happened too. She had kept a diary for years, one day when she went to write in it, she found it was full of a child’s handwriting. She did not know it but the handwriting belonged to ‘someone else’. She’d also find things in her drawers but she did not know where they had come from.

_The ‘Host’ and ‘Parts’_

Practitioners sometimes refer to clients with DID as having a ‘host’ personality, this tends to be the part who presented to therapy initially and one or more ‘alter’ personalities, or ‘parts’. In the example vignette, Kerry is the host and her ‘parts’ are ‘someone else’ and ‘anyone but her’. At present treatment focuses on
fostering communication and co-operation amongst the ‘host’ and ‘parts’, understanding and processing the trauma each ‘part’ has carried and sometimes towards the end of therapy there may be integration of the different identities.

General Considerations for Psychotherapy Prior to Taking on Clients with DID

Therapists may need to assess for DID at the first meeting, if there are conditions under which they will not take on a client. This is because there are a number of differences to take into consideration before working with these clients.

*Psychotherapy Tends to be Long Term*

The length of *psychotherapy* is highly likely to be long term. Kluft (1985) argues anything between 2 and 10 years. Therapy is long term because clients have experienced repeated trauma, either related to abuse or attachment issues, or both, and throughout their childhood, often from different abusers, and tending to be of a particularly grave nature. In addition, there is extra work, which does not normally take place in therapy (see below). The duration of therapy is an important consideration for therapists contemplating retiring for example.

*Longer Session Length*
The length of sessions may need to be longer for some clients with DID, once a strong therapy relationship has developed. **I sometimes recommend** a session length of about an hour and a half, particularly for clients who are working through an incident of trauma, which has been dissociated. Putnam (1989) argues there needs to be time for clients to get into the work, adequate time for the work to run its course and then time for the client to feel grounded afterwards.

*Sessions Will Sometimes Be More Frequent*

Once the initial relationship has been established, **I have found that more regular sessions are often needed.** Therapists who work a fixed number of client hours per week need to take these extra hours into account. Putnam (1989) argues twice weekly is ideal, sometimes three times per week, without which he states therapy may be stalemated. More than this, on a regular basis and he states the therapy relationship may become enmeshed.

**I have found that less than** twice a week, during the middle phase of therapy, particularly when the ‘parts’ are vying for time in the therapy room and out, may result in clients having to carry too much, or there being too much material delivered between sessions in e-mail to keep track (see below). It is when clients feel overwhelmed with the amount of material and trying to contain it, that
compensatory behaviours, for example, excessive drinking, cutting, bingeing and so forth, will be more likely to occur.

**Boundary Considerations**

Keeping strict boundaries to the therapy relationship is even more vital for the client with DID because their background has been filled with broken ones. However, sometimes it may be helpful for clients to have the opportunity to offload their difficulties in-between sessions in an e-mail. This can help to prevent the client becoming overwhelmed. Whilst material need not be acted upon unless it is critical, it tends to need scanning, which places more time demands on therapists in-between sessions. These changes to the normal boundaries put a greater onus on the therapist’s ability to contain the relationship within strict boundaries, despite this increased contact.

Furthermore, this client group can easily draw therapists into their world. Turkus (1991) writes the “helplessness of the victimised patient almost seems contagious” (p.651). However, over involvement can lead to burnout and secondary trauma in the therapist (Turkus, 1991) compassion fatigue (Figley, 1986 cited in Figley, 1996) or vicarious traumatisation (Pearlman & Saakvitne, 1995) as well as cause a breakdown in the therapy relationship and all this may entail for the client (Warner, 1998).
Extra Work

There is also likely to be further work involved with DID clients in-between sessions, in respect to liaising with the GP and members of the client’s mental health team. This may mean letters to write and care plan approach meetings to attend and prepare for. There may be crisis calls from other practitioners, which always seem to come on the spur of the moment and typically arrive at a busy time. If I see a client on a Friday and they seem particularly vulnerable, I will offer them the option of a therapy hour on the phone at a fixed time on a weekend. I do this because weekends are notorious trouble spots but I am frank in that I say I cannot always guarantee this.

Working with Self Harm & Clients at Risk of Suicide Attempts

Tatarelli, Pompili and Giradi (2007, pp.127) write “all the studies on dissociative identity disorder have reported a high incidence of attempted suicide ranging from 61 to 91%”. There is similarly a high rate of self harm amongst this client group. Occasionally I see clients who report being “dumped” because their therapist was unable to work with them due to the risk they pose to themselves. The high risk of self harm amongst this client group therefore places them at an increased risk of this. This can be a traumatic experience for any client but may be worse for clients with DID because typically they have experienced very
disrupted relationships throughout their childhood. They tend not to have had a secure safe base and the belief system they have built up about relationships is one in which people abandon you, do not care or are inconsistently around. This practice therefore reinforces or strengthens the client’s belief system that they are not worthy of care. I therefore would strongly recommend practitioners who are unable to work with complex cases, or who dislike working with clients who pose a significant risk of harming themselves, perform a thorough initial assessment.

Key elements for consideration when working with DID

Stabilisation

Margaret Warner (1998) writes;

“.. when therapists understand dissociative process and remain empathically connected with clients, a natural process tends to develop in which dissociated memories and ‘parts’ emerge on their own. Once this process is established ..clients tend to have a finely tuned sense of timing, allowing just as much dissociated material into consciousness at any given time as they can handle.. they seem to sense the order in which they are able to tolerate working on particular memories and life issues” (p.375).
Whilst Warner (1998) describes ‘parts’ and talks about their contradictory feelings (p.380) this reference appears to be treating the client as if they are one unified force moving in one direction. My understanding from this passage is that Warner (1998) is here referring to the ‘host’ and all ‘parts’ and arguing that we should trust the whole system (‘host’ and ‘parts’) to know what it is safe to say, when and how, and this will be only what the ‘host’ and the ‘parts’ can “handle”. Further references in her article are made to a “client-directed style of work” (p.368). However, the ‘host’ and each ‘part’ may have different beliefs, feelings and actions to the same event, in this way therapy can resemble family therapy where all the family need to be heard and considered. Where the ‘host’ and one or more ‘parts’ believe it is safe to talk about “x” other ‘parts’ may disagree. Also, the ‘host’ is not like a typical client in that they do not have access to all the information of their being. Commonly there are amnesic barriers between the ‘parts’ and ‘host’, particularly in the early stages of therapy. Whilst I value the notion of self directed therapy, in the case of clients with DID one or more ‘parts’ may not have signed up for therapy, or where they have, may not want certain trauma incidents discussed. Therefore, permission for disclosure needs to be sought from the host and known and unknown ‘parts’ in order to reduce the likelihood of harm to the body. A simple question asking if this is safe
to talk about, or does anyone have any objections will suffice. Without this permission, one or more ‘parts’ may attempt suicide or self harm, as in the case I referred to in the introduction. Similarly, later in her article Warner (1998) cites an incident where one of her clients also made “serious threats to slit her throat” in this case because a ‘part’ felt frightened she “would be destroyed”.

A further issue relates to empathy. Typically one or more ‘parts’ have learnt they are “bad” “useless” “stupid” or something similar and that they should be punished. Warner (1998) writes;

“the work we are doing with clients who experience dissociation follows classic client-centred principles. As with other client groups we have found that therapeutic relationships grounded in empathy authenticity and prizing of clients tend to foster latent abilities for self directed change”(p. 375).

Whilst empathy is important with this group of clients they may find empathy for themselves almost impossible and empathy from the therapist may be too much for the ‘host’ or one of the ‘parts’ to bear. This can result in self harming if the ‘part’, or ‘parts’, feels the care is not deserved. Therapists may therefore need to temper their nurturing until they are convinced the client will not be overwhelmed. Lamagna and Gleiser (2007) state trauma survivors struggle as much with feeling positive affect, as they do negative. In addition, they note that
experiences of care and closeness in therapy may trigger a self loathing for having dependency needs, or bring about intense grief in now receiving what was rarely given in childhood (Lamagna and Gleiser, 2007). These challenges to the client-centred approach to therapy, also raise further questions about the more widely held belief that one approach to psychotherapy is sufficient. In my opinion approaches are like one size T shirts, they fit surprisingly few.

Talking Through the Diagnosis

A further difference I have noticed in my therapy with these clients is that I talk through the diagnosis, it often becomes a part of on-going therapy that I revisit several times. A useful starting point may be to offer an explanation of dissociation as arising out of a way of coping with overwhelming feelings. I may use the analogy of people logging off, zoning out or shutting down from an experience that is too painful to face. Descriptions of how and why ‘parts’ come along, commonly to protect the ‘host’ from trauma, may help the client to begin to think about the other ‘parts’ in a more positive light. Perhaps the most crucial piece of information for all ‘parts’ to grasp, is that although there are these ‘parts’, there is only one body. I have used an analogy of the body representing a house and the ‘parts’ representing the rooms, some may have the door open (where there is communication) and some may have the door firmly closed
(where there is no communication or only muttering can be heard). This can also be extended to include how some ‘parts’ can reach each other, through interconnecting doors, whilst others cannot.

**Contracting**

Several therapists recommend making contracts with clients early on in therapy (Kluft, 2003, Putnam, 1984). Whilst contracts are commonplace in some therapy approaches, greater clarity around issues of safety may warrant consideration. Some ‘parts’ have the potential to be aggressive or violent; contracts can be used to set out what is not acceptable and the consequences of breaches to the agreement. ‘Parts’ can be asked what they feel is an acceptable consequence for the violation of a contractual rule. Agreement over therapist availability, time constraints and limitations to the level of support on offer may also be clarified.

In respect to client safety, requesting the ‘host’ always be the one that comes to therapy and leaves, avoids young child ‘parts’ being out at inappropriate times and places alone. If necessary, this can be orchestrated by the therapist.

**Confirming the Client’s Reality**

Sometimes clients will be unclear about what is real and what is dreamt or imagined. They may have had aspects of their reality questioned or denied, by themselves, their abusers, a parent, or all three and over a number of years. This
fosters uncertainty about what is real and, coupled with the client’s amnesic episodes, for example, as the ‘parts’ switch, makes for a very confusing existence. Aquarone (2009) argues a lot of the work with this group of clients is “reinforcing the reality” (R Aquarone, 2009, pers. Comm., 5 May). Strategies aimed to support the client with stability and clarity around greater continuity of experience are also useful. For example, if a ‘part’ speaks in therapy, I will always debrief the ‘host’ on the content at some point, although this may need to be divulged in stages because it may be too much for the ‘host’ to digest in one go. I also offer clients a copy of their notes following a session, this informs them again of what they may have missed if a ‘part’ was present and helps provide a greater continuity of experience. Although in cases where the material may be too much to be digested at one time, a general consensus of what to do in these circumstances needs to be agreed with the client beforehand.

_Fostering Communication and Co-operation Between ‘Host’ & ‘Parts’_

Normally clients with DID will have done everything they can to suppress the ‘parts’. Encouraging the ‘host’ to talk about them in session and for them to start paying more attention to one another is the beginning phase to breaking down the walls between them (or opening doors). Therapy typically focuses on encouraging understanding, co-operation and collaboration between the ‘parts’
and resembles family therapy in some respects. In empathising with X, Y’s feelings need acknowledgement too, as well as the repercussions this may have on Z, A, B and C. This process can make for a fine balancing act with the main aim being to avoid alienating any ‘part’, no matter how angry or aggressive they may present. Lemke (2007) argues that by working towards co-operation and collaboration, the boundaries between the ‘parts’ become permeable, fostering a greater exchange of information, reducing memory loss and encouraging unity. The ability of the ‘parts’ to share their thoughts in this way is known as co-consciousness. As therapy progresses ‘parts’ may be encouraged to call on each other in times of need. Putnam (1984) uses a bulletin board where ‘parts’ can post messages about what is going on. This is helpful in terms of the ‘parts’ knowing what happened when they lost time and slowly the client may begin to have more of a sense of continuity in this respect.

Mapping the ‘Parts’ & Getting to Know Them

As more ‘parts’ emerge, drawing a map together in therapy aids the therapist and the client’s understanding of the ‘parts’. It is helpful to see the relationship between them, who is closest to who, who may control whom and who is accessible to whom. Sometimes ‘parts’ are conjoined. Asking about their age and if a ‘part’ has a name makes for an easier reference. Where ‘parts’ have not got a
name, we make something up, this needs to be value free and neutral and may simply be something like the ‘one who was afraid’.

There are several further pieces of information which can be useful to gather on each of the ‘parts’, for example, knowledge about each of their issues or problems. Braun (1988) asks about when they were created and stresses this is important because it provides a clue as to the trauma which may have been occurring at the time and therefore which other ‘parts’ may be affected by the same trauma.

*Working Through Trauma Events*

Once all ‘parts’ are stabilised and settled in therapy, Remy Aquarone (2009) strongly recommends direct conversation with the ‘parts’. This he argues is necessary because it is they who experienced the trauma first hand. He argues the ‘host’ will not remember trauma events and where memories are accessible these may be devoid of feelings (R. Aquarone, 2009 pers. Comm., 5 May). In recent years there appears to have been a shift from working directly with the ‘parts’ to working as much as possible with only the ‘host’ (Ringrose, 2010). Direct communication between therapist and ‘parts’ may occur but I recommend the bulk of the work be done through the ‘host’. My opinion is that therapy should focus on reducing dissociative episodes and increasing the strength of the
‘host’ to manage without dissociating. I believe that direct communication between ‘parts’ and therapist may strengthen not lessen this coping strategy. ‘Hosts’ often report not knowing what happened during a period of lost time but I have found when encouraged they can work with the ‘alters’ to piece bits of information together. A strategy I have taken from Dr Boat (2009) is to encourage the client to “play detective”. She has also used various strategies to help the client stay in the room and not dissociate. For example, she has given the client scent markers and “clapped her hands or turned on the overhead light” when the client appears as though they are about to switch (B Boat, 2009, pers. Comm., 8 October).

Irrespective of which stance you favour, Van Der Hart, Steel, Boon & Brown (1993) write “experienced therapists concur that this disorder cannot be completely resolved until these traumatic memories have been successfully processed” (p.163). Similarly, Janet (1935) believed that DID clients have not “realised” the traumatic event, it is this realisation that brings together the dissociated ‘parts’.

Clients with DID are continuously propelled backwards into their past lives as dissociated fragments of memories are repeatedly re-stimulated by current events. The process of re-stimulation keeps recurring because the material never
fully registered at the time, and hasn’t been processed (partly through the purging of emotions) absorbed and integrated. Van Der Hart et al (1993) assert the necessity of each ‘part’ involved in the trauma event sharing their experiences with each other ‘part’ involved and eventually those not involved in the trauma, so that all ‘parts’ have the same trauma story but often from different perspectives. I do not believe this is always necessary. I tend to follow the ‘host’s’ lead, they will tell me if something is bothering them and we will try and work out what it is and go through events if they arise but I do not feel that it is necessarily vital to go through every incident of trauma with each ‘part’. However, sometimes different ‘parts’ may recount different experiences and views on the same trauma event which I believe need to be heard. There may also be inconsistencies and distorted cognitions (particularly with young ‘parts’) surrounding the trauma which may be empathically challenged.

The BASK Model

Dissociated memories are made up of four components or levels of experience, Behaviour (B) Affect (A) Sensation (S) and Knowledge (K) or BASK (Braun, 1988). Braun (1988) advocates trauma events be explored from each of these components. My experience has been that often clients do not have each component accessible and I question whether this level of processing is
necessary. However, it is important to note that reporting knowledge of an incident does not mean the person will be able to draw on their affect, or sensations in relation to the experience. For example, these may be dissociated but cause the client to keep getting propelled back to the trauma experience. Working through memories beginning with any one of the BASK components, piecing together accessible constituent elements and purging the emotions attached to them takes away the memories’ power and stops the cycle of re-stimulation.

Pacing & Trauma Disclosure

Once agreement has been sought from the ‘parts’ and ‘host’ about what is safe to disclose, disclosure can evolve at a pace manageable by ‘host’ and ‘parts’. Often it is necessary to slow the pace of therapy down because a young ‘part’ may want to get their trauma issues over with quickly but the ‘host’ cannot keep up with the pace. These issues can be worked through between the ‘host’, ‘part’ or ‘parts’ and the therapist as they arise. Pacing trauma disclosure helps prevent the client from becoming overwhelmed, reducing the risk of self harming behaviours or suicide attempts. Kluft (1993) recommends the therapist ask each ‘part’ to recount their history but “to talk about what happened as if you were watching from a distance - way far from you” (p.142). Van Der Hart et al (1993)
recommend the ‘parts’ “not re-experience their part in the trauma to the full extent but for instance to a degree of 4 on a scale of 1 to 5” (p.177).

Van Der Hart et al (1993) also recommend getting a factual description from one ‘part’ about which other ‘parts’ share some or all of the same experience. I have found that sometimes it may be beneficial to suggest a child ‘part’ go to sleep or go to a safe place perhaps another room where they cannot hear the trauma, if someone fears this may overwhelm a ‘part’.

Exploring Somatic Symptoms

Where clients report somatic or physical complaints, for example, stomach ache, headache and pain in their groin, this can be the starting point of working with the trauma to which it may relate. I ask questions about where the complaint is located and how they would describe it, to begin this process. I also ask clients to use a crude scoring system, like the one mentioned above, where clients can be encouraged not to allow themselves to reach beyond a certain level of anxiety or distress. If you sense a client needs more time before looking at a component of the BASK model, I have found asking them to tell me what it would look like if they had to draw it, can foster clarity without emotional charge. Clients have talked to me using various descriptions. Examples include images of a black lump of tar located in the stomach, a bright red ball made up of elastic bands
pinging in the chest, a dead weight tied to the client’s feet like a ball and chain and the weight of a boulder weighing heavy between the client’s legs. As the client becomes more accustomed to coping, I enquire about the other BASK components simply by asking “anything else?” or “any more?” until they have been drained of all they can disclose. Sometimes these pains and feelings may be accompanied by memory flashes, which can be enquired about too. Where memories have been shared, it may transpire that ‘parts’ will have different feelings attached to the same family member. Hence for example, one ‘part’ may be angry towards mum because they remember telling her about the abuse, and her not believing them, whereas, perhaps the ‘host’ may want to build a new relationship with mum and move on. This may cause rapid switches of emotion towards the family member and also inner turmoil with one ‘part’ feeling angry with another, or hurt by the other’s reaction. Therefore, where there is a change or shift of emotions in one ‘part’, this has repercussions for the other ‘parts’ too, who will be forced to make an adjustment. It is like a rock thrown in a pool, it creates ripples long after it has been thrown.

Considerations on Integration

Kluft (1984) found that clients who elect to live as multiples, often relapse under stress, or if painful material is re-stimulated by current events (Kluft, 1993). He
also strongly advises DID clients who are to become parents integrate because ‘parts’ may exploit or persecute the ‘host’s’ children and the ‘host’s’ amnesias and inconsistencies can compromise them as parents.

However, the reality is, **psychotherapy paid for by the National Health Service** is unlikely to be able to continue for the length of time it takes to complete the integration work and in my experience, completing integration in private therapy is a luxury many clients cannot afford. Nonetheless, talking to clients about the advantages and disadvantages of remaining multiple is necessary in order for them to make a judgement about this goal for themselves. Disadvantages to integration include the financial and emotional cost of staying in therapy longer, which Kluft (1993) argues may be too demanding for older DID clients. **I have found that** where clients have achieved a reasonable level of functioning, they may struggle to sign up for more work which could be viewed as reaping little reward by comparison.

These issues need to be considered with the client at an appropriate time. **Discussing integration** early on in therapy is unlikely to be useful because at this time the ‘parts’ tend to be unable to see what they share in common and are more inclined to focus on the differences between them.
Work to be Completed Before Integration

However, integration is part of a long process in therapy which begins very early on. Kluft and Fine (1993) state that prior to integration, ‘parts’ need to have expressed their trauma. The behaviours, affect, sensations and knowledge (BASK) around the trauma experiences need to have been voiced, discharged of emotion, fully processed and the histories shared with one another before integration can be considered.

Aside from the trauma work, I believe three further elements to therapy are imperative, if the client is going to be able to live successfully either as a multiple, or as an integrated person. Firstly, throughout therapy, I advocate a philosophy of pulling together to fight the common enemy of the after effects of trauma. ‘Host’ and ‘parts’ must be able to work together. Secondly, it is imperative to facilitate equality amongst the ‘parts’, where competition is minimised and where ‘parts’ let go of their desire or need to view themselves as unique discrete entities. Thirdly, it is important to encourage empathy and understanding amongst the ‘parts’, as well as this sense of unity. The overall aim has to be to get the ‘host’ and ‘parts’ to all move in one direction. For example, it would be no use having the ‘host’ wanting to attend university and a ‘part’ sabotaging attendance by refusing to get out of bed. Living successfully, either as
multiple or as an integrated person, can only be achieved if the ‘host’ and ‘parts’ work together; as Claire Schulz (2010) expressed it, like a flock of birds or shoal of fish (C. Schulz, 2010, pers. Comm., 9 April). In the case of integration, ‘parts’ may also fear being killed off, or of losing talents or abilities. All of these sorts of issues need exploration.

Co-Presence, Fading and Merging of ‘Parts’ Prior to Integration

Co-presence is where ‘parts’ share the spotlight which can mean the sharing of talents and abilities with each other prior to complete integration and thus can be a useful stepping stone to this end. However, there needs to be careful consideration of the impact this may have on ‘parts’ not directly involved. In addition, prior to complete integration, often one or two ‘parts’ may appear to merge as their need for separateness diminishes, or similarly ‘parts’ may appear to fade into the background. Whilst these are signs suggesting progress towards integration is being made, they cannot be taken as a foregone conclusion that integration will be acceptable to all the ‘parts’, even those which appear to have faded for a while. Complete integration requires an agreement from all ‘parts’ and there will usually be a period of adjustment afterwards. Finally Kluft and Fine (1993) recommend hypnosis to be used to ascertain whether ‘parts’ have faded or are simply shadows of their former selves that may re-emerge. They
also outline further fusion rituals involving death and rebirth for example, which 
may encourage final integration and mark the passing of multiplicity.

**Conclusion**

In conclusion, working with clients who have DID poses major challenges to 
some psychotherapists' and counsellors' ways of practice. Firstly, therapists are 
sometimes taught to undertake an assessment during their initial meeting with 
clients. However, this may not occur in all cases and assessments may often be 
insufficient to glean adequate information for the therapist to know how therapy 
will progress. Clients with DID will require greater input from their therapist 
than is normally the case. Therapy will be long term, individual sessions may 
need to be longer and will be more frequent at some point. Practitioners will also 
need to allocate time for liaising with other professionals. These clients also pose 
a high risk of self harming and attempting suicide at some point. Assessment 
needs to be sufficiently thorough in order that therapists not wishing to work 
under these conditions opt out immediately and not part way through therapy, 
as this can repeat the client’s experiences of abandonment.

Practitioners working with clients with DID are highly likely to need to change 
elements of their ways of working. Psychotherapy with these clients means the 
practitioner is effectively working with a family, where initially, typically, the
members will not know of each other’s existence and are unlikely to want to work together. If one ‘part’ wants to talk, another may want them to stay silent. Therapists must take this difference into account. A major change to my working practice is that I cannot always trust the client and follow their lead. If they begin to talk about trauma, it may not be safe for them to do so. A ‘part’ may not want this and self harm or attempt suicide as a result. The whole system must always be considered.

A further difference in therapy with these clients, is that it is often directive, instructional and involves a high degree of psycho-education. For example, it will be necessary to talk through the diagnosis. In facilitating the client to co-operate and communicate with their ‘parts’, clients may need information on how to begin. They are unlikely to have had their emotions regulated by a supportive caregiver and thus feel easily overwhelmed which is compounded by a lack of skills to cope and ways to self soothe, they need practical instructions on this.

Having said all this, many therapists stumble across these clients and muddle along well. Putnam (1984) argues that if you find out your client has DID and you have a good therapy relationship and you are happy to continue given the right support, this may be better for the client than ‘abandoning’ them. I would
agree with this but add a strong recommendation that practitioners educate themselves on this different method of practice. This is necessary because clients will need to gain an understanding of their ‘parts’ and a way of working with them, either as multiples or as an integrated person. Finally, the guidelines written by the International Society for the Study of Dissociation on the evaluation and treatment of dissociative symptoms in children and adolescents state “the most successful treatment approach to an individual case is often the most eclectic, with the therapist showing flexibility and creativity in the utilisation of a wide variety of available techniques (p.122, 2004).

**Acknowledgements**

I would like to thank my clients with DID and practitioners who have contributed to my research and knowledge in this field. I would also like to thank my academic adviser, Christine Stevens for her support generally but particularly for helping me to engage with a greater diversity of approach when deriving psychotherapy theory and working in my practice. Also thank you to my academic consultant, Remy Aquarone whose energy and enthusiasm for the subject I have found infectious and engaging. Their input alongside that from fellow practitioners working with clients with DID, has sustained me when confronted by sceptics who question whether DID exists.
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