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Determining How Therapists Make Sense of Dissociative Identity Disorder

by

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ABSTRACT

FACULTY OF SOCIAL AND HUMAN SCIENCES

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DETERMINING HOW THERAPISTS MAKE SENSE OF DISSOCIATIVE IDENTITY DISORDER

Nicole Yvette Stokoe

Dissociative Identity Disorder (DID) is a rare, complex and controversial mental health presentation, characterised by two or more distinct personality states and recurrent gaps in memory. Mental health therapists currently rely on their own assessment of the available literature to conceptualise the presentation of DID. This is due to the lack of guidelines from the National Institute of Clinical Health Excellence. Case formulation is one approach to conceptualising mental health difficulties that has been shown to benefit therapists, particularly for selecting appropriate intervention.

The first part of this thesis is a systematic literature search and narrative synthesis of current conceptualisations of DID. Relevant databases were searched and a total of twenty six articles met the inclusion criteria and were subjected to a full article review. Three key approaches to the conceptualisation of DID were identified as dominant discourses in the literature: *Trauma-based models, Sociocognitive models* and *Invalid diagnosis theories*. The review identified the need for a more collaborative approach to research between these different schools of thought with a focus on prospective, longitudinal and objective research.

The second part of this thesis is an empirical paper describing a study using Constructivist Grounded Theory (CGT) to explore the key themes of DID case formulation with eight therapists experienced in working with this client group. A working therapeutic model of DID was developed from the six major categories that emerged from the data: *The Rationale – Why DID develops, The Client's Internal World, The Appearance of the Internal World to the Outside World, The Direction of the Therapeutic Process, The Qualities and Considerations for the Therapist* and *Service and Support Considerations*. Clinical implications and suggestions for further research are outlined.

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DECLARATION OF AUTHORSHIP

I, Nicole Yvette Stokoe declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

Determining How Therapists Make Sense of Dissociative Identity Disorder

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission

Signed: .....

Date:.....

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I would like to thank the therapists who participated in this research. I feel honoured that they agreed to take part, gave their time and shared their wealth of expertise and experience with me. I was inspired by each participant I interviewed and will aspire to be as knowledgeable, insightful and skilled in my own clinical work.

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Finally, I would like to thank my family and friends; especially my mum Eve, who has vicariously completed two doctorates through her committed proof reading of my work and my friend Anna for all her support both academically and emotionally. In particular her relentless commitment to our mantra of 'It will get done. It WILL get done!'

Chapter 1: Systematic Literature Review of Current Conceptualisations of Dissociative Identity Disorder

1.1 Introduction

The aim of this literature review is to draw together relevant literature on theories and models of Dissociative Identity Disorder (DID). The review begins with a brief introduction to the literature in the area, a description of the purpose and rationale of the review and an outline of the methodology and process. The findings and implications are then discussed.

DID is defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM, fifth edition) (APA, 2013) as a disruption of identity that is characterised by two or more distinct personality states (self-states) and recurrent gaps in the recall of everyday events resulting in significant distress or impairment in functioning. DID is an exceptionally rare presentation with estimated rates of 0.01 (Coons, 1984) to 1% in the general population and 0.5 to 1% in psychiatric settings (Maldonado, Butler, & Spiegel, 2002). The diagnosis is rare, complex, challenging and controversial (e.g. Brenner, 2009).

Although DID is recognised and outlined in the DSM-V, there are currently no National Institute for Health Care Excellence (NICE) guidelines for therapeutic intervention. Without NICE guidance, mental health therapists are dependent on their own assessment of the available literature to make sense of the presentation for the purpose of developing therapeutic interventions. One of the approaches for developing this conceptualisation is case formulation. Case formulation is defined as "*A formulation is the tool used by clinicians to relate theory to practice….It is the lynchpin that holds theory and practice together….Formulations can best be understood as hypotheses to be tested."* (Butler, 1998: 2, 4). Therefore formulation is a theoretically driven explanation of a client's presenting difficulties that provides the foundations on which to develop intervention. Based on this definition, a therapist's appraisal of the literature and theory of DID is critical to the development of treatment plans and consequently practice.

The British Psychological Society's (BPS) Division of Clinical Psychology recently published a position statement (2013) on the psychiatric diagnosis classification system which supported and emphasised the importance of case formulation. They described psychiatric diagnosis as having significant conceptual and empirical limitations and called for a shift

toward more conceptual understandings of mental health difficulties: "*Consequently, there is a need for a paradigm shift in relation to the experiences that these diagnoses refer to, towards a conceptual system not based on a 'disease' model."* (DCP, 2013, p.1)

There is limited research on the process or efficacy of formulation but the evidence available suggests that it benefits the therapist (e.g. Chadwick, Williams & MacKenzie, 2003; Pain, Chadwick & Abba, 2008) and the teams they work with (Summers, 2006). Therefore it is important for therapists to be able to access and critique relevant and current theories and models to make sense of this presentation in their clinical work. To support therapists in their appraisal of the literature, this review aims to a) provide an overview of the current approaches, theories and models for understanding DID b) provide a critical appraisal of this literature and c) identify gaps within the literature and suggest directions for future research.

1.2 Method

In their systematic review, Boysen and VanBergen (2013) reviewed all published research on DID. Their key findings included current research output, research trends, prevalence across culture of DID, diagnostic methods and a review of simulation studies of DID (where participants with DID are compared to participants who are acting/simulating the symptoms of DID). However, the authors did not specifically focus on the different theories and models of DID available, and therefore there is a gap in relation to this aspect of the literature.

This review focuses on systematically identifying current literature describing or reviewing theories or models of the causal and maintenance mechanisms of DID on which case formulation of DID could be developed. Electronic databases (MEDLINE, EMBASE, PsycINFO) were searched for studies published in English between 2000 and 2013 that describe theories or models for understanding DID. Search terms were based on a modified search criteria from the Boysen and VanBergen study and included *dissociative identity disorder*, *multiple personality disorder* and *dissociative disorders*. These key search terms were combined with the terms *model*, *theory*, *framework*, *formulation*, *structure*, *etiology* and *conceptualisation*.

The initial search resulted in 1355 articles (see figure 1 below for flowchart) that were reviewed by title and abstract against the inclusion criteria (described below). Initial inspection found 1178 articles did not address the research question or did not meet the inclusion criteria

(see below). Following removal of duplicates 39 articles were potentially relevant (See Appendix A for a full list).

Studies were included if they were published journal articles. All accepted articles focused on describing or examining theories or models to enhance understanding of the causative and maintenance factors (conceptualisation) of DID in adult mental health. Methodological quality criteria were applied; studies were excluded if they were based on case studies or self-reports, commentaries or correspondence, focused on children or were population or gender specific. Uncertainties about whether a study met the inclusion criteria were resolved through discussion with the research team[1].

Twenty two papers identified through the electronic searches were included in the final review. Examination of these articles' reference lists highlighted a further 21 potential articles, of which three met the inclusion criteria, resulting in a total of 25 papers.

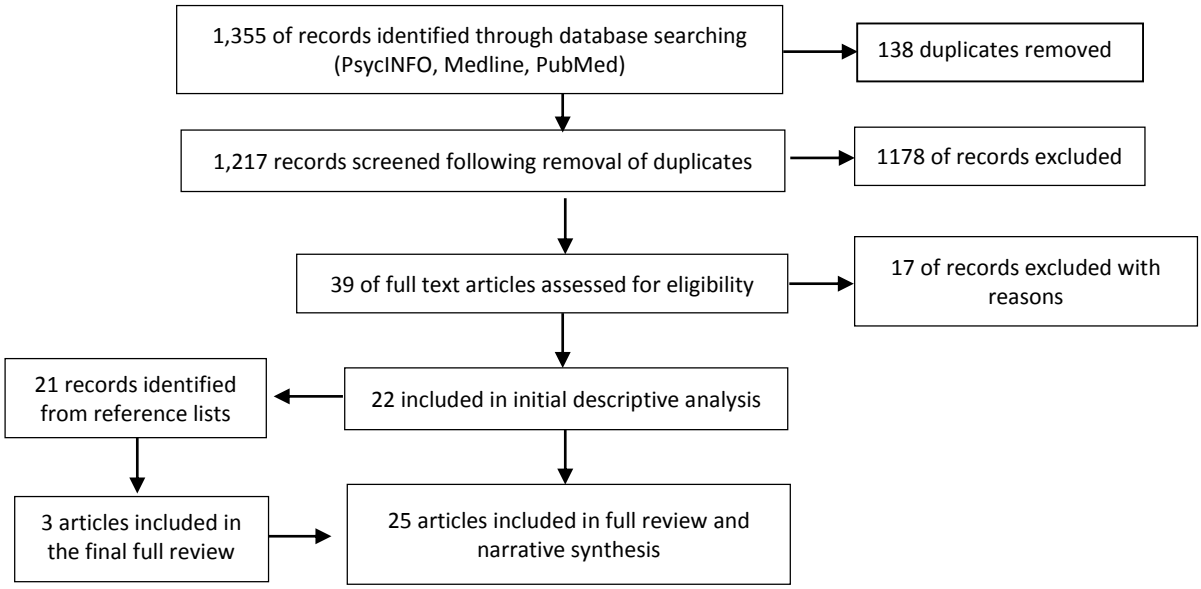

Figure 1: Flowchart of the systematic literature search

[1] 1. The supervisory research team were Dr Lusia Stopa, Director of Clinical Psychology Doctorate at the University of Southampton and Dr Tess Maguire, Clinical Psychologist, Southern Health Foundation Trust.

1.2.1 Data

The final 25 articles for reviewed are outlined in Table 1 below.

Table 1 – List of articles included in the full article review

Reference	Date	Dissociation or DID	Model/Theory
Boysen & VanBergen	2013	DID	Overview (SCM)(TM)(V)
Macintosh	2013	Dissociation	Integration model – Trauma (TM) and Relational (TM)
Dalenberg, et al	2012	Dissociation	Trauma (TM) and Fantasy models (SCM)
Lynn, Lilienfeld, Merckelbach, Giesbrecht & van der Kloet	2012	Dissociation	Sociocognitive model (SCM)
Paris	2012	DID	Invalid diagnosis model (V)
Harper	2011	DID	Structural Dissociation Model (TM)
Nijenhuis, van der Hart & Steele.	2010	Dissociation	Structural Dissociation Model (TM)
Brenner	2009	DID	Attachment perspective (TM)
Dell	2008	DID	Validity model (V)
Korol	2008	DID	Attachment perspective (TM)
Selligman & Kirmayer	2008	DID	Spirits/Trance/Possession
Lester	2007	Dissociation	Subself Theory
Ryle & Fawkes	2007	DID	Trauma model (TM)
Sar & Ozturk	2007	Dissociation	Trauma model (TM)
Liotti	2006	Dissociation	Attachment perspective (TM)
Lyons-Ruth, Dutra, Schuder & Bianchi	2006	Dissociation	Attachment perspective (TM)
Shaffer, Oakley & Jeffery	2005	DID	Trauma model (TM)
Liotti	2004	Dissociation	Trauma (TM) and attachment models (TM)
Kennedy et al.	2004	Dissociation	Cognitive model (TM)
Piper & Merskey	2004	DID	Iatrogenesis Theory (SCM)
Blizard	2003	DID	Attachment perspective (TM)
Thomas	2003	Dissociation	Trauma model (TM)
Rieber	2002	DID	Psychoanalytic conceptualisation (TM)
Forest	2001	DID	Discrete Behavioural States Model
Gleaves, May & Cardena	2001	DID	Valid diagnosis model (V)

Key: SCM – Sociocognitive Model; TM – Trauma Model; V – Valid diagnosis model;

1.2.2 Synthesis

The broad nature and aims of the review question pointed to a narrative synthesis of the data (e.g. Popay et al, 2006). Articles were listed by theory or model and grouped together into overarching thematically related categories (Table 2 below).

1.3 Results

1.3.1 Overview

The systematic literature review found 25 papers that described twelve theoretical causal explanations of DID proposed in the literature (Table 2). Articles described at least one key theory with several describing at least two. Trauma-based models included models/theories that proposed the development of DID is a response to trauma (e.g. Gleaves, 1996), Sociocognitive Models (SCM) included models/theories which proposed that individuals diagnosed with DID act as if they have two or more self-states due to cultural expectations and fantasy (e.g. Lilienfeld et al, 1999). Models of validity included those that challenged the very concept of DID as a distinct and separate diagnosis, suggesting that it is simply a constellation of symptoms that could be better explained by other diagnoses (e.g. Paris, 2012). In addition, there were three stand-alone theories that were not replicated in other articles (see table 2).

Table 2 – Table outlining the key models and theories of DID identified

Theory/Model	Number of papers theory discussed in	Theory/model grouped by theme
Attachment/Relational Perspective	8	Trauma – attachment basis
Cognitive Behavioural Model	1	Trauma – structural dissociation of the mind
Discrete Behavioural States Model	1	Psychobiological model
Fantasy Model	1	Sociocognitive model
Iatrogensis Model	1	Sociocognitive model
Invalidity of Diagnosis Theory	3	Invalidity of DID Model
Possession/Trance/Spirits	1	Spiritual Model
Social Constructionist/Constructivist	1	Sociocognitive model
Sociocognitive model	2	Sociocognitive model
Structural Dissociation Model	3	Trauma - structural dissociation of the mind
Subself Theory	1	Subself Theory
Trauma model	8	Trauma model

Table 2 continued

Theory Clusters	TOTALS
Trauma models	**20**
Sociocognitive model	**5**
Invalidity of DID model	**3**
Psychobiological model	1
Spiritual model	1
Subself theory	1

Twenty out of 25 articles described models/theories relating a foundation of trauma leading to the development of DID referred to as the trauma-based models. Although trauma-based models were similar in their understanding of the roots of DID i.e. stemming from trauma, they propose differing mechanisms for this relationship. The two strongest themes referred to the impact of trauma on attachment (relational/attachment models) and the impact of trauma on the structure of the developing mind (structural models).

The second most referenced model (5/25 articles) was the Sociocognitive Model (SCM) and included theories of iatrogenesis and fantasy. The third most prominent conceptualisation (3/25 articles) was the invalid diagnosis conceptualisation (e.g. Gleaves, May & Cardena, 2001). In addition there were three stand-alone theories; a) a psychobiological understanding (Forest, 2001), b) interpreting DID as the experience of spirits/possession/trance (Selligman & Kirmayer, 2008) and c) the subself theory of personality (Lester, 2007). As these were unique conceptualisations they were not reviewed.

Two of the articles systematically reviewed the literature. One paper systematically reviewed all published research on DID between 2000-2010 (Boysen & VanBergen, 2013) and the other reviewed the published research in relation to the trauma and fantasy models of DID (Dalenberg et al, 2012). The remaining papers provided descriptions of a particular viewpoint supported by empirical data from the literature but not utilising a systematic process. The dominant discourses identified through this systematic search of the literature have been reviewed and critiqued.

1.3.2 Trauma-based models of DID

Trauma-based models of DID were most frequently discussed. These models regard DID as an internal coping mechanism developed by infants to distance them from overwhelming and intolerable trauma through dissociative processes. The infant is forced to turn to internal

mechanisms when all external sources of relief have failed (e.g. Nijenhuis et al, 2010). Trauma-based models propose that, as a result of this process repeating over time, there is an interruption to the normal developmental personality integration. These processes are hypothesised to occur during early critical developmental periods that lead to fragmentation of the personality resulting in a number of self-states (International Society for the Study of Trauma and Dissociation, ISSTD, 2011). These self-states behave as if they are separate and unique personalities often presenting with different sets of memory, experiences, gender, voice and mannerisms.

The trauma-based models grouped together into two key themes; 1. Attachment models and 2. Structural Models. These are outlined and critiqued below.

1.3.2.1 Attachment models of DID

Eight of the articles reviewed from the psychonanalytical literature described attachment perspectives. These suggest that children who experience significant trauma to early attachment relationships are likely to engage in detached behaviours such as dissociation as a method of tolerating the distress this causes (Barach 1991). Attachment theory hypothesises that Disorganised Attachment (DA) develops as a result of these early traumas to attachment. A child with DA is unable to develop a coherent strategy for maintaining attachment to a primary caregiver due to the caregiver offering both a source of protection as well as a source of threat to wellbeing. This ultimately results in the pervasive lack of behavioural and mental integration witnessed in infant disorganisation and dissociation (e.g. Korol, 2008; Liotti, 2006). Lyons, Dutra, Schuder & Bianchi 2006 supported this hypothesis in the findings of their research looking at family environmental factors. This showed a consistent relationship between DA and factors such as inconsistent parenting and parental dissociation.

Blizard (2003) talked about the role of the 'double-bind' scenario on attachment and in the development of DA and DID: "…*the victim is repeatedly placed under a negative injunction, which is contradicted by a second injunction, both of which are enforced by punishment or signals that threaten survival. A third injunction prohibits the victim from escaping*." (p. 29). The key contextual element to the double bind is the conflicting messages e.g. the message spoken is not the message demonstrated. An important additional context to the double-bind is that the child is powerless to escape. As a result of these mixed messages and an inability to escape, a coherent attachment system cannot be formed but instead two or more segregated models of attachment are developed. Here the child is faced with ongoing relational dilemmas;

the need to adapt in order to be attached for survival and the conflict with the need to self-protect. In response, a number of separate attachment models are developed and it is these that are believed to account for multiple self-states or personalities observed in people with DID.

Liotti (2004; 2006) proposes a vulnerability attachment model whereby infants exposed to this paradoxical context develop contradictory attachment models of self and other that predispose them to dissociation. When this predisposition is combined with ongoing severe stressors or trauma this vulnerability is potentiated. In extreme cases, where the contradictory attachment models are consistently reinforced, DID may develop.

Although an interesting hypothesis, the available empirical research to support this understanding is lacking. As described by Lyons et al. (2006), although there is some evidence to suggest that deviant parenting may lead to the experience of serious dissociative symptoms in the absence of trauma, this population are under-represented in research and so research in this area remains sparse. To establish the links between trauma, attachment, dissociation and DID, ideally requires prospective and objective research that could measure variables such as attachment, seen as well as hidden trauma (i.e. emotional or psychological neglect), environmental, physical, genetic and familial factors, to track the development of dissociation and DID over time.

1.3.2.2 Structural models of DID

Three of the articles reviewed described structural changes of the mind associated with dissociation and DID. The *Structural Dissociation Model* (SDM; Nijenhuis et al, 2010) proposes that during critical periods of infant brain development there can be a structural split in the personality when under extreme, chronic and intolerable threat or actual harm. This split occurs between the defensive systems (the Emotional Personality) and the systems involved with functioning in daily life (the Apparent Normal Personality). DID is framed as arising in the evolutionary context of survival whereby severe threat to wellbeing triggers structural dissociation of the personality as a method of self-protection. The Emotional Personality (EP) holds the traumatic material but is unable to piece this information together in a coherent way. The Apparent Normal Personality (ANP) is committed to avoiding this traumatic material, often at a phobic level, in the pursuit of being able to function adaptively day to day. This phobic resistance to traumatic material by the ANP pushes the EP further away, making the divide between them greater, resulting in multiple separate self-states. Empirical evidence relating to the validity of the concepts of ANP and EP is discussed further below.

This idea of a structural dissociation was also presented by other authors in the literature but under different conceptual descriptions. Sar & Ozturk (2007) described a structural dissociation into parts they called the sociological self and the psychological self. Kennedy et al's (2004) model described these parts as modes that became separated at different levels. They defined modes as: "*A mode is defined as a set of schemas responsible for encoding cognitive, affective, behavioural and physiological information and for generating responses. Orienting schemas encode internal and external events and activate these modes, as appropriate to the context*". Kennedy et al. described an inhibitory decoupling of mental processes necessary for coherent information processing at three stages:

1. At the early automatic stage of information processing which may result in the abnormal storage of memory e.g. storing fragmented memories

2. Within modes decoupling whereby normally associated links within a mode (such as the links between cognitive, affective, behavioural and physiological experiences) become fragmented

3. Between modes decoupling which results in the development of DID due to the dissociation and separation of modes from each other into separate self-states. These stages represent different levels of information processing integration. Due to the limitations of this article, this model will not be outlined further here (see Kennedy et al, 2004).

The fundamental premise of these models is that early childhood trauma provokes a structural dissociation in the personality that results in the development of multiple self-states (DID) in an attempt to survive. These self-states display definable differences in their presentation including differences in their in psychobiological responses and sense of self (e.g. Nijenhuis et al, 2010; Reinders et al, 2003).

A difficulty with this understanding of DID is that it simplifies the complexity of the presentation in hypothesising a direct trauma-dissociation link. This A-B relationship does not explain why some individuals who have not experienced trauma demonstrate dissociation or why others who have experienced trauma do not. This understanding neglects the importance of variables that contribute to a child's development such as their environment, society, family, physical and genetic factors that all interact and account to varying degrees for child development. Further exploration of non-traumatised individuals who dissociate is required to address this gap and the outcomes of this research incorporated into models of dissociation and DID.

In addition, there is the challenge of 'hidden trauma' (Lyons et al. 2006), which is difficult to objectively quantify. This is the trauma or threat to integrity resulting from caregiver unavailability, neglect, emotional or psychological abuse. This is a particularly prominent and current issue in England and Wales where the government is considering whether to introduce a further category to the Children and Young Persons Act of 1933 for emotional cruelty. This law would encapsulate impairment of physical, intellectual, emotional, social or behavioural development.

Having briefly outlined the two key theoretical perspectives stemming from trauma-based foundations, this review will now present and critique the empirical evidence presented by these papers in support of their two key hypotheses.

1.3.2.3 Hypotheses of the trauma-based models

Two fundamental hypotheses underpin the trauma-based models and are frequently stated in the literature as areas of contention. Firstly, the trauma-based models believe that trauma is directly related to the development of DID and more specifically that the severity and chronicity of trauma has a relationship to the level of dissociation experienced with DID. Secondly, structural changes in the personality result in the development of separate self-states that respond in fundamentally different ways to stimuli. These hypotheses will be addressed below:

1.3.2.3.1 Hypothesis 1: Childhood trauma is related of dissociation and the development of DID in adulthood.

A central tenet of the trauma-based models is that significant childhood trauma causes the development of dissociation and, in the most severe cases, DID. The full trauma and dissociation literature is vast and beyond the scope of this review. However, it was a point of discussion in 16/26 articles reviewed with 12 presenting evidence in support of the trauma-DID relationship and 4 suggesting that this relationship was either weak or did not exist.

In support of the trauma-DID relationship, Nijenhuis et al, (2010) presented a number of retrospective and prospective studies supporting this hypothesis. In specific support of the relationship between the severity of trauma and the development of DID, they presented evidence from one study (Nijenhuis, Spinhoven, van Dyck, van der Hart & Vanderlinden, 1998) that was retrospective and two of the authors were also authors of the article, leaving it open to criticisms of bias.

A systematic review of research for trauma and fantasy models of dissociation (Dalenberg et al, 2012) presented findings from 38 empirical papers on the relationship between trauma and dissociation. They demonstrated an overall consistent and moderate relationship between trauma and dissociation and found in favour of this. The authors recognised that of the studies they reviewed the base rate of DID within the clinical samples was low and suggested this may result in misleading outcomes simply showing a relationship but not the direction of this relationship or causation.

A significant weakness of the majority of reported research on the trauma-dissociation relationship is that it uses self-report cross sectional methodology to test the hypothesis. This approach is subject to bias and is unable to provide any information on causation (e.g. Lynn, Lilienfeld, Merckelbach, Giesbrecht & van der Kloet, 2012). Piper and Merskey (2004) make this point when they suggest that an A-B relationship between trauma and dissociation is too simplistic and they raise a number of important questions, including "*What percentage of people with histories of trauma fail to develop DID?*" (p.593) and why more cases of DID are not seen in children who have experienced other traumatic childhood episodes such as medical procedures, famine or earthquakes. They argue that more rigorous and objective methods of validating childhood trauma are needed. For example, they suggest obtaining photographic evidence, diaries written by perpetrators detailing specific incidents and contemporary eye witness accounts. Although theoretically sound suggestions, it is not clear how realistic this would be to put into practice.

Liotti (2004) suggests that it is not just the experience of trauma but the nature of the trauma that is an important mediator in this relationship e.g. betrayal by trusted care givers and the impact this has on attachment. Korol (2008) proposed and presented evidence in support of a more complex model of the trauma-dissociation relationship whereby DID results from a combination of factors including a disorganised attachment style, the absence of protective social and familial support in combination with a traumatic/abuse history. More complex models, looking at the relationships between a number of variables is more likely to provide a more realistic representation of the causative factors of dissociation and DID but evidence is required to substantiate them.

1.3.2.3.2 Hypothesis 2: Self-states are definably different and will respond in fundamentally different ways to stimuli.

This hypothesis was supported by two of the articles reviewed with none of the articles presenting arguments against it. Nijenhuis et al. (2010) and Dalenberg et al (2012) reported research showing that patients with DID demonstrate approximately 25% less hippocampal volume than healthy controls. This area of the brain is responsible for the consolidation of information from short-term to long-term memory. Therefore, difficulties in this area may result in difficulties with memory and integration of information. Although interesting and a definable difference, without longitudinal research it is impossible to know whether the differences in hippocampal volume are causative or the resulting symptom of pathology associated with DID. This would be an interesting area for future research to understand further the relationship between hippocampal volume and dissociative symptomology.

Nijenhuis et al. (2010) suggest that research on the differences between ANPs and EPs is possible based on their experience that some patients have the ability to control switching between self-states. They report evidence from Reinders et al (2003) that demonstrated through functional neuroimaging differences in regional cerebral blood flow between self-states, as generated by participants with DID. Participants were asked to listen to two autobiographical audiotaped memory scripts involving neutral and trauma-related experiences. Participants were asked to switch between their ANP and EP self-states during PET investigation whilst listening to these scripts. Differences between self-states were demonstrated when listening to traumatic material but not when listening to neutral information. The authors suggest that these findings support the hypothesis that self-states are definably separate states of being that will respond in fundamentally different ways to stimuli.

Nijenhuis et al., also report the findings of a psychobiological study on the differences between EPs and ANPs in response to audio recordings of traumatic memories (Reinders et al, 2006). This study found that EPs experienced increase in heart rate frequency, systolic blood pressure and diastolic blood pressure in addition to a range of affective and sensorimotor reactions to trauma memory scripts whereas the ANP did not. Although very compelling, evidencing the existence of ANP and EP self-states still requires further controlled empirical evidence to establish their validity.

1.3.3 The Sociocognitive Model

In contrast to the trauma-based models, the Sociocognitive Model (SCM) suggests that DID is constructed by popular culture, the individual themselves (fantasy) or imposed by the therapist (iatrogenesis). The systematic literature search found five articles that directly described and discussed SCM understandings of DID. These theories will be briefly outlined and the evidence relating to key hypotheses reviewed and critiqued.

The SCM posits that some people may unconsciously act as if they have two or more self-states when in reality this is the result of cultural roles created in relation to others rather than the result of a complex internal defence in response to overwhelming childhood trauma (e.g. Lilienfeld et al, 1999). These self-states are seen as resulting from a process of socialisation that is reinforced over time. The model suggests that these individuals have a proneness to fantasy and imagination in the context of a culture or relationship that encourages this presentation. Some researchers argue that DID may only 'be seen' by therapists who believe in DID. They suggest DID is co-created by the therapist with the client (iatrogenesis) through a combination of suggestion and the client's eagerness to please or proneness to suggestion and fantasy (e.g. Piper & Merskey, 2004). These hypotheses are discussed in more detail below.

Of the five papers reviewed, three of the articles provided empirical research outcomes and discussed findings in support of the SCM (Piper & Merskey, 2004a; 2004b; Lilienfeld, Merckelbach, Giesbrecht, & van der Kloet, 2012). Two of the papers were systematic reviews with one presenting findings in support of the trauma-based models (Dalenberg et al, 2012) and the second taking a more neutral stance but with a suggestion that the SCM model may hold the stronger evidence base (Boysen, & VanBergen, 2013).

1.3.3.1 Fantasy Models

Fantasy models (FM) propose that patients who are more suggestible and prone to fantasy are more likely to dissociate and report the symptomology of DID. They effectively turn the trauma-dissociation relationship on its head, putting forward that it is dissociation, proneness to fantasy, cognitive distortion and suggestibility that result in reports of childhood trauma. This theory particularly refutes the reality of trauma memories, believing these to be fantasies rather than factual. This hypothesis therefore interprets the evidence showing a relationship between trauma and dissociation as equally supporting this contention but with the belief that the relationship is in the opposite direction.

Dalenberg et al (2012) carried out a comprehensive systematic review of the literature to synthesise the data available for both the trauma-based models and FM. Based on this conceptualisation of dissociation, they outlined a number of predictions that the FM model would support. Of particular interest they suggest that the FM would predict that:

1. Dissociation is the result of a mental state characterised by high fantasy proneness.

2. Fantasy proneness, not dissociation, should predict trauma report.

3. Dissociative individuals are at higher risk of false memories of personal trauma.

The authors found in favour of trauma-based models for each prediction based on evidence from their systematic review and taking into consideration the weaknesses of measurement tools for both models. They showed only weak and inconsistent relationships between dissociation and event suggestibility/false memory and strong evidence against the hypothesis that trauma history is simply the fantasy of the individual. They summarise by stating that "*fantasy proneness is not the explanation*" (p.30).

It is argued that research outcomes looking into the causes of dissociation and DID cannot be relied on because it is largely made up of self-report and retrospective research that is susceptible to the influence of fantasy. Dalenberg et al (2012) purposefully sought research that uses more objective measures of reported trauma e.g. reported by others. They reported a number of objective studies for trauma verification such as confirmation of trauma by therapists (with access to guardians and Child Protection Service reports) protective agency reports and observer ratings of mothers' treatment of their infants. Again, although based on a limited literature they suggest that the evidence supports the trauma-based models.

1.3.3.2 Iatrogenesis

Piper and Merskey (2004) make a powerful statement about the reliability and validity of DID; "*consistent evidence of blatant iatrogenesis appears in the practices of some of the disorder's proponents*" (p.592). Although presented as a critical examination of the literature, this was not a systematic review and the critique appears only for trauma-based models. Their review did not find any systematic reviews in direct relation to the hypotheses put forward by supporters of the iatrogenesis interpretation of DID. Although they raised some potentially good questions, their tendency to report only one side of the argument makes it difficult to evaluate the evidence presented. For example, in the opening paragraph of the introduction:

Between 1993 and 1998, the principal dissociative disorders organisation lost nearly one-half of its members. In 1998, Dissociation, the journal of the dissociative disorders field, ceased publication. A paper published in 2000 examined the weaknesses in the dissociative amnesia construct. Various dissociative disorder units in Canada and the US (examples given) have closed down. (p. 592)

The authors list evidence demonstrating the reducing influence of the school of dissociation. However, it is difficult to evaluate this evidence without evidence concerning the opposing argument e.g. did organisations, journals or units open during this time period and what ratio opened to closed. This is where systematic reviews provide a more balanced understanding of the available evidence rather than pieces reflecting individual opinion. However, this article raised some important points and presented research findings to challenge the trauma-based model's conceptualisation of DID. There is very little direct research on iatrogenesis, with authors tending to report observations as evidence of this occurring. For example, the Lynn et al (2012) article stated that the number of self-states reported have been observed to increase over the course of therapy (Piper, 1997) which they indicate is suggestive of iatrogenesis.

1.3.3.3 Key hypotheses of the SCM models

The SCM hypothesises that individuals reporting DID are susceptible to cultural pressures, suggestion from others and fantasy. Based on this understanding of DID, it is hypothesised that people reporting DID are assumed to be susceptible to cultural pressure and therefore DID would be culturally specific. For example, DID would only appear in cultures, places or around people where multiple self-state presentations are known and accepted. Secondly, DID is created i.e. healthy participants could imitate or simulate this presentation. Thirdly people prone to suggestibility and fantasising could develop DID therefore these difficulties do not stem from childhood trauma.

1.3.3.3.1 Hypothesis 3: DID is culture specific and clustered to certain areas/researchers

There is a dearth of literature in this area with a heavy reliance on case study evidence. The three articles described below considered evidence of the cultural specificity of DID. Boysen and VanBergen (2013) demonstrated a clustering of cases around certain researchers suggesting this evidence supports the co-creation of DID. In addition, they examined the prevalence of DID across cultures and found that the majority of the case studies were from Western countries. However, there were also cases from Japan, Africa, Taiwan, and Turkey.

Empirical research was obtained from China, Israel, the Philippians and Turkey. Turkey accounted for 79% of all non-Western cases with Western cases accounting for 82% of all newly identified cases of DID.

Piper and Merskey (2004) argue that the increase in the number of DID cases reported over time suggests iatrogenesis. For example, they state that more DID cases were discovered during the 5 years prior to 1986 than had been found in the previous 2 centuries. They outline three possible hypotheses for this increase; 1. That the prevalence of the disorder has not changed but awareness and accurate diagnosis of it has improved 2. That there has been an increase in the disorder and finally, their own hypothesis 3. "*the increase in cases represents faddish overdiagnosis*" (p.596). They suggest that the increase in cases is more likely to be the result of over-diagnosis but do not provide any direct evidence that this is taking place or evidence refuting the first two hypotheses and therefore provides only a weak argument.

Although these authors present interesting arguments, the interpretation of their evidence is key. For such a rare presentation as DID it is more likely that specialists in the disorder will have patients referred to them who are suspected of having DID and additionally they are more likely to recognise the symptomology of the disorder. A survey of 138 mental health therapists completed this year (Stokoe, 2014) showed that fewer than half of those who participated (44%) were able to describe the key features of the DID presentation. Clinicians can only detect DID when they know what they are looking for. Therefore, is the clustering of cases around certain areas evidence of iatrogenesis or simply a lack of understanding, knowledge and training elsewhere?

1.3.3.3.2 Hypothesis 4: DID can be created or acted by healthy participants

Shaffer, Oakley and Jeffery (2005) contend that the reports of self-states cannot be a reliable differential for DID diagnosis until suggestion, faking and malingering have been ruled out. The main approach to answering this question has been based on simulator research. Five of the 26 articles reviewed presented evidence for this hypothesis. Two of the articles reviewed supported the view that self-states can be simulated (Lynn et al., 2012; Shaffer et al., 2005), one presented mixed evidence (Boysen & VanBergen, 2013), whilst two article refuted this hypothesis (Dalenberg et al, 2012; Nijenhuis et al., 2010). Simulator research compares individuals presenting with a diagnostic complaint such as DID to individuals who are acting or simulating the presentation i.e. pretending to have DID. The idea being that an authentic presentation cannot be acted and would demonstrate definably different outcomes to simulators on systematic tests. Boysen and VanBergen (2013) reviewed thirteen studies that

compared a DID group to a group of people simulating DID. Their review showed that nine of the thirteen studies did not find an overall significant difference between both sets of people in terms of implicit memory, event-related potential and the Dissociative Experiences Scale (DES). The four remaining studies demonstrated differences in faking of mental illness, SCID-D scores (a diagnostic tool for dissociative disorders; Steinberg, 1994), eye roll sign for hypnotic potential, reaction times to angry faces and electroencephalogram coherence. They suggest the overall evidence most likely supports the SCM model's hypothesis that DID is a form of role enactment. However, overall the outcomes of this research are mixed and therefore further research is necessary before any firm and final conclusions can be drawn.

Lynn et al (2012) report the findings of Kluft (1984) showing many patients diagnosed with DID do not show clear DID psychopathology until after engaging in psychotherapy. They also report the findings of Piper (1997) that showed the number of self-states to increase substantially over the course of treatment. Again, the interpretation of these findings is key. Trauma-based model theorists would interpret these findings as resulting from the growing therapeutic relationship enabling clients to share these experiences, as opposed to indicating therapists inducing or co-creating self-states through suggestion. Similar arguments have been put forward in relation to therapists inducing suicidal thoughts by asking patients about risk but this has since been refuted (e.g. World Health Organisation, 2000; Gorgon & Angus, 2007). Therefore, it will be important for research to address this relationship more thoroughly before drawing further conclusions.

Boysen and VanBergen (2013) suggest caution should be taken when interpreting the psychobiological outcomes of studies on the differences between participants with DID and participants simulating DID. They point out that the outcomes of research can be interpreted in support of both trauma-based models and fantasy models. For example, fantasy model theorists draw on research (McNally et al, 2004) that shows a significant increase in heart rate, SCR and left frontal electromyography by participants who *believe* themselves to have been abducted by aliens. Supporters of the FM would therefore hypothesise that differences shown in psychophysiological research in DID simply demonstrates the person's belief in their experience rather than the experience having actually happened. This emphasises the importance of interpretation and confounding variables.

Although not captured in this review, a recent systematic review of simulator research (Boysen & VanBergen, 2014) for DID found 20 studies containing several replicated findings. These findings included differences between the simulator and DID groups for symptom

presentation, identity presentation and cognitive processing deficits. Similarities between groups included inter-identity transfer of information including measures of recall, recognition and priming. They conclude that the differences shown by DID may not be as simple as enacting a social role but also highlight the need for vigilance to illusion. This review was published in January 2014 and therefore was not reported in any of the articles reviewed but is clearly relevant to understanding the evidence base supporting these different models.

1.3.3.3.3 Hypothesis 5: Fantasy and suggestibility lead to the development of self-states

Five of the articles reviewed discussed this hypothesis with four of the papers supporting the fantasy model and one supporting the trauma-based models.

Lynn et al (2012) report that research from at least 10 studies confirms the relationship between dissociation and fantasy proneness, but fail to reference these studies. They report the findings of Giesbrecht, Lynn, Lilienfeld and Merckelbach, (2010) showing a relationship between individuals who dissociate and proneness to false memories of childhood emotional events. Paris (2012) hypothesises that memories recovered in therapy are not true but simply stories, citing the work of McHugh (2008) in the suggestion that therapists actively and persistently probe for traumatic memories.

The main difficulty with these arguments is that they are ultimately opinions. Although they provide interesting and useful references to research, they have not reviewed the literature in a systematic manner, leaving their conclusions open to suggestions of bias.

One of the arguments posited by FM theorists is that dissociative participants are at high risk of suggestibility and false memory and therefore likely to develop a fantasy of self-states rather than their presentations reflecting reality. They hypothesise that clients experiencing DID will be more likely to accept false suggestion of having seen or experienced events compared to others. Dalenberg et al. (2012) reviewed 8 studies on non-autobiographical event suggestibility, 13 studies of autobiographical events, 12 studies looking at source confusion and 3 imagination inflation studies. Non-autobiographical studies involve presenting participants with new information which is typically read. Later, participants are pressed to agree with false statements about this material. Autobiographical suggestibility paradigms focus on ‘false memory’. Participants are generally told that a person who knows them well had recalled an event from their life. The participant is then scored on the extent to which they accept the truth of the false memory. Source confusion studies are where the participant is tasked to discriminate between competing sources for an alleged memory. For example,

participants are asked to discriminate whether the alleged memory came from a picture, a paragraph read to them, or a new story altogether. Imagination inflation studies ask participants to imagine a series of incidents and then recall their feelings about remembering these events. Their findings concluded that the literature supports a weak and inconsistent relationship between DID and false suggestion. Of particular interest, Dalenberg et al. (2012) found that the research to date indicates that patients with delayed recall of trauma are less suggestible in the non-autobiographic paradigm than other psychiatric patients. The authors called into question the differentiation between acquiescence and false memory when designing these types of studies, suggesting it as an oversight of researchers aligned with trauma-based models. They suggest this has resulted in poor representative data from the trauma-based model perspective. They suggest that studies looking at the interaction of a number of variables over time (i.e. longitudinal studies) should be the logical next step in this research area and ideally would be a collaborative approach between members of the different schools of thought i.e. between trauma-based model theorists and supporters of the fantasy model. However, 27 of the 36 studies reviewed in the study were based on undergraduate populations with none focusing directly on DID as a population. Therefore, to draw any firm conclusions about suggestibility in this particular population, research needs to be designed and developed to include these and other psychiatric and non-mental health (control group) populations. Based on this perspective, research on fantasy proneness and suggestibility for people experiencing DID still has a long journey ahead.

1.3.4 Invalid Diagnosis Perspectives

Some writers propose DID is not a valid diagnosis and strongly argue in favour of it being removed from the DSM. Of the 26 articles reviewed, three discussed the issue of diagnostic validity with one in support and two against the validity of the DID diagnosis.

Gleaves et al. (2001) acknowledge that DID has been a controversial diagnosis to which there have been two main challenges. Firstly, DID is a construction and is not 'real' and secondly that DID does not represent a distinct valid diagnosis, but is simply a variant of other disorders. In response to these arguments, Gleaves et al. present a convincing case to support the validity of DID, using three comprehensive validity frameworks. They completed a systematic comparison of the validity criteria set out by Robins and Guze (1970), Spitzer and Williams (1985) and Blashfield, Sprock & Fuller (1990), in addition to their own taxometric research (Table 3). Taxometric procedures were developed by Meehl (1995) to address the problem of classification in psychopathology. A taxon describes a group of one (or more)

populations of an organism or in the case of psychopathology, a group of symptoms indicative of a distinct disorder. Taxanomic procedures aim to distinguish between psychological types as opposed to variations along the same continuum. Where a construct is found to be typological, this approach aims to determine a set of indicators for that taxon.

The findings of this study demonstrated that DID meets the majority of the criteria outlined (see Table 3 below). For some criteria the authors were unable to present evidence to either support or contend it. For example, the authors were unable to support criteria 3 (see Table 3) to show that there is no diagnostic bias and argue that nearly all DSM-IV diagnoses would not be able to demonstrate evidence to meet these criteria. For example, diagnoses such as anorexia nervosa and borderline personality disorder (e.g. Tadic et al, 2009) are predominantly found in females. Taxometric research has been proposed as the gold standard procedure for addressing the diagnostic validity problem (Meehl, 1995). The authors present evidence from their own taxonomic research (Table 3. Criteria 4) that supports the diagnosis of DID and points out that DID is one of only a few disorders that has been exposed to this type of research. A summary of the full criteria comparison and the evidence supporting each point is outlined in Table 3. The key evidence for the existence of DID as a valid diagnosis is that it is a clinical picture recognised in the literature (criteria 3.1 and 3.6) for which accurate psychological tests have been developed (criteria 1.1 and 2.1), empirical research has been conducted (criteria 1.2), it is a diagnostic category in its own right (criteria 3.2) and can be reliably distinguished from other psychiatric disorders (criteria 1.3, 2.2, 2.4, 3.3, 3.4, 3.5). It has adequate prevalence rates to be considered a disorder (criteria 3.7) and finally has had taxonomic research completed (criteria 4).

Table 3 – Summary of Gleaves, May and Cardena (2001) DID validity study findings

Framework	Criteria no.	Criteria	Evidence stated
Robins and Guze (1970)	1.1	Clinical Description (phase 1)	DID is a recognisable clinical picture for which accurate psychological tests have been developed.
	1.2	Laboratory Studies (phase 2)	Accurate psychological tests have been developed that identify and diagnose DID (e.g. the DES and the SCID). A number of empirical studies have been completed on participants with DID as a consequence of having the tools to identify and diagnose it.
	1.3	Delineation from other disorders (phase 3)	DID can be discriminated from other conditions. The authors present evidence supporting differences to Schizophrenia, Borderline Personality Disorder, Post Traumatic Stress Disorder and Somatization disorder as these are the most frequently discussed presentations in support of their relationship with DID.
	1.4	Follow up study (Phase 4)	The authors state that the expectations of this criteria are not clearly outlined. The authors suggest that it is more important to identify this

			evidence when the etiology of a disorder is not known but they argue that in this case the etiology is known.
	1.5	Family study (Phase 5)	The authors state that the expectations of this criteria are not clearly outlined.
Spitzer and Williams (1985)	2.1	Face validity	The authors indicate that this is equivalent to phase 1 of the Robin and Guze (1970) model (see above) and therefore present the same evidence.
	2.2	Descriptive validity	The authors indicate that this is equivalent to phase 3 of the Robin and Guze (1970) model (see above) and therefore present the same evidence.
	2.3	Predictive validity	The authors indicate that this is equivalent to phase 4 of the Robin and Guze (1970) model (see above) and therefore present the same evidence.
	2.4	Construct validity	Equivalent to phase 5 of the Robin and Guze (1970) model but they also include evidence that supports the theory that explains the etiology of the disorder. They suggest that the more empirical support there is for the theory of the etiology, the stronger the evidence for the validity of the model. They suggest that the strong body of evidence linking childhood trauma to DID provides evidence for this criteria.
Blashfield et al (1990)		*Inclusion Criteria*	*Inclusion criteria evidence*
	3.1	Literature	The DID literature meets the minimum inclusion criteria with at least 50 journal articles in the last decade.
	3.2	Diagnostic criteria	DID has existed as a separate category in the DSM since the DSM-III (APA, 1980) and there are a number of assessment devices that have been developed to assess whether the diagnostic criteria have been met (see above criteria 1.2)
	3.3	Reliability	The reliability coefficients reported for Structured Clinical Interview for DSM-IV Dissociative Disorder (SCID-D), the Dissociative Disorder Interview Schedule (DDIS), the Dissociative Experiences Scale (DES) and the Questionnaire of Experiences of Dissociation (QED) were cited.
	3.4	Syndrome	The authors presented evidence from a conditional probability analysis based on the items of the DES-T to assess Blashfield's (1990) syndrome criterion and found in support of a DID syndrome.
	3.5	Differentiation	The authors assessed the empirical evidence for differentiating DID from a number of other psychiatric diagnoses including Schizophrenia, Borderline Personality Disorder, Complex Partial Seizures and other neurological conditions, Post Traumatic Stress Disorder and Somatization disorder (the same as criteria 1.3).
		Exclusion criteria	*Exclusion criteria evidence*
	3.6	Literature	DID did not meet this exclusion criteria with more than 50 recent journal articles in the literature.
	3.7	Coverage	The authors present evidence showing prevalence rates for DID have been found to be above 5% of the dissociative disorder diagnoses in all but one of the studies the authors reviewed. The majority of other studies reported between 11-77% of dissociative disordered individuals would meet the DID criteria and therefore DID does not meet this criterion.
	3.8	Diagnostic bias	This criteria was argued to be difficult to assess due to the nature of the presenation. With sexual abuse occurring at a much higher rate in girls (e.g. Kluft, 1996), there is difference in gender presentation. Further to this, race is too infrequently reported to assess if there is a racial bias. This is an area that requires further research in order to be resolved.
	3.9	Disease	Not applicable due to DID meeting all other criteria.

Meehl (1995)	4	Taxometric research	Taxometric approaches help to distinguish psychological types from variations along a continuum. This approach was used by Waller et al (1996) and Waller and Ross (1997) in which both studies supported the validity of the DID diagnosis.

The authors acknowledge that further research and evidence is necessary to support the predictive and construct validity criteria but overall, they suggest that the evidence for the construct validity of DID is far greater than for the majority of most other disorders: "*Thus, based on these numerous ways of examining diagnostic validity, that of DID seems supported and its inclusion in the DSM clearly warranted*." (p.602).

Seven years later, Dell (2008) put forward a paper listing a number of considerations regarding the diagnostic criteria of DID for the DSM. Dell suggests that DID should not be a stand-alone diagnosis but would be better captured under the umbrella of Major Dissociative Disorder. Rather than a denial of the disorder itself, Dell argues that the restrictive nature of the diagnostic criteria leads to under-diagnosis and misdiagnosis that may occur less frequently with a more flexible diagnostic criteria. Dell is concerned with diagnostic criteria being user friendly and accessible rather than refuting the existence of the disorder altogether.

Interestingly, Dell states that there is no published taxometric research to answer this question despite the earlier publication by Gleaves et al. (2001). However, further taxometric research is required for the purposes of replication and reliability but the lack of research does not imply a lack of the existence.

Paris (2012) published a strongly worded piece about the '*fad*' of DID as an invalid and potentially harmful 'diagnosis'. "*This is a trajectory of a medical fad……The problem continues, given that the DSM-5 includes DID and accords dissociative disorders a separate chapter in its manual*." (Paris, 2012; p.1076). Paris argues that the presenting symptoms of DID could be equally well accounted for by other less controversial diagnoses in the DSM-IV-TR, (APA, 2000). Although a valid hypotheses and one that all diagnoses should be tested against, he does not provide evidence to support this statement and apparently ignores the previous evidence provided by Gleaves et al. (2001). Gleaves et al. provide evidence to differentiate DID from the key comparative diagnoses in the literature including Schizophrenia, Borderline Personality Disorder, Post Traumatic Stress Disorder, Somatization Disorder and Complex Partial Seizures/neurological condition.

Paris goes on to explain that the experience of dissociation is quite normal and gives examples such as dissociating whilst driving long distances '*dissociative symptoms do not necessarily constitute a disorder*' (p.1076). However, the very definition of a mental health disorder by the DSM-V states "*A mental disorder is a syndrome characterised by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning."* with a dysfunction reflecting an abnormal process i.e. not a normal process experienced by the average person. For example, by comparison, feeling sad is a normal human experience that does not necessarily constitute clinical depression which is a mental health disorder. Similarly, mild forms of dissociative experience are normal but severe dissociative symptomology observed in individuals with DID are not and constitute and mental health disorder.

Paris continues to discuss the same points raised in the Gleaves et al. (2001) paper but without the systematic review of the literature or a comparison of his points against any validity criteria. He suggests that DID has only been retained as a diagnosis in the DSM-V due to DSM committee members being biased towards supporting the validity of the diagnosis. He cites David Spiegel's (a supporter of DID) involvement in the DSM committee as evidence of this. Gleaves et al. were careful to outline the review process for revisions to diagnostic criteria for the DSM, which includes consensus meetings, a comprehensive review of the relevant published literature and unpublished but relevant empirical evidence, preparation of position papers based on the reviews, deliberation by a dissociative disorders task force on the papers reviewed and any proposed changes as well as voting on proposed changes. The outcomes of this process are finally sent to the DSM committee to make a final decision. This process is a rigorous and comprehensive process that is applied to all disorders, not just DID. Paris ended this piece by stating "*As shown by its shrinking literature, the epidemic of DID is now behind us. Only DSM-5 has failed to notice that this diagnosis fails to meet criteria for a valid diagnosis*" (p.1078). This statement has not been substantiated by a more balanced view of the literature.

What is clearly lacking, despite powerful arguments for both sides, is a comprehensive, unbiased systematic review of the evidence for the validity of DID. Only once bias and opinion have been reduced can a meaningful comparison be made.

1.3.5 Integration of Understandings

In the past, the trauma and SCMmodels have been entirely opposed, but more recently there has been a shift towards finding common ground. Dalenberg et al, (2012) point out that both trauma-based models and SCM theorists agree that the two models are not necessarily mutually exclusive. Both models propose a relationship between trauma and dissociation, but account for this relationship in different ways. It may be the case that trauma results in dissociation for some individuals, but also that fantasy proneness may lead to inaccurate trauma reports in others or at the same time. Both models recognise that fantasy proneness may be an aspect of dissociation caused by childhood trauma where fantasy and imagination serve as an important coping strategy to escape from intolerable experiences (Dalenberg et al, 2012). This highlights the importance of mental health practitioners' skills for individually formulating difficulties. There is no one conceptualisation or remedy that can be generically applied to all.

1.4 Discussion

Therapist's conceptualisation of complex presenting mental health presentations are key to their understanding and ultimately the development of tailored effective intervention (Summers, 2006). DID is a complex dissociative disorder defined by the DSM-V (APA, 2013) but remains without NICE therapeutic guidelines due to a lack of research in the area. As a result, therapists rely on their own appraisals of the literature.

This review systematically appraised the recent literature to summarise and critique the theories and models available for understanding DID with the aims of; 1) providing an overview of current approaches, theories and models for conceptualising DID, 2) providing a critique of this literature and 3) to identify gaps within the literature and suggest directions for future research.

1.4.1 Overview of current approaches, theories and models for conceptualising DID

This systematic review of the literature identified 25 articles describing three key approaches for understanding DID; 1) trauma-based models of DID suggesting self-states develop as a defence against intolerable childhood trauma, 2) sociocognitive models proposing DID is the result of cultural influence, iatrogenesis and fantasy and 3) invalid diagnosis

proponents who suggest that DID is simply a constellation of symptoms that could be better explained by other diagnoses.

How a therapist conceptualises DID has particular implications for delivering therapeutic intervention. If a therapist accepts DID stems from early experiences of trauma, the therapist may decide to address the underlying trauma as a primary objective. If a therapist adopts an attachment perspective, the primary aim of therapy may lie in developing a safe therapeutic relationship on which to break down previously developed unhelpful attachment templates. Alternatively, a therapist aligned with the SCM or invalidity approaches may look towards working with the 'fantasy' of the presentation or reframing the difficulties under a different diagnosis such as psychosis or a personality disorder. Therefore, research aiming to clarify the conceptualisation of DID is integral for moving the research forward and developing appropriate therapeutic intervention.

1.4.2 Critique of the current literature

DID remains a controversial diagnosis. Strong debates and discussions around the authenticity and validity of the presentation continue to be played out in the literature. While this debate is at the forefront of the DID literature, researchers are distracted from moving the field forward in a meaningful way. Although the trauma-based models appear most frequently in the literature, the evidence is not conclusive and further research is needed.

The literature is relatively sparse and those in the field tend to align themselves with a particular school of thought leaving their interpretations of the evidence open to claims of bias. There were only two systematic reviews addressing DID in adults. One of these reviews was conducted by Dalenberg and colleagues (2012), who have a strong history supporting trauma-based hypotheses of DID and therefore bias of interpretation has to be considered. In a research area of such contention and controversy, the influence of bias is particularly important to consider and will be an important factor for future research endeavours.

DID is a complex presentation. Research looking into the causative relationships between trauma and DID have been too simplistic to date. The research has been limited by retrospective research using self-report approaches for identifying the relationships between variables that are unable to imply causation. To address this gap requires prospective longitudinal research using more objective methods of measurement that can empirically test more complex models of DID, accounting for a broader range of variables.

In relation to bias, the approach to the interpretation of evidence was highlighted in this review. Some of the evidence presented in the literature could be interpreted in support of all three core theoretical understandings depending on the angle of interpretation. It is not surprising to see this in a field where the research camps work so separately and rarely meet, if at all. Collaboration between these different schools of thought will be a vital step forward and one that could see significant movement in this research area.

Despite some strong convictions that DID is the result of suggestibility and iatrogenesis, to date there is no compelling evidence to support of this hypothesis. As Shaffer et al. (2005) point out, different self-states cannot be a differential for diagnosis until faking, suggestion and malingering have been ruled out and it appears that this is where the focus of research must remain for the time-being.

The literature opposing DID can be clouded by strong opinion and a lack of consideration for how this might affect people currently living with this diagnosis. For example "*In the end, it is likely to become about as credible as spirits are today…..to predict a steep decline in the conditions* [DID] *status over the next 10 years and a gradual fall into near oblivion thereafter.*" (Piper & Merskey, 2004b; p. 682) and "*DID is only one of many fads that have afflicted psychiatry during the last century …..Among the best known in the past have been frontal lobotomy…*" (Paris, 2012, p.1078). These types of statement could be extremely invalidating for people living with DID. There is a lack of compassion and empathy in this type of writing which impacts those battling with these distressing and overwhelming difficulties. Regardless of the label given, those living with the difficulties associated with DID will surely find this style of writing invalidating, if not offensive.

1.4.3 Directions for future research

This review indicates that overall, more research is required across the field of DID. In particular, research on iatrogenesis and the validity of the DID diagnosis is needed.

The vast majority of research on DID is retrospective and based on self-report. Ideally longitudinal prospective research, that can take into account the role of mediator variables, is required to address the causative relationships between childhood trauma, dissociation and other potentially related variables such as family pathology and protective factors. However, there are a number of ethical dilemmas around this type of approach that need addressing. One approach has been to follow 'at risk' groups of children as part of longitudinal prospective research (Ogawa, Sroufe, Weinfield, Carlson & Byron, 1997). They recruited mothers in their

third trimester who were part of a mother-child project for “at risk” children and their families. They followed the participants through the first 18-19 years of their lives, carrying out periodic assessment. More research of this type is required before any firm conclusions can be drawn.

Interesting questions have been raised about the role of trauma and type of trauma in relation to DID. For example, authors have asked why not all individuals who experience childhood trauma go on to develop DID, what specific types of trauma lead to the development of DID and how ‘hidden’ trauma can be accounted for and measured. This is an area of research that has been left wide open for those interested in this area of research.

In relation to this, more objective methods for confirming the experience of childhood trauma are required. Some methods suggested in the literature appear more realistic than others. For example, family member reports, police and social services reports may be one viable approach. However, suggestions of obtaining perpetrator reports (such as diary entries or recorded evidence) will be undoubtedly more difficult, if not impossible, on a larger scale. This type of research is important but will be associated with a number of ethical and legal considerations.

There appears to be a lack of research directly addressing the existence of self-states. In particular, the need to empirically demonstrate the definable differences and separate nature of the personality states such as the ANP and EP as suggested by the structural dissociation model (Nihenhuis et al, 2010).

A more collaborative approach is needed. Researchers from the different schools of thought are likely to find more conclusive evidence by working together to consider all aspects of research and by jointly interpreting findings. By working together to address some of the complexity and gaps in the literature, progress can be made. In addition, a more flexible and balanced interpretation of findings may provide a more realistic but integrative understanding of research findings that could consider the possibility of the existence of all hypotheses as described by more integrative researchers in the area.

1.4.4 Limitations

This review only included English-language journals which may have limited the results to Western cultural interpretations of this presentation. In addition, this may have implications for understanding the hypothesis related to cultural clustering of DID and the idea that self-states are created in response to cultural expectations. Although a limitation, it also offers a

potential area for further research that will be particularly beneficial for area of research such as DID.

1.5 Conclusions

The limited evidence presented supports the validity of DID as a stand-alone and unique presentation and diagnosis. The next step is to develop some clarity around the causative mechanisms and underlying maintaining processes of this unique disorder.

As highlighted above, despite the dominance of the trauma-based models in the discourse of the current literature, there continues to be a number of unanswered questions and gaps in the research. Moving the field forwards may require more collaboration between researchers of the opposing camps to develop comprehensive research programmes and enhance interpretation of findings.

It is important for therapists and researchers alike to hold an open and flexible mind. It is possible that some clients will present to services displaying imagined and created presentations whilst others suffer from the long term structural or attachment difficulties inflicted by previous overwhelming trauma. Either way, the role of the therapist is to collaboratively make sense of these experiences and difficulties in order to work towards relieving distress and in the direction of a life worth living.

Chapter 2: Determining How Therapists Make Sense of Dissociative Identity Disorder: A Study of DID Conceptualisation and Formulation in Clinical Practice

2.1 Introduction

2.1.1 Dissociative Identity Disorder

Dissociative Identity Disorder (DID) is defined as *"…the presence of two or more distinct identities or personality states [and that] at least two of these identities or personality states recurrently take control of the person's behaviour."* (APA, 1994, p.487).

Dissociative symptomology can be understood as an adaptive and functional coping mechanism in response to severe and chronic trauma (Chu, 2011). It is hypothesised that internal dissociative mechanisms may help to distance, if not separate, the person from the experience of trauma during critical early developmental years and can result in the development of definably different self-states or personalities (e.g. Nijenhuis, van der Hart & Steele, 2010). These self-states enable the person to adapt quickly to different sets of 'rules', especially when rules change unpredictably and dramatically between contexts. However, when the experience of self-states continues after the threat has gone, this mechanism can be unhelpful and distressing due to its automatic nature, the lack of integration of experience, perceived lack of control and autonomy, and consequent confusion (Chu, 2011).

DID is an exceptionally rare presentation with estimated rates of 0.01 (Coons, 1984) to 1% in the general population and 0.5 to 1% in psychiatric settings (Maldonado, Butler, & Spiegel, 2002) and 12-38% among outpatients (e.g. Foote et al, 2006). The reasons for this variability in outpatient prevalence rates is not known but in light of the evidence that fewer than half of UK clinical psychologists report seeing a patient with DID (Ost, Wright, Easton, Hope & French, 2011) it could be hypothesised that this variation is the result of lack of experience and therefore knowledge, awareness and expertise leading to under-diagnosis and/or misdiagnosis.

2.1.2 The DID Debate

DID is a controversial and disputed diagnosis with ongoing debate around its authenticity and validity (e.g. Gleaves, May & Cardena, 2001; North, Ryall, Ricci and Wetzel, 1993).

It has been suggested that, rather than representing authentic separate personalities, self-states represent metaphors for different emotional states (Merckelbach, Devilly & Rassin, 2002), are simulated by highly suggestible individuals (e.g. Giesbrecht, Merckelbach, Kater & Sluis, 2007) or are the result of iatrogenesis (Spanos, 1994). A systematic review of the literature published this year on simulator research (Boysen and Van Bergen, 2014), found a number of variables reliably differentiate participants diagnosed with DID and participants simulating DID. There were significant differences in generalised cognitive deficits in memory and reaction times and differences between trauma-focused and trauma-neutral identities that were not shown by simulators with overall large effect sizes. The authors concluded that the experiences of people with DID are not analogous to those of individuals deliberately faking symptoms. However, there were dimensions on which patients with DID and simulators were similar, for example, levels of inter-identity recall, recognition and priming which could be interpreted as supporting the inauthenticity argument. Therefore, further research is required to understand these differences and similarities more fully.

Some authors argue that DID is not a distinct psychiatric presentation but simply part of a constellation of symptoms of other psychiatric disorders (e.g. North et al, 1993). Gleave et al. (2001) completed a comprehensive investigation of the validity of DID against the validity criteria of Blashfield et al (1990), Spitzer and Williams (1985) and Robins & Guze (1970) (see Gleaves et al. , 2001), and concluded that the evidence for the construct validity of DID was strong, if not greater than that held by most other psychiatric disorders.

Overall further research in this area is required to replicate results and to move the field of DID research forward.

2.1.3 Models of Dissociation

At present there are only a small number of theoretical conceptualisations of DID that have been translated into working models for clinical practice. Two key models are the Structural Dissociation Model (SDM, Nijenhuis, van der Hart & Steele, 2010) and the Cognitive Model of Dissociation (CMD, Kennedy et al, 2004), both based on a trauma model framework.

The SDM model (Nijenhuis et al, 2010) proposes that severe, chronic and overwhelming threat or trauma during critical early years in infant brain development results in structural divides in personality. These divides lead to the development of two or more self-states. Specifically, this model proposes that there is a split between the defensive systems that hold the traumatic material (Emotional Personalities: EPs) and the systems protected from this traumatic material in order to function in daily life (Apparent Normal Personalities: ANP). These develop as a mechanism to ensure survival in the face of overwhelming threat (for a full description see Nijenhuis et al, 2010).

The CMD proposes that dissociation occurs due to the decoupling (separation) of mental processes critical for the activation of modes (self-states) and the smooth transition between modes. Modes are defined *"…as a set of schemas responsible for encoding cognitive, affective, behavioural and physiological information and for generating responses*." (p.28). The CMD model proposes that an inhibitory decoupling process occurs at three stages, the third of which is a between-mode dissociation – that is the partial or complete decoupling of modes demonstrated in the presentation of DID (see Kennedy et al, 2004 for a full description).

The key to both the SDM and CDM is the extent of integration or lack of integration between the systems/modes/self-states. It is hypothesised that DID occurs where there is an absolute or near absolute disconnection and a complete lack of integration between different self-states.

These theoretical models are useful for making sense of the presentation of DID but to date, the study of how therapists understand DID in their real world clinical practice has not been completed.

2.1.4 Formulation

Formulation is the theoretically based understanding of a client's mental health difficulties, based on a set of complex interrelated clinical judgments that have relevance for communicating a hypothesis. This hypothesis is the basis upon which a framework for therapeutic intervention is developed (e.g. Haynes & O'Brien, 2000). Although formulation is recognised as important for deciding appropriate treatment, the evidence for its reliability, usefulness, effect on outcomes and on the client is lacking (Johnstone, Whomsley, Cole & Oliver, 2011). The limited evidence suggests that, especially in complex presentations, it is therapists who benefit most from formulation (Chadwick, Williams & MacKenzie, 2003; Pain, Chadwick & Abba, 2008), especially for understanding complex cases (Chadwick et al, 2003),

for selecting appropriate intervention (Jacobson et al, 1989) and for supporting their team's understanding (Summers, 2006). In a review of the literature published last year, Rainforth and Laurenson (2013) presented evidence from a small number of studies showing that individualised, case formulated interventions, produce statistically significant improved outcomes when compared to manualised approaches (e.g. Persons et al, 2006) but this type of research is lacking overall.

Research has shown that case formulation is effected by practitioner competence, experience, proficiency and effectiveness of delivery with the key variable of knowledge i.e. knowing how to formulate the case. It is emphasised that for case formulation to be effective, knowledge, skills and training is required (e.g. Eells et al, 2005).

Although the evidence base for formulation is sparse, the limited evidence available suggests that formulation may be beneficial for therapists, for their understanding and for developing appropriate intervention particularly with complex presentations such as DID.

2.2 Rationale

DID is a complex, rare and poorly understood clinical presentation. Therapists working with these clients may benefit from the process of case formulation for conceptualising these difficulties and subsequently to guide them toward appropriate intervention. Theoretical models available in the literature provide a way of understanding this presentation but the 'real world' clinical approach to conceptualising this presentation is yet to be investigated. The present study aims to examine how therapists conceptualise DID in practice in order to identify the key themes of DID formulation and understand how this relates to current theoretical models presented in the literature.

2.3 Research Questions

This study aims to address the following primary question:

1. What are the key concepts used in therapists' clinical formulation of DID?

Secondary research questions include:

a. How do the concepts identified map onto theories and models currently described in the literature?

b. What are the main challenges for the therapist in the therapeutic process?

2.4 Methodology

2.4.1 Chosen Qualitative Methodology

This research used a mixed methodology across two phases. The first phase used a questionnaire design to obtain an overview of the clinical context and to identify participants for the second phase. Identifying the context of the research acknowledges that the findings reflect a particular understanding at a particular point in time (Barbour, 2001). The second phase utilised a qualitative research design to understand the phenomena of DID conceptualisation. The overall aims of qualitative approaches are to develop a deeper understanding of the subjective individual meaning grounded in the data from which they were found. This approach was chosen because it uses naturalistic and observational techniques to understand the phenomena without a set of predictions which is best suited for the aims of this study. Qualitative approaches acknowledge the researcher's intimate relationship with the research, recognising that the researcher becomes fully engaged and immersed in the process. The researcher's reflections are recorded and accepted as a source of data used to enhance the research findings (Flick, 2002).

The main research question was to identify the key themes of therapist's conceptualisations of DID with the overall aim of developing overarching theory grounded in the data collected. Taking into consideration the role of the researcher in this process, a Constructivist Grounded Theory approach was adopted.

2.4.2 Constructivist Grounded Theory

Grounded Theory was originally developed by Glaser and Strauss (1967) as a method of theory development through "*the discovery of theory from data*" (p.1) Charmaz (e.g. 2006) proposed Constructivist Grounded Theory (CGT) to acknowledge the role of the researcher in the interpretation of data, seeing data as co-constructed by the researcher and participants. This approach encourages processes for enhancing reflexivity such as explicit and extensive documentation of the researcher's own personal reflections in the form of memos or reflective journals (e.g. Charmaz, 2004). Examples of the researcher's memos are used to illustrate the findings (see section 2.6) and example extracts of the reflective diary from various stages of the research process are provided in Appendix B.

2.4.3 Personal reflections on Dissociative Identity Disorder in clinical practice and the research process: personal context.

CGT recognises that no experience is objective but it is the understanding and acknowledgement of the subjective influence that is important (Charmaz, 2006). The researcher is encouraged to become mindful of their internal world and to recognise these influences in the construction of knowledge from the research. To address the challenge of exploring the researchers own assumptions and influences, a bracketing interview was completed (e.g. Ahern, 1999). Bracketing interviews aim to explore the researcher's personal and professional experiences related to the research area. The aim of this is to "…*enable the researcher to hold the tension of the dialectic process of investigating the nature of the participants' experience, at the same time as holding her own experience."* (Rolls & Relf, 2006, p.286). A bracketing interview was completed by the researcher with a supervisor, utilising clinical supervision skills in the context of research to identify assumptions and beliefs of the researcher. The researcher was asked to describe where the idea for the research came from, expectations of how participants may respond to the interview questions and any responses the researcher would find difficult or challenging.

Bracketing Interview – Key Outcomes

The decision to focus on this research area evolved after the researcher attended group peer supervision for therapists working with clients with DID. This was an area the researcher knew little about at the time and so looked to the literature for information. Following an initial exploration of the literature, it became clear that little research had been completed on the formulation of DID and more specifically how therapists make sense of DID in therapy.

The bracketing interview highlighted areas of potential bias to hold in mind throughout the process of the research These included issues around power and control, in particular power dynamics between health professionals and clients, the desire to support and advocate for those most vulnerable in society, and the desire to make psychological understanding and information less mysterious and more accessible. These themes were held in mind by the researcher during the process of the research and are offered to the reader to consider in their assessment of the validity of the findings (Ahern, 1999).

2.5 Procedure

2.5.1 Participants

2.5.1.1 Recruitment

All mental health NHS Trusts in England were approached to participate in the research (52 Trusts in total). Of these, 19 agreed to participate along with seven independent organisations that provide therapy, training and/or consultation in mental health (see Appendix C for a full list). A link to the online survey was attached to an email circulated by each participating organisation for participants to voluntarily participate in. Ethics approval was obtained from the University of Southampton (Appendix D) and research governance approval was obtained from each NHS trust site who participated.

Interview participants were all practicing therapists who completed the online survey about their knowledge and understanding of DID (section 2.6.1), had worked with at least one client with DID for a minimum of three months and were willing to participate in a research interview. The inclusion and exclusion criteria for the study are outlined in Table 4 below.

Table 4 – Participant Inclusion and Exclusion Criteria

Survey Phase	
Inclusion Criteria	*Exclusion Criteria*
Participants were included if they were therapists practising in England.	Therapists were not included if they were not currently practising in England.
Interview Phase	
Inclusion Criteria	*Exclusion Criteria*
Participants who were qualified therapists who had completed the online survey (phase 1) and indicated that they had provided on-going treatment of at least 3-months duration to an adult patient who met the DSM-IV criteria for DID and agreed to be considered for further participation in the study. A cut-off of 3 months on-going treatment to a client with DID was chosen to ensure a minimum level of experience.	Therapists who had not completed a formal therapeutic qualification. Therapists who had not provided treatment to an adult patient who met the DSM-IV criteria for DID for on-going treatment of at least 3 months and were not able to read English.

2.5.1.2 Sample size and characteristics

Of the 138 participants who completed the survey, 27 volunteered to take part in a qualitative interview. Theoretical sampling is where participants are sought who will illuminate categories (Charmaz, 2006) and this approach was utilised for the purposes of this study. Based on the outcomes of the initial interview, therapists with the most experience of working with this population were recruited from the sample pool to participate in the interview stage. Qualitative research using CGT only expects a small sample (Charmaz, 2006) with the focus on theoretical saturation. Theoretical "*saturation means that no additional data are being found whereby the sociologist can develop the properties of the category*" (Glaser & Strauss, 1967, p.61). This is achieved when new data no longer elicits new theoretical insights. No new theoretical concepts emerged after the seventh interview. A further interview was conducted to check for content saturation and this confirmed that recruitment could cease. A total of eight therapists were recruited (two males, six females). Ages ranged from 42 to 74 years, with a mean of 53.6 years. Years of therapeutic experience ranged from between 13 and 28 years (mean 20.3 years) and therapists had worked with between one and 100+ clients experiencing DID. Therapists were a mixture of Psychodynamic therapists (four) and Clinical Psychologists (four).

2.5.2 Procedure

Participants who completed the online DID survey (section 2.6.1 below), met the inclusion criteria, the theoretical sampling criteria and volunteered to take part in a semi-structured interview were contacted. This research collected and analysed data simultaneously (Charmaz, 2004) to allow each to influence the other for the purposes of allowing research to naturally evolve (Patton, 1990). Data was collected until theoretical saturation was reached. The Participant Information Sheet (PIS) (Appendix E) and interview questions (Appendix F) were sent one week in advance so participants had an opportunity to process the questions and reflect on their answers. Interviews were held at the participant's convenience. All participants signed a consent form before starting the interview (Appendix E). Interviews were digitally recorded and lasted between 60 to 120 minutes (approximately). Participants were sent a copy of their transcript and the list of major categories developed from the data to give an opportunity to offer feedback and reflections on the data.

2.5.2.1 Online Survey

An online survey was developed by the research team[2] (see Appendix G). This aimed to obtain an overview of therapists' knowledge, understanding and experience of DID to set the context of the research and to identify participants for interview.

2.5.2.2 Semi-Structured Interview

A semi-structured interview schedule was developed to elicit an understanding of how participants' conceptualised and formulated DID in their clinical practice (Appendix F). These questions were developed with the research team and piloted with two DID clinical specialists[3].

There were four key question areas with a number of prompt questions:

1. How did the therapist understand and make sense of DID?

2. What images, metaphors, descriptions, models or pictures did the therapist use to help describe the presentation of DID?

3. What were the key challenges and rewards of working with a client with DID?

4. What advice or guidance would the therapist give to another therapist who was about to meet with their first DID client?

Data collection and analysis took place simultaneously as suggested in CGT with the intention that the interview questions could be modified to reflect the emerging theory (Charmaz, 2006). However, the emerging theory did not indicate significant modification of the main interview questions but influenced the prompt questions used to elicit further information.

[2] Dr Lusia Stopa (University of Southampton) and Dr Tess Maguire (University of Southampton)
[3] Dr Fiona Kennedy and Dr Vivia Cowdrill (Southern Health NHS Trust)

2.5.3 Data Management and Analysis

2.5.3.1 Transcription

Interviews were transcribed by the researcher to facilitate immersion in the data and so the researcher could remain theoretically sensitive. All identifying information was removed.

2.5.3.2 Data Analysis

Data analysis was influenced by the work of Glaser (1978) and Charmaz (2004). The interview data was collected and analysed concurrently where possible. Concurrent data collection and analysis is where data from the first interview is coded and analysed before the second interview takes place, which is coded and analysed before the third interview takes place and so on. This is to allow the data from the earlier interview to influence later interviews therefore allowing the research to naturally evolve (Glaser & Strauss, 1967). The first step involved listening to, transcribing and reading the interview data several times. Following this, analysis of the data involved open coding (also known as substantive coding) (See Appendix H for an example) followed by theoretical coding which conceptualises how substantive codes relate to each other with the ultimate aim of developing this into a theory. Transcripts from earlier interviews were coded directly from the transcript data to ensure that the codes were grounded in the data. These were grouped together into similarly meaningful descriptive codes, and then grouped again to develop categories that described a thematically similar area. The most significant categories were developed into major categories for the theory developed through this research (Charmaz, 2006). Major categories are seen to have theoretical reach and are related to other categories. An example of the process of a developed major category is shown in Appendix I. The ultimate aim of this process is to develop a refined list of major categories that summarise a key overarching theme or core category from which theory is developed.

2.5.4 Reliability and Validity

Reliability and validity in qualitative research are complex areas that have received research in their own right. In the simplest terms: "*Reliability refers to the trustworthiness of observation or data: validity refers to the trustworthiness of interpretations or conclusions*." (Stiles, 1993, p.601). Yardley's (2000) criteria for assessing reliability and validity of qualitative research was used as a framework to assess this research It assesses sensitivity to context,

commitment and rigor, transparency and coherence and impact and importance (this is outlined in Appendix J).

For the purposes of inter-rater reliability coding of the researcher was compared to the coding of a second coder. The purpose of this process was to identify the degree of agreement but also the areas of variation. Identifying areas of variation allows the research to discuss these and refine the coding framework through discussion with the second coder (Barbour, 2001). In addition, categories developed were checked for reliability by asking a second researcher, unrelated to the project, to match up quotes from the transcript to descriptors. Although multiple coders is not essential to CGT, it can be helpful for the researcher to think about the areas of discrepancy and look at the insights this brings to the data (Barbour, 2001).

2.6 Findings

2.6.1 Online Survey

In total 138 participants completed the online survey. The majority of participants were either Clinical Psychologists (56.5%), Psychoanalyst/Psychodynamic therapists (17.4%) or Cognitive Behavioural (CBT) therapists (9.4%), largely from an NHS background (79.0%) and with variable experience of working with people with DID (range 0-39 years experience mean 11.1 years). (Please see Appendix K for complete tables).

Of the 138 participants, 104 said that they would be able to describe some of the features of DID and were given six open text boxes to described these. Based on the Diagnostic and Statistical Manual of Mental Disorder criteria for DID (4th edition, APA, 1994 – see Appendix L for outline of diagnostic criteria), descriptions including suggestions of amnesia and multiple identities were accepted as a full understanding of DID. Sixty one participants described a full understanding of DID and six outlined all four criteria of the DSM-IV. This suggests that 44% of participants had a working knowledge of the presentation of DID, with 56% of participants not able to identify these key features.

Participants were asked if they had identified particular model/s to help them in their understanding of DID. In total 24 different models/theories were suggested. The models/theories indicated by at least two or more participants are summarised in table 5 below.

Table 5 – Models identified form the survey data for understanding DID

Models identified as useful for understanding DID	
Model/Theory	**Frequency**
Trauma/Post Traumatic Stress Disorder (PTSD)	16
Psychodynamic/Psychoanalytic	14
Attachment Perspectives	10
Cognitive Analytic Therapy	9
Cognitive Behavioural Therapy	8
Structural Dissociation Model	7
Family model/Systemic/Group	5
Schema Therapy	5
Sensorimotor Therapy	4
Dialectical Behaviour Therapy	3
Developmental	3
Eye Movement Desensitization and Reprocessing	3

The most popular models were the trauma/PTSD models. However, only approximately 1% of participants identified abuse/trauma experiences as a key feature of DID.

Participants were asked if they had worked therapeutically with a client with DID. Thirty seven percent of participants reported that they had worked with clients with DID, 52.2% reported that they had not worked therapeutically with a client with DID and 10.9% reported that they had possibly worked with a client with DID but had not realised it at the time. Of those who reported having worked with this client group, the length of therapy varied considerably with a range of less than three months to more than four years with the majority working with clients for over a year (70.6%) (Appendix K).

Therapists were asked to describe the approach they would most likely use if they were to work with a client with DID (Table 6). Of those who answered, 23% said that they would not know which approach to use due to a lack of knowledge/experience/training/evidence base. Three participants openly stated that they had not heard of DID before completing the survey and one therapist exclaimed that they did not believe in the "*pseudo-diagnosis*" believing it to be "*made up by hysterical practitioners".* The majority of therapists (42.1%) stated that they had chosen their therapeutic approach based on their understanding of DID with the second largest group of responders indicating their choice of model was based on their own training and knowledge. Only one practitioner stated that they would look towards guidelines

(International Society for the Study of Trauma and Dissociation, ISSTD, 2011) for working with a client with DID.

Table 6 – Therapeutic approaches used by survey participants

Therapeutic Approach	No.
I'm not sure	30
Psychodynamic Therapy	18
Cognitive Behavioural Therapy (CBT)	17
Cognitive Analytic Therapy	13
Dialectical Behaviour Therapy	13
Sensorimotor Therapy	5
Narrative Therapy	4
Schema Focused Therapy	4
Acceptance and Commitment Therapy	3
Mindfulness Based Cognitive Therapy	3
Person Centred Therapy	3
Art Therapy	2
Behavioural Therapy	2
Other (therapy approaches indicated by 1 participant)	12

Therapists were asked to report whether they had received any training and/or supervision that would be either directly or indirectly relevant to working with a client with DID. There was a fairly even divide with 45.7% reporting that they had and 54.3% reporting that they hadn't received any training or supervision.

Interestingly three participants indicated that they did not believe in the diagnosis. One quite strongly rejected and referred to practitioners who did believe in it as "*idiotic*".

2.6.2 Interview Findings

This section discusses the findings of this research in relation to existing literature and the socio-political context of DID. Following this, the implication and methodological limitations of the study are discussed and directions for further investigation outlined.

This section describes the main findings and an interpretation of these results before describing the theoretical framework developed from the integration of interpretations. Six major categories emerged from the data:

Chapter 2

1. The Rationale: Understanding why DID develops

2. The Client's Internal World

3. The Appearance of the Internal World to the External World

4. The Direction of the Therapeutic Process

5. The Qualities and Considerations for the Therapist

6. Service and Support Considerations

CGT methodology offers preliminary findings that are relative to a particular context and time and represent one perspective of the many that could be available in accordance with the constructivist view point.

The major categories developed described the *phenomena* of DID, the *process* of therapy and the *context* in which it is understood i.e. from the perspective of the therapist (figure 2). The interpretation and understanding of the major categories are discussed and illustrated with transcript extracts from the interviews and excerpts of the researcher's memos to ground the findings in the data. Extracts from the researcher's reflective journal can be seen in Appendix B.

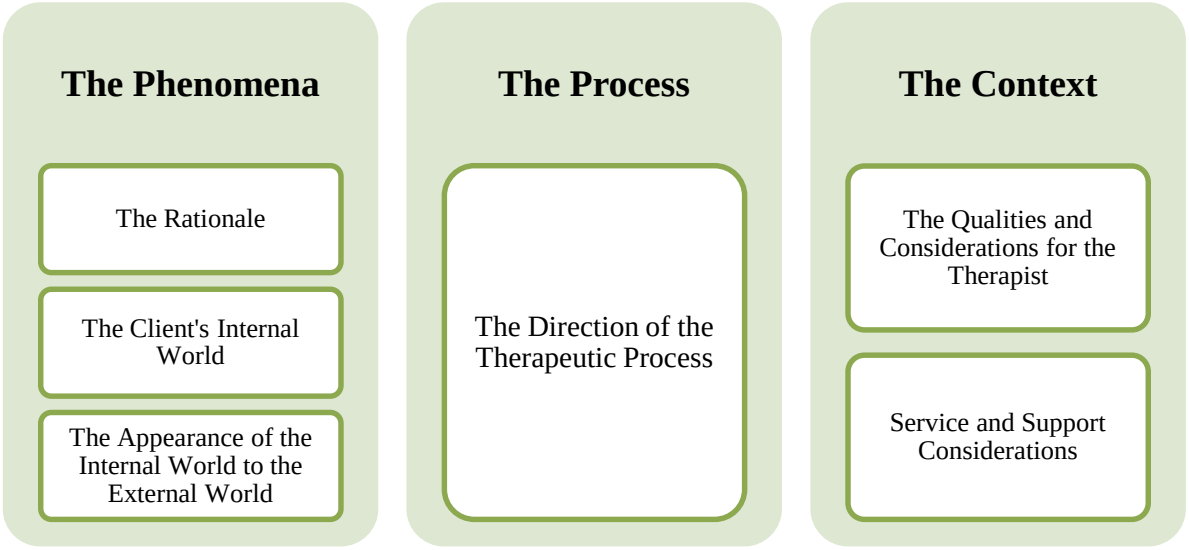

Figure 2: Overview of the major categories developed through the qualitative analysis of the study data

2.6.3 Description of Major Categories

2.6.3.1 The Rationale: Understanding why DID develops

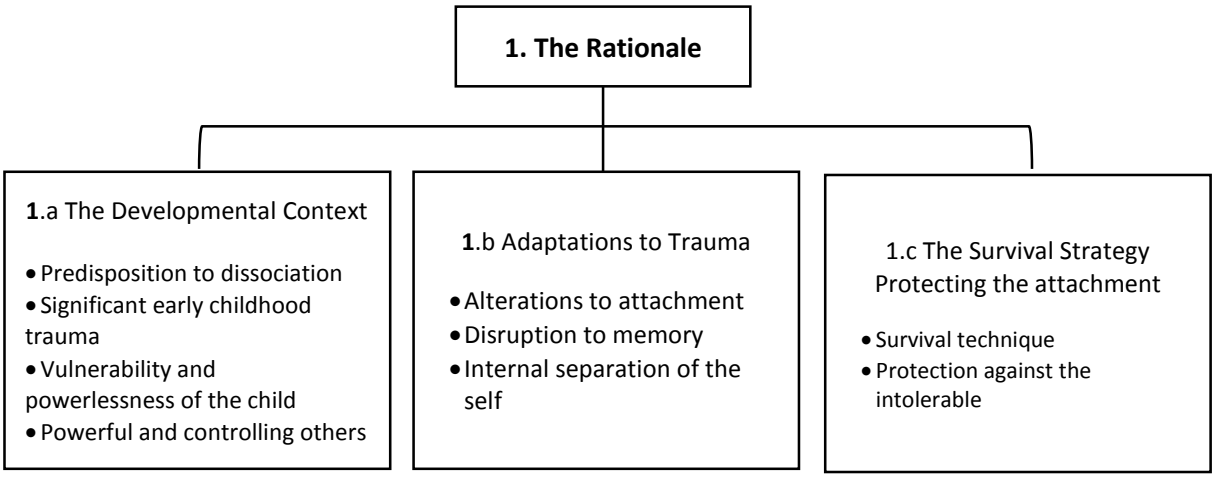

Figure 3: Major Category 1 – The Rationale: Understanding why DID develops.

All participants talked about the rationale for why DID develops (figure 3). Participants conceptualised DID based on the foundations of a trauma-based model (e.g. Ross, 1997). *The developmental context* of DID was key to making sense of *why* the mind in its infancy followed a path to fragmentation. This predisposition to fragmentation was understood to evolve as a necessary adaptation to trauma in a vulnerable and powerless child. Participants described DID as a *survival strategy* for coping with the intolerable and emphasised the importance of this understanding for their formulation.

1.a The Developmental Context

All participants described DID as stemming from an *early* childhood history of significant trauma, abuse or neglect, where the young infant was powerless to defend themselves against the intolerable:

> *Because it's a survival response to remove you from shock or trauma. But it's been used in a very specific way on a set of experiences. So for an experience that happens over and over again, a chronic repeated level of powerlessness and fear (Participant M, P11, L377).*

> *And it does start with something going seriously…. And that's physical, sexual, emotional abuse something seriously wrong with the attachment issue…..I think, I think it's always a fundamental issue (Participant R, P10, L299).*

Participants related the development of DID with trauma to early attachment experiences. This model is supported by researchers in the field who advocate the importance of early attachment, in particular disorganised attachment, as a precursor to the development of DID which is consequently triggered by the experience of trauma (e.g. Liotti, 2006).

Five participants made reference to the theory of nature and nurture (e.g. Pinker, 2004), the idea that it is the combination of a predisposition to dissociation in combination with the experience of significant childhood trauma that results in the development of DID:

> *So that urrm clearly dissociation, which has an element of predisposition, an element possibly of whether generations before, like whether their parents used that mechanism Is normally to do with something that is overwhelming for a child growing up to actually be able to process in the normal integrative way. [r:mmm] And the earlier it is, the more it's likely to be an absolute amnesia, an absolute brain actually compartmentalising (Participant R, P3, L54).*

The majority of participants shared their belief that early childhood trauma was generally purposeful, intended and manipulated by figures in positions of power and control: *"Um, and then, um, some people are unfortunate enough to be in families where this is an advantage and people use it to create people for their own uses." (Participant S, P1 L21).*

This emphasises the helplessness and powerlessness of the infant to escape or to use external coping mechanisms, leaving them with the only the option to cope inwardly and to utilise internal mechanisms to survive.

1.b Adaptations to Trauma

Participants described the development of self-states as a method of adapting to trauma:

> *So that within urrrm when people have a lot of attachment trauma that is overwhelming to them, [r: hmm hmm] they might urrr kind of somehow distance themselves from that by developing a number of self-states in order to survive it (Participant A, P2, L6)*

All participants described their client's experiences of amnesia. This was also framed as a survival mechanism, a way of distancing and separating away from traumatic material:

> *As you get older, if it only happens to you at an older age, like probably six onwards, there is not always an absolute amnesia. Urr it's more a mechanism to, more like a clear defence mechanism to protect you from something. But certainly earlier on it isn't. Once you have that in place, of course, like any defence you're more prone in adulthood as well. When something becomes experience, is overwhelming to find yourself using the same mechanism (Participant R, P3, L63)*

The age of onset is emphasised in this quote, suggesting that these automatic, unconscious defence mechanisms are triggered when trauma is experienced in the earliest years of life, when the infant is particularly vulnerable. Internal adaptations are described as a mechanism for coping with trauma in the absence of available external coping strategies. The use of the word 'mechanism' suggests that this is a mechanical or structural adaptation of the mind:

> *If there is nowhere for that person to turn, then the way that I am looking at it, they will go inwards. Why would you not turn inwards …..And then try and create a safety for yourself somehow in order to, order to keep themselves sane. (Participant V, P9, L268)*

The developmental context and the adaptations made in response to this context underpinned participants' understanding of why DID developed. This fits with trauma-based models of DID and in particular the structural and attachments models of DID.

1.c The Survival Strategy

The concept of survival was key and used as a descriptive term by the majority of participants.

> *So an explanation for me that's much more useful is the one that got taught to me by people with DID which is that it's survival. That the brain has the ability to relocate experience in order to continue the likelihood of survival. [r:mmm] So if there's a mind- numbingly atrocious threat that's happening to you, if you sat and stared at it and completely understood and took in all that*

> *information, you could die just from the sheer shock of it [r:mmm]and the overwhelming fear (Participant M, P10, L337).*

The trauma literature supports this hypothesis, evidencing the tendency of trauma victims to experience amnesia and fragmentation of memory (Schobe & Kihlstrom, 1997). The DID survival strategy functions to protect the attachment to significant and needed others, without whom the young infant would not be able to meet their basic needs to survive physically into adulthood (e.g. Maslow, 1943):

> *So, if, in my understanding, urrm if paramount it's important to keep an attachment and if you have as an example urrm someone who's got a dad who's the only parent around and most of the time will do everything that that child needs in terms of emotional and physical and psychological needs and reads to them at night but comes home every Friday drunk and then beats up their daughter let's say, that child, has to somewhere, not thinking about it, keep that attachment to the good experience [r:mmm] because that's what keeps them going. So that bad experience is literally shut off or compartmentalised (Participant R, P3, L68)*

Participants described not only the presence of significant trauma but also the unpredictable and confusing nature of these experiences. This was reflected on by the researcher:

> *The literature seems to suggest that trauma-DID models of DID are too simplistic. If it was this simple then it could be expected that all children exposed to chronic trauma in their early years would develop DID but they don't. There appears to be the idea of 'mixed messages' running through the interviews. The idea that there are one set of rules for one context and another set of rules in another context which is unpredictable and confusing for the child. This is similar to the double-bind situation described in attachment theory (Memo 9.1, January 20th 2014)*

In summary, the rationale for the development of DID was described as embedded in the early developmental context where significant psychological trauma was experienced, largely at the hands of people in positions of power and control. The vulnerable and powerless child turns to internal survival mechanisms that act to disconnect and protect the child from these experiences (to protect their emotional and psychological wellbeing) whilst maintaining

the attachment (to protect their physical wellbeing). This is achieved through internal methods of avoidance including the separation and fragmentation of memory and aspects of self that result in the development of separate self-states. The idea that the infant may be predisposed to these mechanisms which are then triggered by the environment has similarities to the biosocial theory proposed by Linehan (1993). The biosocial theory suggests that individuals pre-disposed to certain personality or emotional traits, may develop a particular constellation of personality traits called Borderline Personality Disorder (BPD) in the context of an invalidating environment. The theory suggests that traumatic events can initiate the emotional and interpersonal disregulation that may then develop, through repetition, into BPD. Similarly, therapists in this study suggest that individuals predisposed to dissociation, in the context of a chronic and enduringly invalidating environment are vulnerable to developing DID when faced by chronic childhood trauma.

2.6.3.2 The Client's Internal World

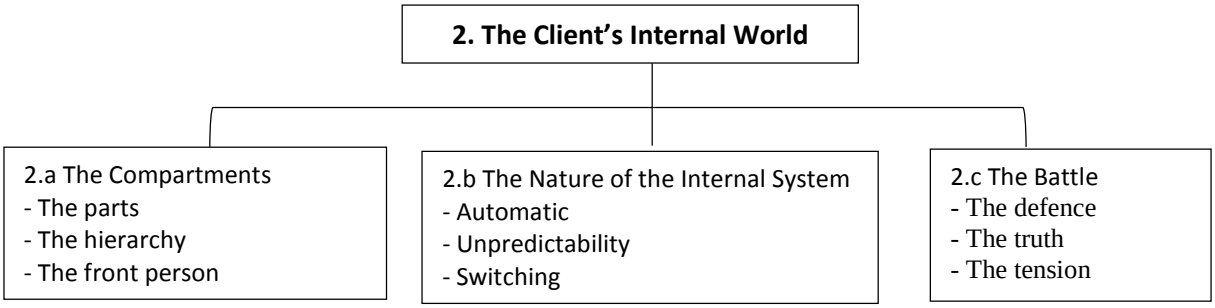

Figure 4: Major Category 2 – The Client's Internal World

All participating therapists talked about their client's internal world (figure 4) of self-states and the dynamics between them. These self-states differed in their level of power, influence and control over the internal system. Therapists shared their understanding of the nature of the internal system, describing the automaticity and unpredictable nature of self-states and a sense of ongoing tension or struggle between them.

2.a The Compartments

Participants viewed their clients as a whole person made up of number of internal compartments (self-states) that responded to different triggers. There was a theme of separateness with the idea of differing levels of co-conscious awareness.

Participant M used the metaphor of an old fashioned train to describe this understanding which was developed collaboratively with a client:

> *It's about a train carriage. Like the old fashioned, like the ones on the Harry Potter films sort of thing. You know where you've got the long carriages and the separate compartments going off the corridor…People duck into those carriages. The person is like the train carriage and there's a corridor going all the way through that someone walks up and down. So the person who is often referred is the person going up and down the corridor. [r: okay] But they don't know what's in the compartments leading off the corridor. And at any time at any point they can be replaced by a person that comes out that compartment. [r: okay] So as they're walking down the corridor a person from the, a person from inside the compartment may come out and remove them and then they're the ones that are walking up and down the corridor or another person can come in and join them. So they're side by side in the corridor. But they, if they go back in and close the door the person walking up and down the corridor has no idea what's going on inside [r: mmm] that compartment. Unless they join with that person when they step outside of that compartment (Participant M, P5, L179).*

This metaphor describes some of the key aspects of the presentation. The person referred to mental health services is the one visible in the corridor but there are a number of self-states hidden from view in separate compartments. This idea of separation between self-states fits with the structural divisions described in both the Cognitive Model of Dissociation (Kennedy et al, 2004) and the Structural Dissociation Model (SDM, Nijenhuis, van der Hart, & Steele 2010).

At times, different self-states appear and the original person in the corridor disappears. This participant also describes the experience of two or more self-states walking in the corridor together and how going into different compartments enables the client to start communicating with the different self-states.

Participants described a complex internal hierarchy whereby self-states had different roles, functions, influence and power. Some self-states were more obvious and 'on show' but not necessarily the most influential or powerful. Participants described making sense of this hierarchy in order to understand who's who, who is in control, who has power and influence and who is the front functional person.

> *…..and then you get into very complex network of who's who within the system……. Who's got most influence? Who calls the shots? Could be the most important. Or it could be the one who holds the most important memory. Or it could be the one that decides whether the knife gets picked up or whether the knife gets put down can be the most important one….they might be the one who's around the least but that could hold the power of life or death…..You have to get to know the person and the system really well to even think about levels of importance and power…[r: the hierarchy I guess] the hierarchy and things….yes (Participant M, P8, L270)*

> *…"Who well they don't want me to do any, any work and that she's coming. I really want to do this work. I wanna …" Okay, well what are we going to do about these two people who don't wanna do any work then?"…..I can't ignore them. They are very much a part of her and she brings them with her every session. (Participant V, P19, L607)*

Standing at the front, facing the world, participants described a 'front person'. This self-state was described as functional, cognitive and logical, the one that interacted with the world and 'keeps the show on the road'. Participants explained this self-state as acting to fulfil the practicalities of life such as going to work, taking care of the family and attending appointments. All participants described a 'front person', a self-state responsible for the day to day functioning, which fits with the Structural Dissociation Models (SDM, Nijenhuis, van der hart & Steele, 2010) description of an Apparent Normal Personality (ANP).

Seven of the eight participants explicitly referred to this functional front self-state:

> *There's usually, yeah, there will usually be somebody who hmmm sort of in a way runs the show. So the person who might turn up to the appointment, the person who goes into the GP with the headaches, who's name's may be on the birth certificate, has the driver's license, who drops the kids off at school, and does all that stuff is probably [r:mmm] the main person. (Participant M, P8, L238)*

> *You've got the person on the outside, the ANP [Apparent Normal Personality], who is likely to be very cognitive. Who is likely to have a very good understanding of the whole condition and knows more about the subject than I do (Participant R, P8, L245)*

Although this front person can be extremely adaptive and effective for daily functioning, they can prove to be an obstacle to making use of therapy.

> *…… obviously would appear to demonstrate someone who's functioning well [r:mmm] and the idea is not to get rid of that because what can happen is, is that person stops functioning in the world out there where they've got a job and that's no answer either. You've got to have both. But the difficulty is that DID when they are offered, I don't know CBT, is they are experts at CBT they are experts at adapting to situations. They know how to adapt, they know how to rethink things. That's not the issue. The issue is to take ownership (Participant R, P12, L392)*

Due to the front person's functional nature, they are well adept to participate in structured therapy such as CBT, with their strengths in the cognitive and logical arenas of life. This may also prevent them from accessing services at all:

> *It strikes me that a number of people with DID never come to the attention of services because of how well the front person functions and interacts with the outside world. I wonder how often people living with DID, who may be falling apart in particular areas of their life, may never receive appropriate support because of how well they appear in the G.P's office?" (Memo 10.6, 23rd February 2014)*

2.b The nature of the internal system

The internal system was described as functioning out of the person's control, switching outside of the person's conscious awareness and without warning.

> *Particularly because they just erm, they are doing things that they don't want to be doing or they find that they are doing things they have no control over. Erm, erm …..They actually say "That's not me", you know "I don't do, you know, people are saying these things about me and I know I'm doing it but it's not me, it's not what I want to be doing" (Participant V, P1, L23)*

Participant M explained these automatic processes by comparing it to the flinch reactions learnt in childhood:

> *So if you get burnt as a two year old child on the oven you're much more likely to not want to go near an oven when you're four. The brain does that for*

> *you. There's no conscious process, that's preconscious survival response…..So DID is almost the same thing. If those experiences are happening over and over again, it's creating a response that your conscious mind might not be aware of…… so that by the time you become 6, and 10 and 15 and 20 and 30 you've been doing this stuff for years so you keep doing it. So then any response that occurs out in the environment automatically triggers an action which is a shift away from the thing that is frightening (Participant M: P12 L381)*

This quote emphasises how self-states become more engrained and more habitual over the course of the person's lifetime. Linked to the automatic nature of switching between states is the unpredictability of when, where and why that switch may occur: *"And then. I don't know what happened. Maybe it was something at work that u..upset her or something and boom they were all there [child self-states]" (Participant P, P10, L284).* This links with behavioural interpretations of DID that suggests self-states develop through a form of operant conditioning (Comer, 2007) whereby the mechanism of dissociation is reinforced over time through the experience of repeated trauma: *"reinforced acts of forgetting...help them escape anxiety"* (Comer, 2007 p. 211). The structural dissociation model of DID would suggest that the repeated use of this dissociative mechanism results in this separation becoming structural within the mind (Nijenhuis et al, 2010).

The complexity and confusion of this presentation is present in therapy and held by the therapist, described as the sense of consistent inconsistency: *"Yes, and I think it's going back to the role of the therapist being in part to urrr accept the level of complexity and confusion and the fact that we probably can't hold it all in mind and just being clear about that urrm yeah." (Participant K, P17, L500)*

> *How was our relationship when we went to visit my father's grave. And how upset I was. And then the other personality comes in and denies it all…..But quite consistent. If you think about different levels of dissociation and what is tolerable then it is all congruent in a way (Participant J, P6, L186).*

All participants talked about clients moving between self-states with six of the participants directly referring to the process of switching: *"I asked her what switching was like and she'd say 'Well, one moment I'm not here and the next moment, I am". (Participant P,P4, L94).* This quote emphasises the lack of control therapists experienced clients to have over switching between different self-states which could be a particular challenge in the therapeutic process in terms of predictability and being able to plan the therapy.

2.c The Battle

The idea of the internal battle was described by seven of the participants with four participants referring directly to the idea of internal sabotage. Tension and struggle was a key theme. The tension was the result of efforts to avoid traumatic material at a phobic level whilst simultaneously seeking change: "*And I think with DID, they just don't really want to know but they know they can't continue as they are." (Participant S, P27, L740).* This tension between knowing and not knowing often became a battle:

> *And the person can wander up and down the corridor for years… and sort of be okay as long as the compartments never open. [r:mmm] But inevitably they do as there's no such thing as a truly locked box. [r:mmm]…….So, the ANP [Apparent Normal Personality] may go through life trying to hold all the doors closed but then an event in the world can cause the doors to kind of smash open and then the other people come out (Participant M, P7, L225)*

This battle is an obstacle to therapy whereby the client is pulled in different directions:

> *I repeatedly offered to her that she could stop therapy if she wanted, um, but she said, "No, there's a bit that wants to come out and I can't stop it and it makes my life hell so, um, I've got to go there even though I don't want to (Participant S, P27, L749).*

> *The problem is that sometimes one personality plays the alliance and other plays the sabotage (Participant J, P3, L74)*

The therapist is caught in this struggle, working with the person and their reactions:

> *Because it's like you know, "I had millions of barbarical attackers and I had to build this Chinese wall and it took a huge amount of energy and I'm finally safe and you are saying that this wall was NOT a master piece, is not my masterpiece, the very proof of my human value, of my resilience, of my best skills, you are attacking this, attacking this masterpiece, that this Chinese wall…well what's wrong with you? (Participant J, P5, L123)*

A 'Chinese wall' is a metaphor for an information barrier generally used in business. Chinese walls are implemented in organisations to prevent exchanges of information that could cause conflicts of interest. This quote captures the possible experience of a client whose

internal world is being challenged and consequently the defences of that internal world and rejection of the challenge or indeed the therapist.

One participant talked about the wider systemic defences against the intolerable with the possibility of society not wanting to know what has taken place:

> *And I think, similarly, that energy to quieten them is there in the system as well…..People don't want to know so like, using Jimmy Saville again as an example….The number of people who can now say that he was a strange man but didn't say it at the time or not openly …… so something about people just not wanting to know...don't want to know about it (Participant S, P47, L1312).*

> *It's to keep it quiet; to keep the, um, people safe, the group safe who- who induced this. (Participant S, P25, L682)*

2.6.3.3 The Appearance of the Internal World to the Outside World

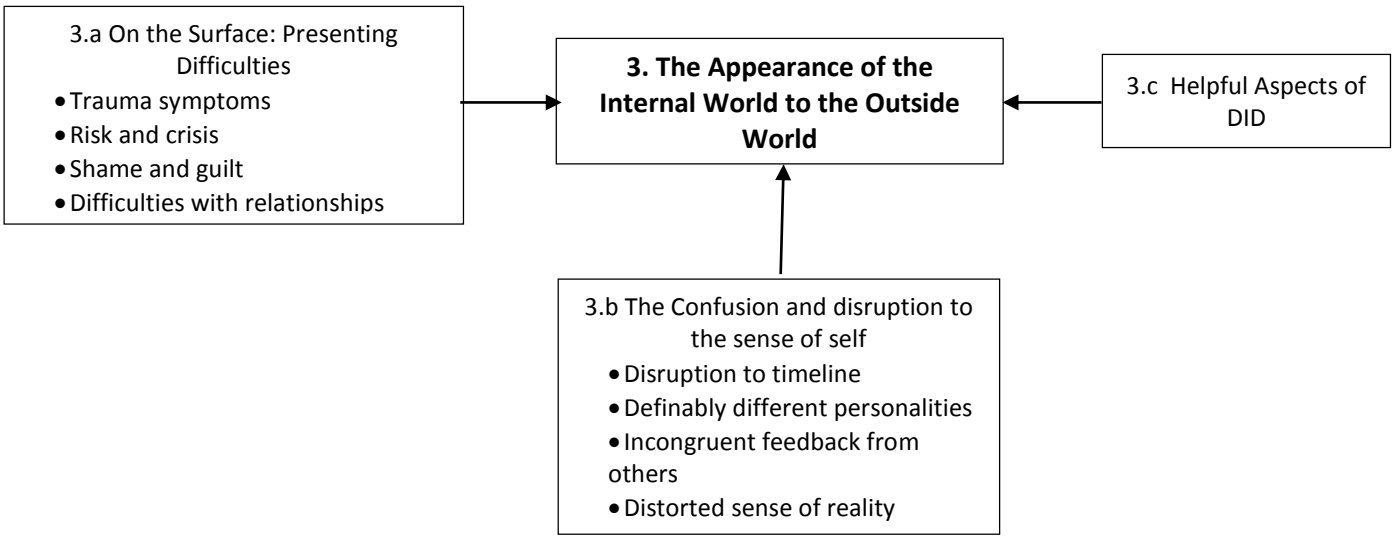

Figure 5: Major Category 3 - The Appearance of the Internal World to the Outside World

All participants described the appearance of the client's internal world to the outside world (figure 5). Therapists talked about 'on the surface' presenting difficulties such as dissociative symptoms, trauma symptoms and difficulties with relationships. Both the client and the therapist were described to experience confusion as they struggled to make sense of the presenting difficulties. The client struggled to have a coherent sense of self due to their disrupted life timeline, the presence of definably different self-states and detachment from self. However, there were also helpful aspects of DID described. For example, self-states were

seen as enabling the person to function well in particular contexts of their life such as at work or with family despite the difficulties they faced.

3.a. On the surface: Presenting Difficulties

Trauma Symptoms

Trauma symptomology was described by all participants. The findings will be outlined using the DSM-V criteria for Post-Traumatic Stress Disorder (PTSD) (American Psychiatric Association, 2013; Appendix M) as a framework for discussion.

As outlined in section 2.6.3.1 all therapists described a significant childhood trauma history underpinning the development of DID (PTSD criteria A – Stressor). Furthermore, clients demonstrated behaviours representative of intrusive and dissociative experiences (PTSD criteria B – Intrusions) resulting in distress:

> *And I unwittingly about six months ago caused a real trigger in this room. Somebody gave me some perfume, 'Poison'…..But I sprayed some on me and [teenager part personality] went into a freak…….as a teenager, she used to spray all her clothes with poison, to take away the smell of semen, I suppose, and men….. It's urrm. It's as though the body remembers these things. And all the sense are still….[tapers off] (Participant P, P22, L651)*

Therapists recognised clients' avoidance of traumatic material (PTSD criteria C - avoidance), with one therapist describing this as a phobia:

> *No. No, I work with other people who have been traumatised [pause] so, say with people who have had car accidents, there will be bits that are not held in memory …… or the whole incident won't be held together…….. but there is not the phobia that people with DID have to knowing what's in … what is held …… by these different parts (Participant S, P5, L148)*

> *….I think therapists should be more there alongside as partners to the adult to help them be willing to …….allow ownership of that traumatic material. That's the bottom line. That has not been possible. Because there has been such a fear of that. Because dissociation is about keeping them separate (Participant R, P9, L278)*

In relation to negative alterations in cognitions and mood (PTSD criteria D) therapists identified amnesia, fear and panic.

> *….. I work with people who had horrific childhood histories, horrific. And those who cannot remember probably have the most horrific. Urrrm. And urrr my patient with DID, actually one of them would say 'I can't remember anything before when I was 15' which always alerts me to something the person cannot afford to remember (Participant J, P5, L131)*

Alterations in arousal and reactivity (PTSD criteria E) were reported including irritable, aggressive and self-destructive behaviour:

> *Okay. And that very very often you have either what's described as a very angry or very aggressive internal abuser, someone who seems to get self-harming that's there and you may get someone saying that 'I don't like getting that angry part of me' but there's no getting rid of that…" (R, P11, L361)*

In addition, therapists described clients' hypervigilance with unusually heightened senses:

> *…..her hearing, her senses are over developed. She could hear my husband who was upstairs in a room at the other end of the house in his study….. a heightened sensitivity to alarm bells going off. She hears something before anybody else, she'll say 'oh and the alarms are going..'….before anyone else (Participant P, P3, L50)*

In terms of duration (PTSD criteria F), therapist's describe clients' difficulties persisting over the course of their whole lives. Functionally, (PTSD criteria G – functional significance) the clients were affected by their early childhood trauma in terms of how they functioned day to day and how they relate to others: "*But she's allowing her husband to put his arm around her these days. She says when they're sitting on the couch*." *(Participant P, P30, L925)*:

> *Urrm but actually I do believe that these people have experienced such harm as to shape their urr current ability to function in the world and experience themselves urrm profoundly errm and in a way that and yes, profoundly disabling and disturbing for them (Participant K, P6, L146)*

Risk was described as being unusually high for those clients due to the risk of ongoing abuse or threat of harm from others e.g. *"Um, so say someone's coming and they've told you*

that they were, um, abused as a child by a group of people and then they tell you that they're still being abused by that group" (Participant S, P49, L1366).

Additionally, unusually high risk of self-harm was noted:

> *Huge amounts of suicidal risks, huge amounts of self-harm. Could be self-harm in the session. You could be sitting there with somebody with DID and they dissociated into an angry teenage part who starts self-harming right in front of you. I've never known that outside of DID work (Participant M, P25, L855)*

Participants described these clients as being notoriously difficult to assess:

> *But that can bely what's going on. I think for some people that actually present quite well, [r:mmm] they're very articulate and are very thoughtful, they don't get into services because they appear well [r:mmm] but actually all hells breaking loose in their life (Participant M, P32, L1228)*

Clients were described as being frequently in a cycle of acute mental health crisis *"So they tend to go for the next crisis or as things start calming down they go straight into hyper-arousal which is like depression, pointlessness and suicide." (Participant R, P6, L195)*

This consistent link with trauma symptomology is an important consideration when looking at the type of therapeutic intervention suitable for supporting these individuals. The role of trauma focused work in DID therapy will be discussed further below.

3.b. The confusion and disruption to the sense of self

Therapists described a sense of confusion both for the client but also within themselves as therapists. This confusion stemmed from the shared difficulty in making sense of the client's experiences due to their disrupted timeline and lack of integrated experiences.

> *And I've got a complete clothes line. So from my birth and up until today all the things that have been put on my clothes line are all there and are all available to me. Someone with DID, they do not have that. [r:mmm] So if they try and go back they'll be something that will either stop them or there will be absences on their clothes line. So they'll be looking at it and they can't see or can't understand what is on the clothes line…….And I think to me that's what DID is. Is that, you don't know who's put those things on the clothes line [r: mmm] or*

when things aren't there that should be because someone else has removed them [r: mmm] and you don't know about it. (Participant M, P1, L11)

Clients were described to present different self-states to different people at different times. The following quote provides a description of how this could occur between services or over time:

The person I knew was a mild- mannered, well spoken, educated, middle-aged women, grandmother. This other one is a tyrant who had been threatening people, forensic teams are involved erm all sorts of erm different parts of our service are involved with her care. She'd been Sectioned for being delusional and paranoid and [pause] [whispers 0:06:06.3] and to, you know, that we all needed to take care and, you know because she had been threatening professionals and yet "hold on? This is a really nice … how can this be?" But it was the same women (Participant V, P3, L75)

As a result client's experience of the world and the feedback received from others was confusing and disorienting.

[They] are surprised by various things that people say to them. Dismiss what people say to them, as if they don't understand what's going on. That they can't make sense of things. Erm, in terms of, you know, er finding themselves in different places. Well, finding themselves in places that they are unaware of. Erm, oh I host of things. [Participant V, P1, L9)

The lack of integration and disruption to the life timeline resulted in a struggle to develop a coherent sense of self. *"Often feels like 'if it wasn't for my children, I wouldn't be alive' my biological children. Because there is no sense of essence of self. The essence of self is within those different parts inside." (Participant R, P12, L398)*

This challenge of a core sense of self was intimately tied up with the experience of having a number of different self-states, each of which could have a different set of beliefs and values about the world.

3.c. Helpful Aspects of DID

Therapists identified helpful aspects of living with DID:

> *Those self-states become more elaborate as time goes on as they serve a useful function. If I give you an example. Urrrm. A child whose been abused at home might be able to go to school and carry on at school as if everything is fine and that's quite a relief but and, and they'll kind of need different set of behaviours and motivations when they are at school. So they actually the dissociative division in itself helps the person to function well (Participant A, P2, L8)*

Self-states were described to help the individual as a child as well as an adult:

> *And she said 'Well! I don't know. I changed the wheel. I don't know how I did it! I don't know how to change a wheel!' And, and of course she was always finding that. She could do things that she had no idea she could do. (Participant P, P8, L226)*

In the original context of childhood trauma, the survival mechanism of DID is portrayed as serving an important and useful function. However, for those presenting to services, the balance of how helpful the mechanism is has altered and it serves as an obstacle to the client's desired direction in life.

2.6.3.4 7.3.4 The Direction of the Therapeutic Process

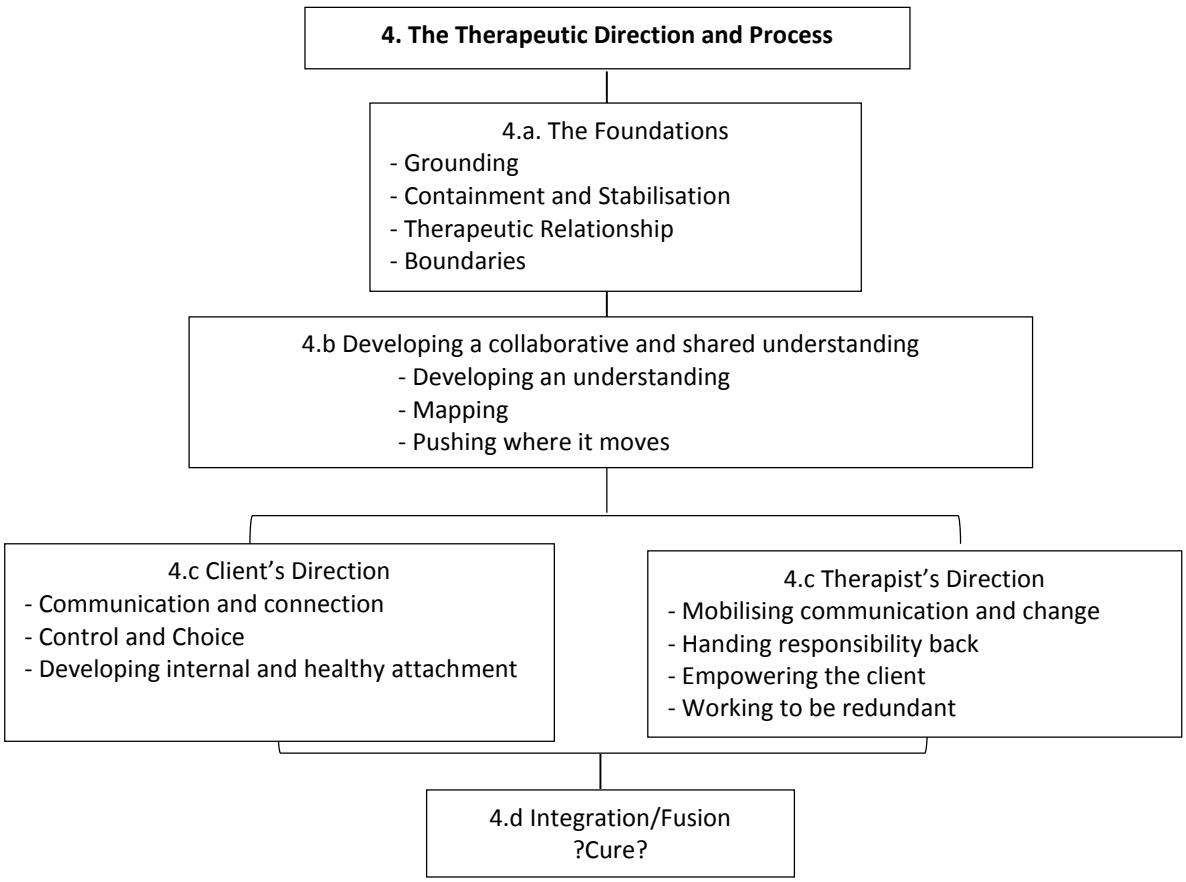

Figure 6: Major Category 4 – The Direction of the Therapeutic Process

Participants shared their understanding of the direction and process of therapy (figure 6). Therapists recognised the importance of building firm foundations on which therapy could evolve. Grounding, containment and stabilisation were seen as paramount alongside the development of a strong healthy therapeutic relationship. In order for the therapeutic relationship to function well, the need for clear firm boundaries was highlighted. With this established all therapists described collaboratively working towards developing a tailored map of the client's internal world. This enabled the client to become aware of their internal processes so therapy could work towards connecting self-states through enhanced co-conscious awareness and communication. Alongside this trauma work was described as developing in parallel to the main focus of the therapeutic work. It was described as something that was addressed in the moment but not necessarily systematically worked through at this stage of therapy. The ultimate aim of this early stage of therapy was to give the client more control and choice over their lives and to build internal attachments with themselves.

4.a. The Foundations

Grounding, containment and stabilisation were seen as crucial elements to therapeutic work:

> *So many little factors that you have to do before you actually get to addressing a symptom…….that's why you spend so much time on stabilisation work. That's one of the most important parts of therapy, isn't to go back and look at what's on the clothes line [the trauma], it's, it's just today how do you work? [r: So that grounding work at the beginning, [t: yep] stabilising..] …And once you've got those you can start to think well "I wonder why you've got this in the first place." [r: yeah]Coz if you don't do that all that first then people [r: it's quite unsafe isn't it?] Yeah it's too unstable, [r: mmm] it's too risky (Participant M, P17, L591)*

This quote discusses the role of trauma work and highlights the importance of grounding and stabilisation work as a precursor to future therapeutic intervention including specific trauma work. This process was closely related to the establishment of the therapeutic relationship and the development of the attachment between the therapist and the client. This fits with literature suggesting that the therapeutic relationship (e.g. Lambert, 1992) and the therapist's attitude towards therapy (e.g. Wampold, Minami, Baskin, & Tierney, 2002) are key variables for determining the outcome of therapy above the choice of therapeutic intervention. This was viewed as a process that took time, sometimes years by participants:

> *….but the amount of time that someone needs to form the attachment so the person I was just speaking about, um, I have been seeing her for six years before she was able to let me know that it was something else behind it and that was all that time…….it took a very long time for her to feel safe enough to start talking (Participant S, P18, L481)*

For participants working in the NHS, this posed a particular predicament due to funding considerations and service provision:

> *Just because of the nature of the work that we are er in or I suppose because of the amount of funds that we have now, I think we have to be thinking more in terms of having specific goals, we achieve those goals, let the person go. Let them cope of their own to a certain extent and then come back. That's how I'm seeing it. (Participant V, P27, L87)*

The trust and faith in the relationship was paramount in the work completed, especially for individuals with histories of traumatic abuse at the hands of 'trusted others'.

> *Well as I said I think it's trust. She said to me once, 'I know you don't lie to me and if you say I was here last Tuesday then I must have been'. So there was a gradual feeling of trust that grew up between.. with her. Took her a long time obviously. It took years I would say. Urrm So urrm what does that….well it enables one to lower the defences. You know, that it is safe to lower you know when you're feeling very vulnerable then you keep your defences high and when you feel safe you begin to lower them and I suppose (Participant P, P26, L796)*

> *Yeah but also people with DID think that their traumas are horrific, and they are horrific, that they will somehow contaminate me or damage me in some way or I will be overwhelmed by it or affected by it. Or that they are too ashamed to show it. It's those kinds of issues really. Which I think are quite a leap of faith for people. They place a lot of faith in the therapist I think, to embark on that journey with them (Participant A, P19, L564)*

Boundaries were essential for creating a containing safe space to allow the therapeutic relationship to thrive:

> *…..and the use of boundaries and maintaining good clear boundaries is incredibly important [r:okay] but I've noticed with DID that it's much harder to stick to those boundaries. That stuff tends to overlap a little bit. On time and phone calls. Things like that ....[r: Phone calls outside of the sessions?] ...Yeah, so I have very few people who contact me in between sessions. [r:mmm] But they're all ones who have attachment and trauma ? (Participant M, P28, L978)*

Interestingly, the boundaries described earlier refer not only to the client but also to other professionals.

> *They can bring their chaos, you know, into the … into the session. Um, you can find that other professionals try and get involved. … and do things, which are really unprofessional because they're just in such a mess about it themselves. Um, er, the supervisor of a therapist ringing up another therapist to say they didn't think they should be working with them. Um, what else? People were threatening to take people to all sorts of tribunals and all that (Participant S, P45, L1268)*

The destabilising nature of DID and the ripples of its effects are captured in this quote. The chaotic nature of the presentation and how this can get others into a "mess" suggest the importance of boundaries to maintain structure and a sense of stability for all involved.

4.b. Developing a collaborative and shared understanding

All participants described mapping out and describing each of the client's self-states to think about their functions and internal relationships: *"urrm at the moment is more mapping out those states [r: okay] and the, the, urrm different qualities of those states. So what, what they're like those different states of mind." (Participant K, P8, L216)*

> *…like your Venn diagrams and stuff. As a sort of a global one and then there are little interconnecting circles which might resemble parts and feelings or experiences and you look to find the overlaps between the circles and you can sort of draw out things with people. And get parts to fill stuff in. So I've done ones where I've drawn a square, and thought well that's you the person, who is with me at the moment. So what we're going to do is just leave the pen and paper on the…coffee table in the room and then when people dissociate, another part comes through I would like them to draw where they are in the square….. And at the end of the session the person has come back and there's a jumble jigsaw of representative figures and shapes within (Participant M, P18, L611)*

4.c Directions of Therapy

Mapping the internal world was one of the first stages of therapy for all participants. There was a shared belief that approaching the traumatic history too early in therapy was not helpful and should be directly addressed only once the relationship, trust and safety had been established:

> *But at the moment errr I, while I might look for opportunities to help her to make sense of some memories that come back intrusively, urrm I'm not systematically going back through her history. [r: okay] Because I don't think she's yet ready or she doesn't have the skills to manage the emotional response that that's likely to evoke (Participant K, P8, L216)*

This describes the skill of the therapist in establishing what the client is ready for, working with traumatic material as it occurs in the moment but not necessarily going systematically through it at the earlier stages of therapy.

There was a strong element of the client developing an attachment within themselves, developing self-compassion and acceptance:

> *If you have someone who's coming to see you who has been deprived and abused and hasn't had any experience of that childhood nurturing. And you can often in DID just see it there and your heart goes out to it often. There is, we can't as therapist replace that. [r: no] The only person who can is the, is the person themselves. And that's the adult in DID who has to learn to nurture and care for her children that she carries inside (Participant R, P8, L253)*

Another core element of the therapeutic work involved developing communication and connection between different self-states. The first step in this process was to enhance awareness:

> *So if I'm talking to Jimmy and I'm talking to you separately, [r: yeah] then it's a triangle. So at some point I need to step away from that triangle and allow you and Jimmy to communicate. [r: yeah] Regardless of how that goes. That's got to be the goal. [r: yeah] Because if you and Jimmy never communicate and spend any time figuring each other out or never looking at each other you either always rely on the third person to do it for you or you never agree on anything. (Participant M, P17, L570)*

> *"Well….at the beginning, I don't know that any of them knew about each other. It was a very gradual…..my sort of suggestion that they needed to know about each other." (Participant P, P9, L237)*

These quotes also highlight the therapist's role of mobilising communication and change but also working towards handing back the responsibility to the client and the therapist becoming redundant from the process:

> *Which is always the goal of any therapy is that the therapist works to be redundant. [r:mmm]So the, you know, the point at which the person turns round and says I don't need you anymore is a great day [r:yeah]……and DID is probably no different to that [r:mmm] it's just, you've just got more factors to throw into it. (Participant M, P17, L577)*

Initially the therapist mobilises and mediates between the self-states, but as therapy progresses, the therapist steps back and enables the client to do this by themselves. This is

emphasised by Participant J who talks about the zone of proximal development (see below), a concept by Vygotsky (1978) who suggested that a person may be able to achieve with others, what they cannot achieve by themselves, a process described as scaffolding.

> *Yes. And it is a model of therapy that is urrr some would feel that is non-directive, actually is very directive but is done in a way that requires imaginative skills. [r: mmm] An atunement. Constantly searching for where the patient is at any moment. And working with what is available [r: mmm]. And from what is available in the room in that moment. Trying, constantly aiming at establishing connections creatively though, creatively. In the zone of proximal development that changes constantly. And in that process of testing the boundaries between different personalities, all the times, that builds up a space in between. (Participant J, P13, L405)*

The above quote talks about the non-directive nature of therapy, allowing the work to naturally evolve and simply working with what is there in the moment. *"Because I don't think she's, yet ready or she doesn't have the skills to manage the emotional response that [trauma] that's likely to evoke" (Participant K, P8, L223)*

Participants suggested supporting clients to develop emotional coping skills in the earlier stage of therapy to support the client in dealing with future trauma work. One of the aims of the first stage of therapy is for direct communication between self-states, in the moment as needed:

> *…….. and then another level is well how do you get the person and Jimmy to communicate in the shop. {r:mmm]. So that if Jimmy wants a lego, instead of taking over and putting the lego in the basket…… and buying it, can Jimmy then say 'oh id like this' and can you then say back 'well we haven't got enough Jimmy so is it alright if we get some next time because I haven't got enough money today' and then Jimmy going 'yep that's fine' (Participant M, P16, L549)*

As described above, part of the process of enhancing awareness and communication is to enable the client to have more control and agency over their actions and their life:

> *Allow herself to talk about things. Allow herself to see the pictures that were in her head without disintegrating. She, I, you know, I used to say 'what does it feel like when you see an awful picture?', she says 'I just disappear'. Yes she did describe recently, 'it's like going into a black hole and I don't know if I'm*

going to come out of it'. It's urrm. And she's dipping into the black hole sometimes, and finding that she can come out of it. (Participant P, P26, L814)

4.d. Integration and Cure

The idea of 'cure' was addressed by several participants:

But one of her alters, or whatever you want to call them, was creating a lot of risk at home. And persuading the staff that it was a good idea that they didn't need to get rid of this alter or rather they couldn't get rid of this alter, they needed to engage with the alter to find out what it needed. (Participant A, P17, L496)

A wider picture I think, I don't think there is such a thing as cure in this type of severe……. Some books I've read by DID patients say that they don't mind being fragmented…….Or or they would feel a bit lost without…. (Participant P, P20, L619)

The concept of 'a cure' in relation to a client's personality was not a direction any of the participants advocated. The direction of integration was the strongest theme, representing greater communication and connection between self-states with the overall aim of having more self-agency and choice:

The idea of cure for this client group appears to be quite a challenge for therapists. The balance between fully accepting the person as they are, their personality however fragmented, whilst recognising that aspects of this present difficulties for the person themselves and those around them. One of the participants referred to the humpty dumpty nursery rhyme and the idea that 'all the King's horses and all the King's men couldn't put Humpty together again'. The question posed here is whether 'cure' is the answer or whether 'living more healthily with' is more realistic. (Memo 5.3 3rd January 2014)

The therapeutic process outlined by participants reflected aspects of the ISSTD guidelines (2011) phases of treatment but there were also some key differences. The ISSTD suggest a three phase model; 1) Establishing safety, stabilisation and symptom reduction, 2) Confronting, working through and integrating traumatic memories and 3) Integration and rehabilitation. The first and third stages of the ISSTD are similar to the treatment processes suggested by participants here. However, participants in this study suggest that trauma work

initially takes place in parallel with the main focus of which is on establishing the foundations of the therapeutic relationship and enhancing communication and connection between self-states. In the early stages of therapy, trauma work is addressed in the present, for understanding the different self-states, experiences and memories as they arise. A more systematic approach to trauma work is suggested as a future direction of therapy or a second stage of therapy once the client is in a stronger position to manage this material. This is similar to the approach used in Dialectical Behaviour Therapy (DBT) which is one of the therapeutic approaches suggested by NICE guidance for client's meeting the criteria for Borderline Personality Disorder. DBT suggests a staged approach to therapeutic intervention with the first stage of therapy focusing on supporting the client to move from being out of control of their behaviour to being in control (Linehan, 1993a). The second stage of therapy is trauma focused work which can be pursued once the foundations of stage 1 have been laid down.

2.6.3.5 The Qualities and Considerations of the Therapist

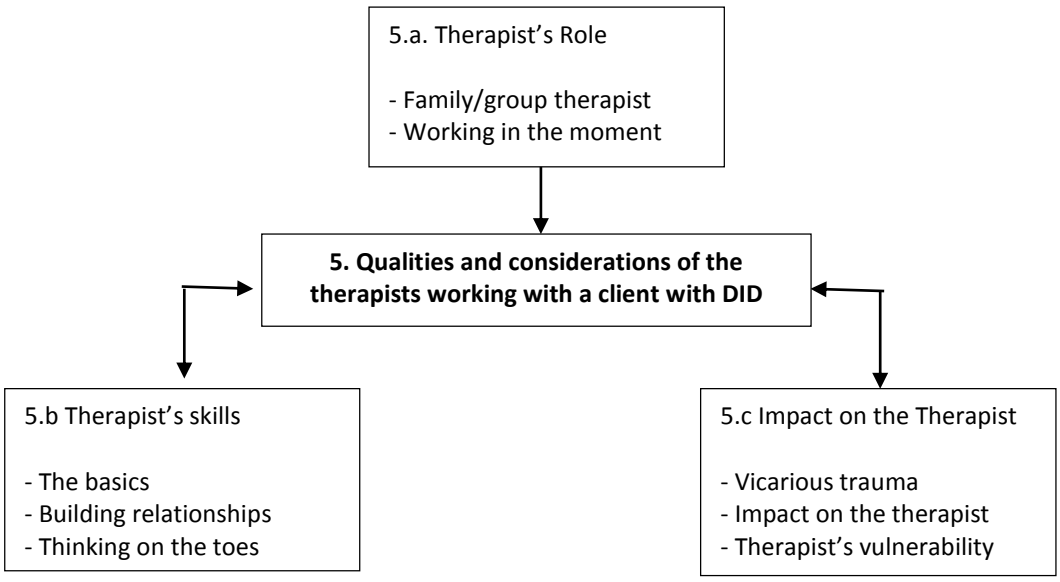

Figure 7: Major Category 5 – The Qualities and Considerations of the Therapist

All participants talked about the qualities and considerations of the therapist (figure 7). Participants described the therapist working in a family or group therapy approach and working flexibly in the moment. The therapist required a solid foundation in basic therapeutic techniques that could be utilised as needed. There was recognition of the impact on the therapist in terms of exposure to traumatic material that could shake their beliefs and world view.

5.a. The Therapist's Role

Participants described the sense of carrying out group or family therapy:

> *Well… yes….urrr I mean [teenager part personality] said to me one time 'this is a bit like group therapy isn't it?' and I said 'yes I do feel like, a bit like a group therapist but' I said but 'you're not all listening all the time (Participant P, P19, L559)*

> *….it's like having a group of five, four year olds. Four year old, oh my gosh, four year olds. Not quite, can't pay attention, lose their concentration, come on talk about a different subject, change the subject, all sorts of things, bring it back, are we here? Are we all on board now? Can we all? Okay, who can do this, chatter, chatter, chatter. Come on be focused (Participant V, P22, L721)*

As part of the therapeutic process, therapists acknowledged that they were very much a part of the system:

> *…it's gonna be, it's difficult for you to then remember what it is you're allowed to talk about and not allowed to talk about and if you say something and one of the other people say 'sorry, what was that? I didn't know that?!' you're already, you're in the mix. And in DID it can be like that (Participant M, P3, L91)*

There was a sense that the therapist could act as a parent figure, developing and modelling healthy relationships:

> *This is trying, perhaps for the first time, someone beginning to get a sense of what a relationship can do. And it's you as the other person that is the only model someone has as to what, perhaps, might be a preferable way of relating to themselves and to other people (Participant R, P7, L224)*

This idea of developing an alternative relationship template links with ideas associated with Schema Therapy approaches where therapy is used to as a method of 're-parenting' (e.g. Young, Klosko & Weishaar, 2003). The client learns new ways of relating to themselves, the world and others through their relationship with the therapist who models a healthier and more adaptive relationship template.

5.b. Therapist's skills

Participants talked about the importance of having 'The Basics' in place. They saw these as core competencies that were needed to work in the moment. Therapists needed skills to build relationships with the front person as well as all self-states in the system. They worked with who was listening in the moment, thinking about the internal as well as external dynamics and dealing with issues of consent and privacy. There was an emphasis on the therapist being able to think on their toes, working flexibly in the moment with the client:

> *And you think "Oh, God. What I am working with? What's the problem? And that's what I mean. Just not knowing erm exactly what your goal, because you start off with your set of goals, you use your erm, as I said you use your normal protocols of how it is you, you, you are needing to work and then it all goes out the window. (Participant V, P5, L178)*

> *Planning a session? Forget it *Laughs*. (Participant V, P23, L729)*

The issue of therapists engaging in personal therapy was raised. This was suggested for developing self-awareness and insight into strengths and limitations of the therapist. This was viewed as important for understanding what belongs where and with whom due to the nature of the work.

> *Is your, is, is the most powerful thing is your countertransference. Because as you already mentioned earlier on it, it evokes enormous feelings in countertransference. Now there's nothing wrong with countertransference how we react, it's how we use it that's important. That's why it's problematic if people have not had sufficient personal therapy [r: okay] because there's got to be enough sense of self-awareness (Participant R, P7, L218)*

Interestingly Clinical Psychologists do not require personal therapy as a part of their training despite this being an essential requirement for other therapeutic orientations such as Psychodynamic training and Cognitive Analytic Therapy.

The intensity of this type of work was highlighted with the sense of the therapist needing to get to know each self-state and their individual characteristics as well as understanding their own responses and feelings towards them:

> *…..you learn over the years ways of sometimes being able to get you know a personality well the other day I, I sort of said to [teenager part personality]*

> *please let [patient's name] back in because I wanted to tell her something. 'No!' she said 'I'll tell her!'. And I said, well you won't because you'll tell her your own thing. Or you'll ..Because she's awful you know. Last time she was here I said, it didn't look as though [self-state – front person] was coming back in, so I, I got my urrrm bill out for her. I said to [teenager self-state] 'will you give this to…" "no" she said "you better give it to her when she comes back in." I said "Is she coming back in then?" "Yeah, well I better not take it because I'll tear it up or hide it and that upsets her (Participant P, P19, L559)*

Participants talked about the need for therapists to use their flexibility, intuition, attunement and relationship with the client as well as transference and countertransference in the room to work with people with DID. Therapy took place in the moment. Following a schedule was seen as futile, and therapists relied on their tool kit of skills and their ability to adapt to what was needed at the time:

> *…and I think if all the other therapists could embrace this level of flexibility, urrrrr if any model we practice incorporates this urrr urrr centrality of the here and now, use what you have in the room. Trust all yourself as a human. Your signs. Your heart. Your imagination, your common sense, but mainly your being human, you being human and … and respecting the patient, take risk, take risk all the time. [r:mmm] So then that's how I have I understand, working with fragmented mind (Participant J, P10, L318)*

Working in the moment and with what is there, was seen as incredibly overwhelming for the therapist. This left the therapist with self-doubt, feeling de-skilled and incompetent:

> *Well, you certainly feel incompetent. You're constantly asking yourself [pause] Have I done that right? Or somebody else would have done that a lot better than me.*….. the general or, the only feelings that you have…… like "I'll never get there" "I haven't got a clue what I'm doing" and "I'm incompetent (Participant V, P23, L751)

The unpredictable nature of DID means the therapist cannot be sure who will turn up to therapy, what that self-state's agenda will be and if that will be in tune with the work completed previously. Therefore, a step by step approach to therapy is not possible. The skill of the therapist lies in the balance between a structured direction and flexibility of approach.

5.c. Impact on the Therapist

Participants talked about the impact of working with this client group. Participants described issues related to vicarious trauma; hearing the material of traumatic histories and seeing what could not be unseen. Participants talked about feeling emotionally and physically drained, feeling overwhelmed and helpless, and being aware of their own vulnerabilities and internal world.

> *You feel a bit mad yourself. …… I'm worn out by the end of each and think "Oh God"……you're going to write up your notes, before you move to ….I can't do that. I need to go to the toilet; go and make a drink; go and talk to somebody [laughs]. I need to have that space before I can say, okay I did write my notes up now. And then, you know, this idea of seeing so many people one after the other is just nonsense with this level of severity. You just can't do that. If you want to stay safe. (Participant V, P21, L681)*

> *I guess what I would say is that the trauma histories that the two people I have worked with are very extreme and quite shocking. Errrrm yeah…….I found it and find it, as one of the people I'm working with at the moment, really quite disturbing urrm and yeah as I say, quite shocking. Some of the information that is passed on is it just hadn't occurred to me and I don't think of myself as particularly naïve urrm yes, as alarming and very disturbing to hear.....Mmmm. Errm I suppose I urrm more aware of some of the more extreme forms of systematic abuse that occur than I was previously…..And now I am aware of some of that. Urrrm and frankly I'd rather not be (Participant K, P4, L67)*

In the earlier category "On the surface: Presenting Difficulties" (7.g) clients were described as responding in a phobic manner to discussing their experiences of trauma. In terms of transference, it may be useful to think about how this may be internalised and reproduced by the therapist in their approach to this type of information or how the therapist's reaction to this traumatic material may influence how this type of information is shared by the client.

Participants talked about working with these types of clients and how it shook and shaped their world view:

> *I don't think I've necessarily got any vicarious traumatisation but I do see the world differently….. I think it's done that more implicitly rather than me*

*being able to say 'yes, you know' articulate that. I think it probably has. I think I notice it more when I'm talking to other people. I just think 'They're just so naïve' You know people who don't do this kind of work. I think 'God you're so naive'…….and thinking 'are you living on the same planet as me or what!' *laughs* (Participant A, P18, L529)*

This experience for the therapist is challenging and difficult. Participants talked about how this would activate their own defences against this material, making them feel avoidant of sessions or avoidant of the material being shared:

…the aversive nature of the work probably comes to play, into play as well. In so far as some people that think 'Of course all that couldn't happen. I can't bear to think about that. I simply don't believe it' urrm and therefore there's no explanation than that this person is making it up.' Or urrm……[r: So they reject the person?] I think so yes. As a way of preserving their own understanding of the world (Participant K, P12, L325)

This highlights the therapist's vulnerability and their own responses against intolerable information that challenges their world view. This reaction could result in invalidating the client's experience to protect what is known and safe.

2.6.3.6 Service and Support Considerations

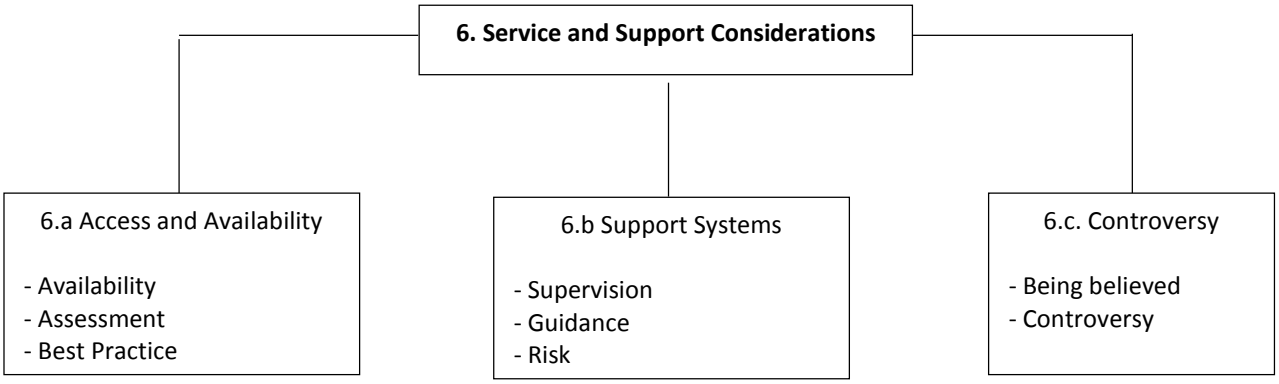

Figure 8: Major Category 6 – Service and Support Considerations

The issue of service and support considerations (figure 8) was particularly pertinent for participants. Participants talked about the difficulties clients had accessing statutory services and issues around misdiagnosis. Participants were aware of the level of support this type of work required due to the unpredictable nature of the work, the impact on the therapist and

the elevated levels of risk associated with the client group. Participants also talked about the additional challenge of the controversy surrounding the diagnosis.

6.a Access and Availability

The issue of availability and access to appropriate longer term therapy and the cycle of receiving and withdrawing support was raised.

> *Urrrm, I think theeee big one that people talk to me about is the availability, is access. Like so if you have somebody that's DID how can you organise your work so that you can stay with them long enough so you can actually make a difference. [r:mmm] So, like, some therapists are constrained by urrrm just the, the, number of sessions [r:okay]… they're allowed to have (Participant M, P23, L806)*

> *[R: And-and you said six years?] Yeah [r: To feel safe] And so you can imagine that within the statutory services. I mean, it just wouldn't happen (Participant S, P18, L488)*

Concerns were raised that this resulted in fire-fighting whereby clients only received support when they were in crisis. This is one of the considerations of DBT which emphasises the need for long term therapy and the importance of the consistency of approach (Linehan, 1993).

> *It replicates this thing that crisis gets the attention. What's better is that after a period of things being exactly as you would normally do which I think is important to get that structure is to then work with the adult to say 'What you can and what you could..'. So it's structured in. So if it's needed to structure in a phone-call between sessions that's fine but it's structured there whether they are in crisis or not. So that the person gets to learn that that attention is there irrespective of whether they're high or low (Participant R, P9, L290)*

Challenges to assessment were highlighted. In particular the difficulties of under-diagnosis and, more worryingly, misdiagnosis: *" ... she had just been told 'well you're psychotic and that's, you know, its delusional'. And actually for her we found corroboration and we found corroboration quite easily. So it couldn't be dismissed as delusional." (Participant A, P6, L150)*

> *[Client]…. is clearly DID now…….She is still in our service and she is been treated for somebody with Schizophrenia and everybody who comes in contact with her says "You're not schizophrenic, there's something else going on". But her, her particular Consultant Psychiatrist is insistent on giving her the diagnosis of Schizophrenia. (Participant V, P14, L439)*

This highlights the importance of team working, of sharing knowledge and accessing training to ensure that clients experiencing these types of difficulties have access to appropriate and consistent treatment.

One of the obstacles to diagnosis related to structural and resource considerations of services:

> *It's not part of our erm, erm, payment by results, let's put it that way. It's not high up on, on, we do have clusters now. You know, it's not high up on their ..., so it doesn't really get a look in….. I don't think so the only reason, erm, but it's very good at masking, you know that's probably why, you know, we all see people who are diagnosed, as I said with, with Psychosis or Schizophrenia…….. Because it, it will fit, you know, it will help us. Monetarily, it will help us……. But if they have DID, well? Well, that's a bit of a nonsense isn't it? (Participant V, P25, L803)*

However, even with the right diagnosis, access to appropriate treatment was problematic with an over-emphasis on medication and popular structured therapies:

> *But the difficulty is that DID when they are offered, I don't know, CBT is they are experts at CBT they are experts at adapting to situations. They know how to adapt, they know how to rethink things. That's not the issue. The issue is to take ownership (Participant R, P12, L391)*

Although shorter term structured approaches such as CBT and EMDR are advocated for PTSD (NICE Clinical guideline 26), complex mental health difficulties related to personality require longer term therapy using an integrated approach, consistently followed by the team and therapist and involving twice weekly sessions where required as suggested by the NICE guidelines for Borderline Personality Disorder (e.g. NICE Clinical Guideline 78).

6.b. Support Systems

Participants emphasised the importance of support systems, good supervision and specialist guidance:

> *I know having had quite a bit of training and knowledge behind it and just working with other people who work with DID, I think it's incredibly important so that you don't feel isolated and feel like a fool. (Participant V, P28, L916)*

> *I think having excellent supervision is essential and I think it's probably unreasonable to expect people to do this work in the absence of excellent supervisions [r: What would make it excellent supervision?] I think urrr regular boundaried supervision with somebody who is experienced in, at the very least, Borderline Personality Disorder. But ideally working directly with dissociation and DID (Participant K, P22, L659)*

The suggestion of accessing specialist DID supervision is logical but how this is accessed may require more thought. Identifying specialist supervision may be difficult due to the low prevalence rates of this disorder and therefore low numbers of supervisors who have worked with this client group. In addition, the issue of funding and resource allocation to support access to this type of specialist supervision must also be considered.

Support systems and team dynamics were highlighted:

> *And I think that's also quite important that you have a good relationship [with the team]…… You can't do this kind of work urrm disconnected from what else is going on because that person will get too many mixed messages. …….. Working away, trying to build up good relationships, trying to show how you framework, how this framework can be helpful. What the implications are, what the implications aren't. ….. Urrm and you've and you, part of that integrated care team, everybody has to working from the same diagnosis. And DID is controversial. Not all medics want to give that diagnosis (Participant A, P15, L430)*

There was a call for more specific and tailored therapeutic guidelines:

> *Urrrm there's also the issue around that there aren't specific guidelines for this so you having to do by the work that you're doing on the basis of an international set of guidelines which are very wordy, brilliant, but huge*

> *guidelines. And when you look at the other NICE guidelines for different treatments they're very very organised and layered and it's very clear what people should do. So for new therapists coming into this it's very difficult for them to know where to start [r:mmm] unless they're willing to download a paper and read an entire paper or buy a specific text book [r:mmm] and then learn it from the text book.(Participant M, P24, L815)*

Although the ISSTD guidelines are available, there are still no specific NICE guidelines at present. This is, in part, due to the low prevalence rates of this disorder and consequently the lack of research in the area of therapeutic intervention. Without a more centralised, focused and collaborative approach towards research in this area, it will only make slow progress.

DID presents a particular risk to the individual, the therapists and the services supporting them. Therapists and teams were described as being shaken by these clients, causing splits, divides and conflict where there hadn't been before:

> *But I think another thing about DID for me is the level of urrr suspicion that creeps in to every level of work. I've noticed. … I've noticed that the wider team is or, or, or quite a number of the wider multidisciplinary team is quite suspicious if not disbelieving of some of the things that this particular person who I'm seeing at the moment has said. I'm also aware that sometimes I've sat in session and think 'Really? Really? Is that the case? (Participant K, P5, L127)*

As described earlier (section 2.6.3.5), the risks carried in the therapeutic work were described as greater and at a level not observed with other client groups. The unpredictable nature of therapy was emphasised:

> *Extremely more complex than that. And you think you're going down a, a, a particular path and then it just takes, like it turns a, it's like it turns a corner that you didn't actually see this corner coming up because it looked like a straight road. So that's what it, that's what it feels like. (Participant V, P5, L138)*

There is a sense that a therapist can be working with a client for a considerable length of time and still not know the entirety of their internal world:

> *Or it's just gone you know. You're sitting with a person you haven't, you don't know who's there. [r:mmm] So a part could come out that you've never seen before, who's alien to you entirely. You don't know who they are, you don't*

> *know what they're doing…. and you've got no idea what they're capable of doing. [r:mmm] Now that isn't something that you normally get in therapy session with somebody you could have known for a year. (Participant M, P25, L864)*

Participants described the difficulty of working with clients with DID, who live with an overbearing *sense* of being under threat but also may literally be under threat too: "*Urrm so..but there were safeguarding processes that were followed. So as far as we could gauge, she wasn't being harmed. But there was still a sense of, if this person knew, then they would want to disrupt the process." (Participant K, P20, L601).* The possibility of ongoing abuse or risk of abuse was also a consideration:

> *For a long period of time. Errr and she wanted this person, well she was concerned about this abuser, having access to another member of her family…..And she wanted that child to be protected and she insisted that that's the work that I did on her behalf and contact Protection Service and all that type of stuff, which I did do. (Participant V, P4, L108)*

Therapists working in this field need to be aware of these types of safe guarding issues and to consider them in their formulation and when deciding the most appropriate route forward. For example, considering Maslow's hierarchy of needs (1953), if a client is not safe, if they are living with threat and in fear, psychological intervention may not be appropriate until these basic needs are met.

6.c. The Controversy

In the wider context, there is the ongoing challenge of dealing with the controversy around DID. The issue of simply being believed was a theme running across all interviews. Therapists described clients feeling that they weren't taken seriously by others, including professionals, and the role of the therapist in building that understanding and breaking down defences in the wider system:

> *I don't know whether it's just a belief. Lack of understanding. Some people don't necessarily believe the condition. Some people don't really want to know. [r:mmm] I think it triggers that aspects of people's experience in that in order to accept that a person has DID you've got to accept the things that have happened to them are real in the world. And that's the difficult thing for some people to take on (Participant M, P32, L1219)*

> *..so there was a lot of, er, people not wanting to see things that they don't have to deal with and I think some of the issues that these clients bring … I mean, I'm up here in the North where it's really common for people to know that Jimmy Saville was involved with paedophile groups but, I mean, nothing was ever done about it because there is that weight of, "Who's going to believe me?" and "What's it going to get me involved in, if I actually say anything?" (Participant S, P18, L499)*

DID is a controversial diagnosis and one that is disputed openly in the literature (see systematic review, Chapter 1). Therapists specialising and working in this field are faced with suspicion and disbelief:

> *There are considerations at the therapist and client levels but there are also important considerations at team and organisational levels too. For example, how do teams remain consistent in their approach when faced with switching, splitting, disbelief and working from different models…….and all in a context of suspicion? What structure is necessary to make working with this client group safe for the therapist, client, team and service?(Memo3.1; 21st August 2014)*

2.6.3.7 A Working Therapeutic Model of Dissociative Identity Disorder

The six major categories all related to the core category of a working therapeutic model of DID. This model is outlined in figure 9.

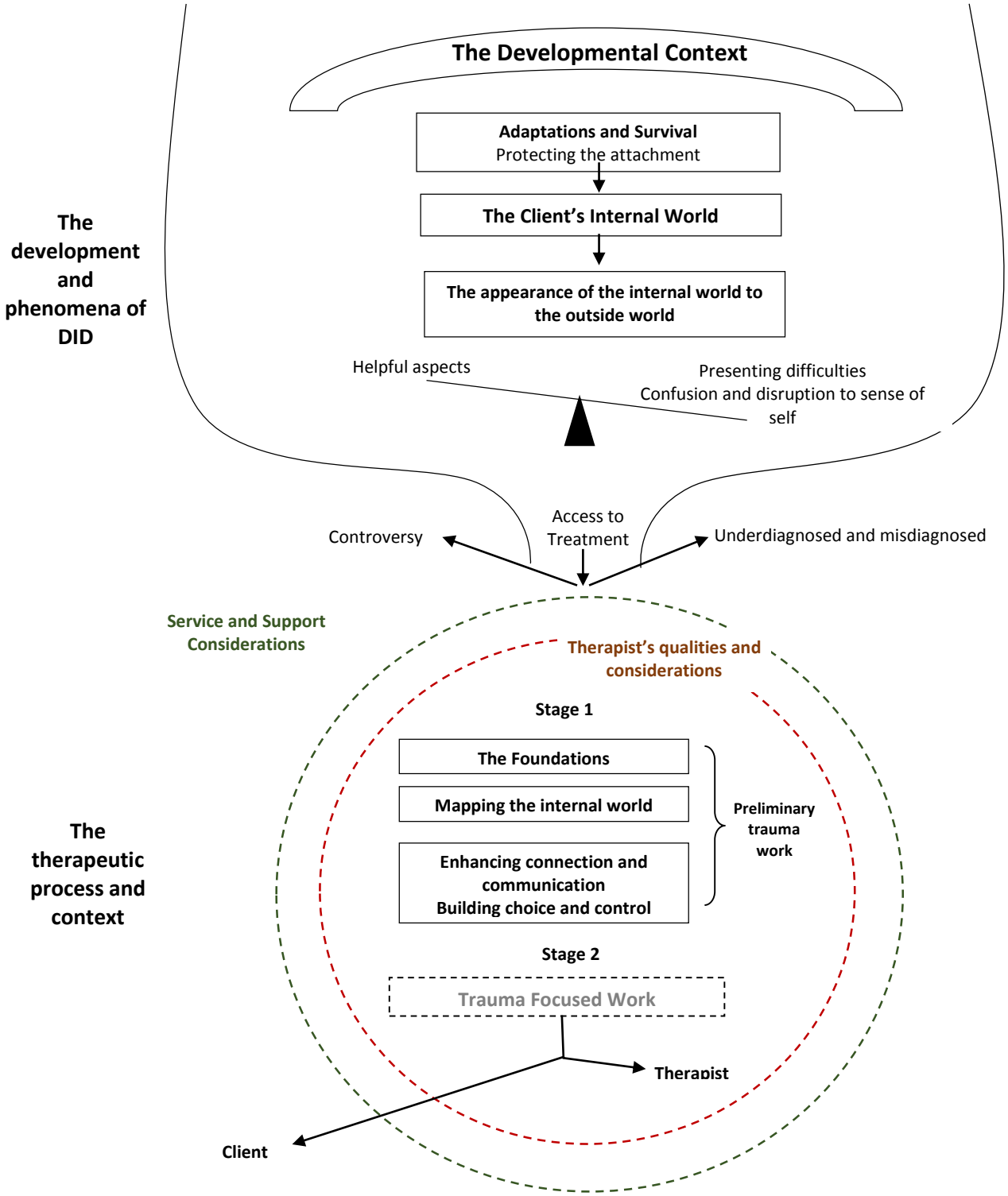

Figure 9: Staged Therapeutic Model of DID

Figure 9 outlines the working staged therapeutic model of DID developed through this research. This model highlights the phenomena, process and context for conceptualising and working therapeutically with individuals experiencing DID. The model emphasises the importance of intra and interpersonal factors as well as the wider systemic considerations involved in the processes of therapy for the client and the therapist.

The client is understood to develop a complex internal world comprising of a number of self-states as the result of a survival strategy in response to early chronic and enduring trauma. The ensuing presentation reflects the internal conflict, confusion and distress experienced. The initial function of these self-states is to separate and protect the vulnerable and powerless child from emotional, physical and psychological harm. Although adaptive in the original context of inescapable threat, the balance between helpful and unhelpful aspects of living with multiple self-states shifts when the context changes. Consequently, the difficulties associated with DID outweigh their helpfulness and bring the individual to the attention of support and/or services.

Participants described the wider systemic considerations and barriers for accessing support. DID was under-diagnosed and misdiagnosed at the point of access to services and often met with suspicion and challenges to its validity. This is represented by the semi-permeable barrier between the individual and appropriate services. The sharing of and access to specialist knowledge, training and supervision for this presentation and the support of the wider team is an important ingredient for determining whether the system becomes a support structure containing therapy or an additional pressure pressing down on the therapy.

Within these systemic considerations, the therapy itself took place. A two stage approach to therapy was outlined with the ultimate aim of the client leaving the system and the therapist becoming redundant. The first stage of therapy focused on establishing a safe therapeutic relationship, followed by developing a collaborative and shared understanding of the internal world and developing communication and connection between the different self-states. The overall aim of stage one is to work towards greater control and choice. Alongside stage one, preliminary trauma work takes place in the moment, in the context of an established safe and containing therapeutic relationship where clear boundaries have been established to protect both the therapist and the client. Trauma work was not identified as a focus of therapy at this stage but was seen as part of the process and something that would unfold naturally through the therapeutic relationship, possibly becoming the focus of work at a later stage of therapy i.e. stage two. This is similar in approach used in Dialectical Behaviour

Therapy (DBT) which is advocated by the NICE guidelines for Borderline Personality Disorder (NICE clinical guideline 78). The similarities to this approach and the place of trauma work were outlined in section 7.3.4. This approach may provide some insights to the type of structured therapy that could be beneficial to this client group with appropriate tailoring and adaptations.

2.7 Conclusions

2.7.1 Implications

The survey data suggests that less than half of therapists who took part had a working knowledge of DID. Enhancing knowledge and understanding may support coherent and collaborative understandings of these types of complex difficulties that will strengthen the therapist's and their team's ability to conceptualise, appropriately diagnose and treat these individuals. Greater training on dissociative disorders including DID was seen as key in moving the therapeutic area forwards.

The therapeutic model developed through the findings of this study suggests an interpersonal, intrapersonal and systemic team approach using a staged therapy. Although the presence of trauma symptomology was strongly supported by all participants, the place of trauma work was described as a focus for later therapy i.e. the second stage of therapy. This is a similar approach to that used for individuals with BPD but would need to be adapted, researched and evidenced for people with DID. Participants emphasised the importance of the service structure supporting the therapeutic intervention.

This model of working is similar to the framework set out for personality disorder services by the NIMHE guidance: Personality Disorder: No Longer a Diagnosis of Exclusion (2003). These guidelines suggest that a specialist multi-disciplinary teams of specially trained practitioners, led by clinicians with appropriate expertise and dedicated resources, who offer appropriate intervention and containment should be developed for these types of clients. These guidelines stress the importance of good working relationships within the team and the need for close collaboration and consistency of approach. It also outlines the team's systemic role in working on behalf of the patient with courts, housing, or social aspects of care. This may offer a template for therapeutic services for people living with DID.

Training, specialist supervision, support and research in the area of DID has been highlighted as an area for development. However, due to the low prevalence rates of DID, only a small number of therapists specialise in the area and access to these types of specialist resources are limited. The Clinic for Dissociative Studies is a national NHS service for assessment, treatment and training in dissociative disorders including DID. This organisation is based in London but accepts referrals nationally through the NHS. In addition, there are a number of independent organisations such as First Person Plural and PODS (Positive Outcomes for Dissociative Survivors) who provide support, information and guidance for people experiencing dissociative disorders. It may be of value to develop a wider and more flexible network of individuals experienced in the field, practicing across England and the UK who can offer support, expertise and supervision in this area of practice. Additionally, to overcome the obstacles of DID research, it would be beneficial to have a specialist service/organisation as a centre for excellence and research where a centralised database of potential research participants could be held.

Issues related to vicarious trauma as well as possible vicarious growth were raised and will be important for considering factors related to the therapist's resilience, stress and possible burnout when working with these clients. A recent metasynthesis study (Cohen & Collens, 2013) of the impact of trauma work on those working with traumatised clients showed that this type of work could increase both the short and long-term levels of distress experienced by the therapist. It was shown that this increase in distress could be supported through both personal and organisational strategies. It was highlighted that vicarious trauma does not necessarily result in vicarious growth but generally resulted in changes in schemas and day-to-day routines (both negative and positive). It would be helpful to consider the types of organisational, area or national (for example online support) support structures that could be put in place to support therapists working with clients who have invariably experienced significant trauma.

2.7.2 Limitations and Further Research

The design of this study was constrained by resources and timescale. It would have been beneficial to identify and interview 'negative cases' (Charmaz, 2006) for comparative purposes i.e. therapists who did not believe in DID as a mental health condition. However, of the few participants who took this stance in the survey phase of the study, none put themselves forward for the interview phase.

The researcher was fairly naïve to research in the area of DID before commencing on this project. This is both beneficial in terms of approaching the data with fewer preconceived ideas of the study area but is less beneficial for considering the results of the data in relation to current theory and own clinical experience. The bracketing interview helped highlight areas of potential bias in the research which were held in mind throughout the research process but it is acknowledged and expected that these ideas and values will have influenced the interpretation of the data. These types of limitations are present for all qualitative research and it is handed to the reader to decide whether the interpretations made by the researcher have validity.

Qualitative research using CGT requires a small sample size. The quality and credibility of the findings lie in the richness, depth, suitability and sufficiency of the data (Charmaz, 2006). The study also lies within the interpretative tradition and it is recognised that the analysis and therefore findings are contextually situated in a particular time, culture and situational frame (Charmaz, 2006). Therefore the findings of this research are exploratory and cannot be generalised but do offer a number areas for further research:

- To develop and formalise the therapeutic stages suggested by the model presented in this research for the purposes of empirical research. For example, it will be helpful to examine whether the work focusing on mapping out the internal world and on building communication and connection between self – states results in changes in symptoms, interpersonal experiences or factors related to quality of life and daily functioning.

- Further research on working with the traumatic material of clients with DID will be important for understanding when it is most helpful to address this material and the most helpful approaches for this. The guidelines for PTSD prioritise addressing traumatic material whilst DBT approaches for individuals with BPD aim to address these aspects in a later phase of therapy which was similar to the outcomes of this research.

- Research looking at the role of the therapeutic relationship with clients with DID in comparison to other client groups. It would be hypothesised that the therapeutic relationship would be more significant in determining the outcomes of therapy for this client group compared to other diagnoses due to the type and chronic nature of trauma and mistrust experienced in early attachment relationships.

- Further investigation on the issues of vicarious trauma and growth in therapists who work with clients with DID. For example, it will be useful to investigate the factors that influence the impact of traumatic material and how this relates to the development of vicarious growth.

Appendices

Appendix A- Table of Full List of Articles Resulting from the Systematic Review

Reference	Date	Dissociation or DID Focus	Model/Theory	Supporting or opposing featured theory/model?
Biswas, Chu, Perez, & Gutheill,	2013	DID		
Boysen & VanBergen	2013	DID	Overview (SCM)	Support of sociocognitive model
Dell.	2013	DID	Sociocognitive model (SCM)	Sociocognitive model
Macintosh	2013	Dissociation	Integration model – Trauma (T) and Relational (R)	Support of an integrative model
Reed-Gavish	2013	DID	Integration model – Iatrogenic (I) and Trauma (T)	Support of an integrative model
Sar, Martinez-Taboas, Middleton, & Warwick	2013	Dissociation	Sociocognitive (SCM) and Trauma (T)	Support of both models
Aquarone	2012	DID	Invalid diagnosis (V)	Opposing invalid diagnosis
Dalenberg, et al	2012	Dissociation	Trauma (T) and Fantasy models (I)	Support of the trauma model
Lynn, Lilienfeld, Merckelbach, Giesbrecht & van der Kloet	2012	Dissociation	Sociocognitive model (SCM)	Support of the sociognitive model
Merskey, H.	2012	Dissociation	Invalid diagnosis model(V)	Support of the invalidity model
Paris	2012	DID	Invalid diagnosis model (V)	Support of the invalidity model
Harper	2011	DID	Structural Dissociation Model (T)	Support of the Structural Dissociation Model
McFadden	2011	DID	Relational (R) and attachment theory (A)	Support of an integrative model of relational and attachment
Nijenhuis, van der Hart & Steele.	2010	Dissociation	Structural Dissociation Model (T)	Support
Brenner	2009	DID	Attachment perspective (A)	Support
Manning & Manning	2009	DID	Trauma model (T)	Support
Korol	2008	DID	Attachment perspective (A)	Support
Selligman & Kirmayer	2008	Dissociation	Possession/Trance/Spirit	Support
Lester	2007	Dissociation	Subself theory	Support of the subself theory
Naso	2007	Dissociation and DID	Psychoanalytic Conceptualisation (P)	Support
Ryle & Fawkes	2007	DID	Trauma model (T)	Support
Sar	2007	Dissociation	Sociocognitive Model (SCM)	Support
Dell	2006	DID	Subjective/Phenomenological Model	Support
Giovanni	2006	Dissociation	Attachment perspective (A)	Support
Coons	2005	DID	Invalid diagnosis model (V)	Opposed to the invalidity model
Humphreys, Rubin, Knudson & Stiles	2005	DID	Assimilation model	Support of the assimilation model
Kyle	2005	DID	Psychoanalytic conceptualisation (P)	Support of the psychoanalytic conceptualisation
Shaffer, Oakley & Jeffery	2005	DID	Trauma model (T)	Opposed to trauma model
Giovanni	2004	Dissociation	Trauma (T) and attachment models (A)	Support of the trauma and attachment model
Kennedy et al.	2004	Dissociation	Cognitive model (T)	Support of the cognitive
Piper & Merskey	2004	DID	Iatrogenesis Theory (I)	Support of the iatrogenesis
Blizard	2003	DID	Attachment perspective (A)	Support of the attachment perspective
Hall	2003	Dissociation	Constructivist view (SCM)	Support of the constructivist view
Peter	2003	Dissociation	Trauma model (T)	Support of the trauma model
Rieber	2002	DID	Psychoanalytic conceptualisation (P)	Support of the psychoanalytic conceptualisation
Bull	2001	DID	Phenomenology model of therapeutic exorcism	Support phenomenology model of therapeutic exorcism

Forest	2001	DID	Discrete Behavioural States Model (T)	Support of the discrete behavioural states model
Gleaves, May & Cardena	2001	DID	Validity model (V)	Support of the validity model
Rosik	2000	DID	Social constructionist view (SCM)	Support of the social contructionist view

Appendix B - Extracts from Reflective Journal

First Interview

I notice how fortunate I feel to have had such an experienced therapist for my first interview. XXX has a wealth of experience, not only with DID but with the breadth of mental health difficulties with a particular focus on personality disorders. I'm aware that I felt quite connected to her as a person and with the way she spoke about DID and her work. I'm mindful that this may influence how I interact in future interviews, especially if I've bought in to the way she understands DID. It will be important to hold this in mind in my future interviews and to remain open and curious about other ways of making sense of the difficulties associated with DID. I feel this is a skill I have developed through my own clinical work, and although in a different context, I am hopeful that I will be able to stay open to new ideas and perspectives.

Transcribing the First Interview

Wow! I missed so much information in the interview. I hadn't appreciated how easy it is to miss information during a conversation when trying to listen to what is being said whilst thinking about the direction the conversation is going in. I realise that this is probably a very common phenomena but I'm curious to think about how I may have pursued different lines of enquiry had I been able to hear all of what was being said in the moment. But I guess that is one of the benefits of using CGT methodology in that it gives the opportunity to change the interview schedule, to adapt it to the evolving research and to pursue different lines of enquiry if it is going to be valuable to the research area.

Comparing Interview Data

I'm feeling a little overwhelmed. There is a lot of data and I am surrounded by codes and yet I'm only on the fifth interview. Keeping track of what code came from which interview and noticing where patterns are emerging across the interview data is difficult and my mind feels full to the brim. I want to stay open to the possibility of new concepts emerging from the data but I'm noticing my resistance to this as well because of the implications of this e.g. developing the interview structure and going back over the previous interviews to see where this occurs. Pacing is going to be important to allow myself time to process my thoughts and organise the analysis as it develops. I'm starting to appreciate the importance of breaks and reflective time too. I think I will need to plan these in more regularly to my timeline.

Receiving Feedback from the Second Coder

I'm looking forward to seeing the relationships and differences between my coding with XXX who agreed to be the second coder for the project. I'm interested to see if they looked at the data differently to me and what insights that will give for the analysis. But I'm aware that I'm also a little anxious. Although I'm open to there being differences, I'm aware that I am concerned that there will be significant differences that will lead me to question the analysis. However, I'm trying to remember that overall this will only add strength to the analysis and to the overall results so it is important to stay open to the process.

Writing up the findings

It's so satisfying to see it all come together. It's interesting to see the similarities between therapist's experiences of working with people with DID, especially when they live in such vastly different areas of the country and are from different orientations and service providers. In some ways, I wish there had been more differences between the interviews, that there had been at least one negative case as a contrast. It has been a 'nice' process for me to look at data that has come from advocates of DID and of therapeutic intervention for this disorder but I'm sure that it would have been interesting and challenging to see this from the perspective of someone who does not believe in the diagnosis and to look at how this influenced my analysis and interpretations. The bracketing interview definitely suggests that this would have been a more challenging perspective for me to have worked with.

Appendix C - List of organisations who agreed to participate in the research

NHS Trusts

2gether NHS Foundation Trust

5 Boroughs Partnership NHS Foundation Trust

Avon and Wiltshire Mental Health Partnership NHS Trust

Berkshire Healthcare NHS Foundation Trust

Bradford District Care Trust

Cheshire and Wirral Partnership NHS Foundation Trust

Cornwall Partnership NHS Foundation Trust

Coventry and Warwick Partnership Trust

Cumbria Partnership NHS Foundation Trust

Greater Manchester West Mental Health NHS Foundation Trust

Hertfordshire Partnership NHS Foundation Trust

Humber NHS Foundation Trust

Lincolnshire Partnership NHS Foundation Trust

North Essex Partnership Foundation Trust

SLAM

Somerset Partnership Trust

South Essex Partnership Trust

South London and Maudsley NHS Foundation Trust

Tavistock and Portman NHS Foundation Trust

Non-NHS organisations

British Psychological Society

European Society for Trauma and Dissociation

Social Networks

The Association for Cognitive Analytic Therapy

The Association for Cognitive Analytic Therapy -South

The Pottergate Centre for Trauma and Dissociation

Word of mouth

Appendix D - Southampton University Ethical Approval

Email from Southampton Ethics and Research Governance (ERGO) confirming ethics approval:

From: ERGO [ergo@soton.ac.uk]

Sent: 28 February 2013 13:51

To: Stokoe N.

Subject: Your Ethics Submission (Ethics ID:5503) has been reviewed and approved

Submission Number: 5503

Submission Name: Determining how Therapists Make Sense of Dissociative Identity Disorder. A Study of DID Formulation in Clinical Practice

This is email is to let you know your submission was approved by the Ethics Committee.

You can begin your research unless you are still awaiting specific Health and Safety approval (e.g. for a Genetic or Biological Materials Risk Assessment)

Comments

1.Good luck with your project

Email from Southampton Ethics and Research Governance (ERGO) confirming their agreement to act as the Research Sponsor for the project:

From: ERGO [ergo@soton.ac.uk]

Sent: 08 July 2013 09:02

To: Stokoe N.

Subject: New note/attachment to your ethics submission (Ethics ID:6942)

Submission Name : Determining how Therapists Make Sense of Dissociative Identity Disorder. A Study of DID Formulation in Clinical Practice (Amendment 3)

Submission ID : 6942

A note has been added to your ethics submission

Comments : I am writing to confirm that the University of Southampton is prepared to act as Research Sponsor for this study under the terms of the Department of Health Research Governance Framework for Health and Social Care (2nd edition 2005). We encourage you to become fully conversant with the terms of the Research Governance Framework by referring to the Department of Health document which can be accessed at: http://www.dh.gov.uk/en/Aboutus/Researchanddevelopment/Researchgovernance/DH_4002112 If your study has been designated a Clinical Trial of an Investigational Medicinal Product, I would like

to take this opportunity to remind you of your responsibilities under Medicines for Human Use Act regulations (2004/2006), The Human Medicines Regulations (2012) and EU Directive 2010/84/EU regarding pharmacovigilence If your study has been designated a \'Clinical Investigation of a Medical Device\' you also need to be aware of the regulations regarding conduct of this work. Further guidance can be found: http://www.mhra.gov.uk/ The University of Southampton fulfils the role of Research Sponsor in ensuring management, monitoring and reporting arrangements for research. I understand that you will be acting as the Principal Investigator responsible for the daily management for this study, and that you will be providing regular reports on the progress of the study to the Research Governance Office on this basis. Please also familiarise yourself with the Terms and Conditions of Sponsorship on our website, including reporting requirements of any Adverse Events to the Research Governance Office and the hosting organisation. If your project involves NHS patients or resources please send us a copy of your NHS REC and Trust approval letters when available. Please also be reminded that you may need a Research Passport to apply for an honorary research contract of employment from the hosting NHS Trust. Both our Terms and Conditions of Sponsorship and information about the Research Passport can be found on our website: http://www.soton.ac.uk/corporateservices/rgo Failure to comply with our Terms may invalidate your ethics approval and therefore the insurance agreement, affect funding and/or Sponsorship of your study; your study may need to be suspended and disciplinary proceedings may ensue. Please do not hesitate to contact this office should you require any additional information or support. May I also take this opportunity to wish you every success with your research.

ERGO : Ethics and Research Governance Online

http://www.ergo.soton.ac.uk

Appendix E - Participant Information Sheet and Consent Form

UNIVERSITY OF Southampton
School of Psychology

Participant Information Sheet

Version 3 (07/07/2013)

Determining how Therapists Make Sense of Dissociative Identity Disorder. A Study of DID Formulation in Clinical Practice

You are being invited to take part in an interview to understand your experience of making sense and formulating the presentation of Dissociative Identity Disorder (DID). This will enhance our current understanding and knowledge of DID and ultimately support other therapists in their practice by sharing the outcomes. Before you decide whether you would like to participate, please take some time to read the following information.

Talk to others about the study if you wish and please ask us if there is anything that is not clear or if you would like further information.

Why are we interested in understanding your experience of working with adults with DID?

We are interested to find out how therapists make sense and formulate the presentation of DID. We hope to understand the essential features of this presentation with the aim of bringing this information together in a coherent and structured way to share with others. It is hoped that the findings of this study will help lay the foundation of future research.

Why have I been chosen?

You have been chosen because you have worked therapeutically with an adult with DID for at least 3 months and indicated that you would like to participate in an interview in an online survey you completed.

Do I have to take part?

No! Not at all. It is completely up to you whether or not you would like to take part.

What do I need to do if I decide to take part?

I will be asking you to take part in an interview that will take approximately 1 hr. I will be asking you to answer questions about your experience of working therapeutically with a person/people with DID and how you made sense of this presentation for your therapeutic work. I will be digitally voice recording your interview so that I can transcribe and then analyse our conversation later. By the time you are reading this, we will have arranged a time to meet for the interview and you will be reading this in preparation. All you need to do now is complete the consent form if you are happy to take part which I will collect at your interview. If you change your mind and decide that you no longer wish to take part, please get in touch using the contact details at the bottom of this form to cancel or postpone.

Confidentiality and storage of information/data

The information you provide will be made anonymous for sharing following the interview. The voice recording will be transcribed following the interview to make it completely anonymous and then the recording will be destroyed. The voice recording will be saved as encrypted data on a secure network that is password protected within 24 hours of your interview and will be destroyed as soon as it has been transcribed. Direct quotes from your interview may be used from your interview but these will be anonymous and any identifiable data removed. The only person who will have a record of who has taken part will be the researcher (Nicole Stokoe). The only time anonymity will be broken is if there is a disclosure that suggests there is a serious risk of harm to yourself or to others.

Disadvantages and Benefits of taking part

It is not expected that there will be any disadvantages to taking part but please do get in touch with either myself or the two supervisors of the project if you have any concerns, worries or problems relating to the project.

The benefits of taking part will be your contribution to the development and improvement of our understanding of the presentation of DID. It is hoped that this research will provide a springboard from which other research can be launched so that this presentation can be better understood and effective treatment approaches identified. Ultimately, it is hoped that the outcomes of this study will support therapists in their work with people with DID.

What if there is a problem?

Any compliments or complaints you have about the study will be addressed. Please contact either myself or the supervisor to the study (contact details below).

Contact details

Nicole Stokoe

Trainee Clinical Psychologist

University of Southampton

ns25g11@soton.ac.ul

Lusia Stopa

University of Southampton

l.stopa@soton.ac.uk

Thank you for taking the time to read this information.

UNIVERSITY OF Southampton
School of Psychology

Consent Form

Determining how Therapists Make Sense of Dissociative Identity Disorder. A Study of DID Formulation in Clinical Practice

I have read the information sheet and have had the opportunity to discuss it/raise any questions and I understand the contents. Based on the information I have received:

	Please initial in the boxes below to indicate agreement with the statement
I confirm that I have read and understand the information sheet dated 07/07/2013 (version 3) for the above study and have had the opportunity to ask questions.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	☐
I understand that the interview will be voice recorded and that this voice recording will be destroyed once it has been transcribed.	☐
I understand that direct quotes from my interview data may be used but that these will be anonymous and all identifiable data removed.	☐
I agree for the information gathered from my participation to be included in the above name study.	☐
I understand that the information I share will be anonymous with only the lead researcher (Nicole Stokoe) having access to identifiable data. However, if I share information that raises significant concerns about risk to myself or to others, I give permission for this information to be shared with others as appropriate to manage the identified risk safely.	☐

Participant Signature:……Date:…… Print name: ……

Researcher's Signature:……..Date:…… Print name:…….

Appendix F - Semi-structured Interview Outline

Introduction

The interview aims to understand the presentation of Dissociative Identity Disorder, what the key features of the presentation are and how this differs and is similar to working with other mental health presentations in terms of presenting difficulties and the therapeutic processes experienced.

The interview is expected to take between 1 to 2 hours. There are seven key questions outlined for the interview that aim to facilitate discussion. However, if you have any experiences or information you would like to share that you feel would be helpful in developing our understanding of DID, please feel free to talk about this at any point. I will also ask at the end if there is anything further you would like to share as part of the interview that hasn't been discussed already.

Interview Questions

Questions about your experience of DID

- How do you, as a therapist, understand DID?

- What are the key themes that stand out for you?

- What stands out as being different for a person with DID compared to other presentations you have worked with? What differentiates a person with DID to other dissociative experiences?

- How do you describe DID?

In preparation for the interview I asked you to look at the Cognitive-Behavioural Model of Dissociation.

- What were your initial thoughts and reactions to this model?

- Do you think this represents the experience of dissociation and DID from your personal experience of working with people with DID?

- Do you think this could be expanded, changed, or described differently to help communicate the information for effectively?

- Are there any particular metaphors, images, descriptions or models (we haven't covered already) that you find helpful in communicating this presentation?

Questions about therapy and DID

- What have you found are the main challenges of working with people with DID?

- Think about how working with this client group may be different to other client groups you work with.

- What are the main challenges for the therapist? What is the impact on the therapist?

- What are the main challenges for the client? What is the impact on the client?

- What do you think are the rewards of working therapeutically with a person with DID?

Think about how this may be different to the rewards gained from working with other client groups.

- What do you think would be helpful for therapists working with clients with DID?

- What types of information would be helpful?

- What types of support would be helpful? Is there any specific training or knowledge that you think is needed?

- Finally - Is there anything else that you think would be useful to share for understanding the experience of DID and therapy?

Appendix G - Online Survey Questions

Section 1 – About You

1.1What is your gender? (M/F)
1.2How did you hear about the study? (multiple choice including 'other' option and open text box)
1.3What is your profession? (multiple choice including 'other' option and open text box)
1.41.4 How many years experience do you have as a therapist? (to nearest year since starting training qualification or having own case load).
1.5Has the majority of your professional career been working in:
1.5.1National Health Service
1.5.2Private Practice
1.5.3Both
1.5.4Other
1.6Which client group do you currently work with?
1.6.1Working age adults
1.6.2Older adults
1.6.3Child and adolescent
1.6.4Learning disability
1.6.5Other

Section 2 – Your Knowledge and Ways of Understanding Dissociative Identity Disorder (DID)

2.1 Would you be able to describe some of the features of Dissociative Identity Disorder (DID)? (If answered 'yes', two further questions opened up).
2.1.1 What do you think are the features of DID? Please describe up to 6 features using the boxes below.
2.1.2 What do you feel is the main key feature of DID?
2.2 Have you found using model/s helpful for understanding the presentation of DID? (yes/no – none of the available models are helpful/no – I have not used a model before)
2.3 Even if you have never experienced working with someone with DID, which therapeutic approaches would you be most likely to use if you were to work therapeutically with someone with this presentation? Please rank as many as appropriate. You do not need to rank all of them. (comprehensive list including 'other' option with open text box given).
2.4 Please briefly describe why you chose your top ranked option from question 2.3.

Section 3 – Working Therapeutically with Dissociative Identity Disorder

3.1 Have you worked therapeutically with a patient who had DID? (Yes/No/Possibly but I didn't realise they had DID at the time)
3.2 If participants answered 'yes' to question 3.1 the following question opened up:
What is the longest period of time you have worked therapeutically with an adult with DID? (options given)
You will be asked to described up to three examples of patients you have worked with who had DID.
Thinking of your first example, what were they referred to therapy for? (Options: DID/other presenting difficutly with text box)
Did you work therapeutically with this person for the reason they were referred?
Which therapeutic approaches did you use to work with this patient? (Please state the approaches and briefly describe why you chose to use them).
Participants were asked to give up to three examples of patients they had worked with.

Section 4 – Training and Supervision in Dissociative Identity Disorder

4.1 Have you received training and/or supervision that has been relevant to working with someone with DID (this may be directly or indirectly relevant).

4.1.1 If participants answered 'yes' they were asked to describe.

4.2 Is there anything you have read that has helped you to understand or treat people with DID?

4.3 Has anything else prepared you (apart from training and reading) for working with people with DID?

Section 5 – Research Participation

5.1 Would you be interested in taking part in a qualitative interview to talk about your experience of working with patients with Dissociative Identity Disorder? (Yes/No)

Participants who answered 'yes' were asked to provide contact details.

5.2 Would you like to receive a summary of the study when it is completed? (Yes/No)

Participants who answered 'yes' were asked to provide contact details

Appendix H - Coding Example

Extract from Participant K's interview transcript

64 65 66 67 68 69 70	T	I think that's a fascinating question and I also think that applies to a whole range of presentations. So I often wonder why, for example, somebody with a urr history of urrr disrupted attachments errr one person with a history of disrupted attachments may develop personalities difficulties, somebody else may develop psychosis and somebody else may develop DID. I suspect it's may be a combination of the nature of the trauma and the individual differences between people. But I think generally cognitive behavioural models tend to be good at describing but not necessarily explaining causal links between history and current presentations. And I guess that's one way of saying that I don't know.	The question to be answered – why does DID develop rather than other presentations? (203) Why DID – combination of the nature of trauma and individual differences. ?Nature V nurture? Predisposition (4) Trauma (54)
71 72	R	Yeah and I guess as you were saying you having quite limited experiences so it's just based on the experience you have had and the sense you made at that time.	
73 74	T	Absolutely. I guess what I would say is that the trauma histories that the two people I have worked with are very extreme and quite shocking. Errrrm yeah.	Extreme trauma histories (54) Shocking trauma histories
75 76	R	So you found it quite shocking [t: yes] to hear their stories. [t: yeah] And how did you find that as a therapists? Hearing about that kind of trauma?	
77 78 79	T	I found it and find it, as one of the people I'm working with at the moment, really quite disturbing urrm and yeah as I say, quite shocking. Some of the information that is passed on is it just hadn't occurred to me and I don't think of myself as particularly naïve urrm yes, as alarming and very disturbing to hear	Disturbing trauma history (54) Shocking trauma history Alarming and disturbing for the therapist to hear
80 81 82	R	You say, you describe it as disturbing. So I guess that work brings this idea of a change or something has been moved in you. Have you noticed any differences in yourself in, I don't know, how you view the world, or how you view others since experiencing these clients?	
83 84 85 86 87 88 89	T	Mmmm. Errm I suppose I urrm more aware of some of the more extreme forms of systematic abuse that occur than I was previously. I guess previously I may have had a vague sense that, for example, ritualised abuse may occur but wouldn't necessarily have had or wanted to know, urr much of the detail of that. Urrm. And now I am aware of some of that. Urrrm and frankly I'd rather not be. Urrm. But yes, I think, telling, within safe limits, safe boundaries so that it, it, so that the process doesn't become ruminative urrm I think telling, people being able to tell their story and knit together a narrative coherence is probably very important therapeutically. So as therapists we probably do need to hear that. Um, Yeah.	Extreme systematic abuse (54) Ritualised abuse Therapist not really wanting to know (230) Sharing trauma stories in safe and boundaried environment (141) Not becoming ruminative Coherent narrative/clothes line (22)

90 91 92	R	You said urrr knitting together the narrative to get some coherence. Is that something you feel they didn't have before therapy? [t: yes yes]. And that's, is that part of your understanding of the presentation? Not having that coherence?	
93 94 95 96	T	Yes I think so. Yeah. So that, that fragmentation of experience or disconnection of states of mind urrm I think is extremely shocking and disturbing to the individuals themselves and I think part of the therapeutic process is to make sense of what's happening day to day, minute by minute, moment by moment. So that person can take that overview and be able to understand their experience even if it does remain quite extreme.	Fragmentation of experience (23) Disconnection of states of mind Disturbing and confusing for the individual (95) Sense making (162) Taking an overview/taking a step back (277)
97 98	R	Okay. So I've got a kind of sense of where you feel the presentation develops from and extreme trauma in childhood or just earlier? Or just any time it can occur?	
99 100 101	T	I don't, I don't know. I assume that it would probably be need to be disruptive of core developmental processes for people to be so urrr disruptive to people to adults ability to function in the world in any coherent way. Urrm Yeah. So early, early development disruption of the early development I assume?	Disruption to core developmental processes (79) Adult's ability to function (288) Early developmental disruption (1)
102	R	And early? How early were you thinking?	
103	T	I don't know, I would have to go back and look at my development! But probably pre 3? 2?	Pre 3 years old? 2 years old?
104	R	Okay, so yeah really young?	
105	T	I assume so but yeah, I'm not sure. I, I'd need to go back and think about that more probably.	
106 107 108 109 110 111	R	And you talked about early attachment so I guess that would link in with that kind of age as well [t: yes, yes] And the word extreme has come up a few times. So like extreme trauma and then the extreme nature of their presentation as well. In terms of on that continuum of dissociation being right on the end of DID. You talked a little bit about the impact that it's had had on you. And I guess hearing about things that if you had realised, you wouldn't have wanted to hear about Have you noticed how it has affected you day to day or has it not affected you in that way?	
112 113 114 115	T	I feel quite exhausted after I've seen these individuals. Well I'm only seeing one person currently so after I've seen her. And just a bit overwhelmed by it really. I tend to see her at the end of the day which is probably a bad idea. Errm and often there isn't, there aren't many people around when I finish seeing her. Which again I probably need to do something about.	Therapist feeling exhausted after session. (147) Overwhelmed Needing people around after session. Support (269)
116	R	Is that important to have people around afterwards do you think?	
117	T	I think so. I certainly recommend it to other people [r: okay] but don't necessarily follow that myself.	
118	R	And what do you think is helpful about having other people around?	
119 120 121 122	T	I think just being able to have a brief off-load really and urr debrief. Urrm In a way that I don't necessarily feel the need for with other people with other presentations. Urrm And I think it challenges your assumptions about the world. And… the broadly, if one assumes that people around us are broadly benign, it challenges that.	Offloading after session (269) Different to other presentations Challenges therapist's assumptions about the world (246)

123	R	What do you mean by benign?	
124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140	T	I think I, I, I do assume that people generally well intentioned and benign and do not intend to harm other people. urrm And so hearing urr in some detail about the harm that has been done especially to quite young children is quite awful to hear and makes me wonder how prevalent this might be. And whether my assumptions about other people generally are if not mistaken, then maybe too general. [r: yeah] But I think another thing about DID for me is the level of urrr suspicion that creeps in to every level of work. I've noticed. So, [*coughs*] I've noticed that the wider team is or, or, or quite a number of the wider multidisciplinary team is quite suspicious if not disbelieving of some of the things that this particular person who I'm seeing at the moment has said. I'm also aware that sometimes I've sat in session and think 'Really? Really? Is that the case?' I'm not assuming that she's making things up but I do wonder whether that is really the case and whether ideas or fantasies or different experiences have been conflated or misremembered or experienced at such an age that it seems that it's completely overwhelming or that everybody is harming her or had harmed her when possibly it wasn't everybody in the system. So I'm,… she's suspicious of me understandably. Urrm I'm sometimes questioning what she's saying. In my mind. The wider team are suspicious of her too. [r: yeah] Urrrm and I even noticed that suspicion come through in supervision sessions. urrr Where in group supervision sessions where some people would be questioning the validity of what was being said. And a group supervision session with a lot of experience of DID errrr where people would question that person's opinion as well. So it seems to creep into the system at every level that, yes, is quite unnerving really.	Belief that people are well intentioned. Challenge to world view (246) Awful to hear Assumptions are found to be mistaken (246) Suspicion. Being believed. (165) Team becoming suspicious or disbelieving (199) Really?? Making things up/fantasies Conflated/misremembered – not being believed (163) Completely overwhelming Suspicious of therapist – trust (140) Suspicion seeping out into other areas – supervision Challenge to the therapist's integrity (199)

Appendix I - Example Major Category

Major Category	Category	Sub-category	Focused Code
The Rationale Describing why DID develops	The developmental Context	Predisposition	Predisposition to dissociation
			Internal dissociation mechanism
		Significant Childhood Trauma	Significant childhood trauma or abuse
			Purposeful or Non-purposeful
			Response to overwhelming trauma
		Vulnerability and Powerlessness	Early childhood
			Vulnerability, powerlessness and fear
		Powerful and Controlling Others	Manipulation
			Invalidation
			Powerful and controlling others
	Adaptations to trauma	Alterations to Attachment	Disruption to healthy attachment
			Attachment for survival
		Disruption to memory	Psychological coma/amnesia
			The choice of memory
			Unconscious defence
		Internal Separation of Self	Compartmentalising of the mind
			Fragmentation
			Development of different roles/identities/personalities
	The Necessary Coping Strategy of DID	Survival Technique	Survival mechanism
			Creating safety
			Early coping template
		Protection Against the Intolerable	Dissociation as the child-minder of traumatic material
			Protection mechanism
			Response to minimise the impact of trauma
			Adaptive in original context

Appendix J - Reliability Criteria

Sensitivity to context:

- *Knowledge of the literature and current contextual influences*; these support the researcher in their understanding and interpretation of the data. The theoretical context of this research has been outlined in the introduction and some of the considerations for the clinical context have been outlined in the survey data obtained (section 2.6.1).

- *The socio-cultural context of the study setting:* As outlined in the systematic literature review and summarised in the introduction of this paper, there has been substantial controversy around the presentation of DID. More recently evidence has demonstrated some challenging results for those who doubt the authenticity of this diagnosis.

- *The context of the relationship between the researcher and participants.* The research participants for this research were specialists in their field who volunteered to participate. My role as a Trainee Clinical Psychologist, and a novice in the area of DID meant that my research participants were in the more powerful position of the relationship dynamic. This reassured me that participants were volunteering freely to take part in the interviews and would be able to voice any concerns they had about the research.

Commitment and Rigor

This refers to the commitment of the researcher to data collection and analysis in order to ensure that the data collected is comprehensive and representative of the potential data pool and that the interpretation of this data is complete, going beyond simply describing the content of the interviews. Data was collected from experts in the field using a parallel

approach with the aim of working towards an acceptable level of data/content saturation. The interpretation and analysis of the data was then compared to current understanding in the literature. Research participant validation was invited by requesting participant reflections and feedback at each stage of the process to ensure that their views and understanding were represented faithfully.

Transparency and Coherence

All research is potentially biased by the researcher's own beliefs, values and world view. This can impact every stage of the research process (Stiles, 1993). Qualitative research values the explicit understanding of these biases, encouraging the researcher to be transparent about their world view, their role within the research and greater context. No researcher is without bias and therefore the process of reflexivity is crucial. Reflexivity is the process of examining one's effect as a researcher on the research process (Stiles, 1999; Yardley, 2000). For the purposes of this research a reflective diary was maintained throughout the research process and a self-reflexive bracketing interview was conducted with a colleague to facilitate personal reflection in order to ascertain my position in relation to the research topic.

Coherence refers to the "apparent quality of the interpretation" (Stiles, 1993, p.608). As part of the process of the research, participants were asked to feedback at key stages of the research including the interview stage, transcription, development of themes and final write up. Coherence also relates to the validity of choice of methodology in the context of the research aims. The choice of CGT approach was outlined and discussed in section 2.4.1.

Impact and Importance

Research should add meaningfully to the literature base. DID is an under-researched and poorly understood presentation, posing a particular challenge to clinicians for whom there

is little guidance at present. This was supported by research participants who reported finding the research interesting but also would be integral to their clinical practice.

Appendix K - List of Tables for Survey Data

Gender of survey participants

Gender	No.
Female	107
Male	22
Did not state	9

Therapeutic orientation of participants

Therapeutic Orientation	No.
Clinical Psychologist	78
Psychotherapist	24
CBT Therapist	13
Therapist other	6
Counsellor	5
CAT Therapist	4
Mental health nurse	3
Trainee Clinical Psychologist	3
Psychiatrist with therapy specialism	2

Organisation of therapeutic practice of participants

Organisation	No.
NHS	109
NHS & Private	17
Private	5
NHS & Charity	2
Private & Charity	2
Academic	1
Charity	1
NHS & Academic	1

Length of therapeutic intervention with clients with DID

Length of therapy	Frequency
Less than 3 months	5
Between 3 to 6 months	1
Between 6 months to a year	8
More than a year	13
More than two years	4
More than 3 years	7
Four years plus	12
Did not state	1

Appendix L - DSM-V Diagnostic Criteria for Dissociative Identity Disorder

Diagnostic and Statistical Manual of Mental Disorders DSM-5 (300.14) criteria for Dissociative Identity Disorder

A. Disruption of identity characterized by two or more distinct personality states. This involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and sensory-motor functioning.

B. Amnesia is defined in the DSM-5 as recurrent gaps in the recall of current, everyday events that go beyond ordinary forgetting.

C. The symptoms cause clinically significant distress or impairment in important areas of functioning.

D. Religious practice is omitted, as is normal fantasy play in children.

E. Physiological effects from a substance are omitted. (DSM-5 2013)

Appendix M - DSM-V Diagnostic criteria for Post Traumatic Stress Disorder

DSM-IV criteria for PTSD

Criteria	Title	Description
A	Stressor	Client was directly or indirectly exposed to a traumatic experience: death, threatened death, actual or threatened serious injury, actual or threatened sexual violence.
B	Intrusion	The traumatic event is persistently re-experienced for example through recurrent, involuntary and intrusive memories, recurrent distressing dreams, dissociative reactions, intense or prolonged distress after exposure to traumatic reminders, marked physiologic reactivity after exposure to trauma-related stimuli.
C	Avoidance	Persistent effortful avoidance of distressing trauma-related thoughts or feelings
D	Negative alterations in cognitions and mood	Negative alterations in cognitions and mood that began or worsened after the trauma including an inability to recall key features of the trauma (usually seen as dissociative amnesia) and persistent negative trauma-related emotions (e.g. fear, horror, anger, guilt, or shame.)
E	Alterations in arousal and reactivity	Trauma-related alterations in arousal and reactivity that began or worsened after the trauma including irritability, self-destructive behaviours, hypervigilance, exaggerated startle response, problems in concentration and sleep disturbance.
F	Duration	Persistence of symptoms for more than one month
G	Functional significance	Significant symptom-related distress or functional impairment (e.g. social, occupational)
H	Attribution	Disturbance is not due to medication, substance use, or other illness.
Specify	With dissociative symptoms	Client experiences high levels of depersonalisation or derealisation
Specify	With delayed expression	Client does not meet full diagnosis until at least 6 months after traumatic experience.

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