

## Article 10

### **Stories of Survivors With Dissociative Identity Disorder: A Qualitative Investigation of Symptoms, Traumatic Experiences, and Relationships**

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#### **Abstract**

Individuals diagnosed with dissociative identity disorder (DID) experience both challenges and advantages in their intrapersonal (e.g., relationship to self) and interpersonal (e.g., relationship to others) relationships. However, limited research focuses on survivors of DID and their subjective experiences of their relationships with self and others. Thus, this study examined individuals diagnosed with DID ( $n = 12$ ) and their perspectives on symptomology, self-disclosing their diagnosis, and the impact of surviving DID in relationships. Results identified several areas describing the DID phenomenon including symptoms, abuse and trauma history, consequences of diagnosis disclosure, and coping mechanisms.

*Keywords:* dissociative identity disorder, subjective experiences, classical content analysis

The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013) describes dissociative identity disorder (DID) diagnostic criterion as a disruption in personality resulting in at least two personality states, in which the following occur: (a) the personalities take control of the individual's behavior and (b) the individual experiences an inability to recall important

information. These various personality states often exhibit different experiences, characteristics, and conditions across several domains including: (a) physical health, (b) emotional health, (c) gender identity, (d) sexual orientation, (e) thoughts, (f) feelings, and (g) behaviors. For the purpose of the current study, the term *alter* refers to any personality state beyond an individual's core disposition in which the alternative personality takes control and the individual's core identity loses time. In addition, the term *survivor* stems from a strength-based framework and highlights that someone with a DID diagnosis is not merely a victim of trauma, but a survivor.

Individuals diagnosed with DID account for less than 2% of the general population (APA, 2013). Of these cases, research suggests that development of multiple identities begins at an early age, although symptoms may not be recognized until a later time (APA, 2013). Foote, Smolin, Kaplan, Legatt, and Lipschitz (2006) found that approximately 71% of clients with DID experienced childhood physical abuse and 74% experienced sexual abuse. DID prevalence rates increase in trauma-related populations, strongly suggesting that dissociation may be linked to traumatic experiences (Cohen, 2004). Though DID survivors account for a small portion of the population, the extreme trauma accompanied with the diagnosis makes it an important population for clinicians to be aware of, and to have knowledge of appropriate treatments.

### **Research on DID Signs and Symptoms**

Since the early 1980s, researchers and clinicians focused on understanding DID symptoms, characteristics, and diagnostic criterion. Despite professional skepticism regarding the credibility of the DID diagnosis, consistent scholarship has provided support for its symptomatic criteria (e.g., Putnam, Guroff, Silberman, Barban, & Post, 1986; Rothschild, 2009). For example, Putnam and colleagues (1986) reviewed 100 cases and concluded that “there is a stable set of core symptoms and behaviors found in MPD [multiple personality disorder] patients” (p. 292). However, little attention was focused on treatment of DID until at least a decade later.

In the early 1990s, the focus of research shifted to effective treatment of DID. Ross (1997) found that practicing clinicians often consider clients diagnosed with DID to be the most disturbed individuals among those who seek the services of mental health professionals. In doing so, counselors and helping professionals appeared to view survivors of DID within a pathological framework. However, for counselors working with survivors of DID and witnessing treatment progress, clinicians reported that the survivors' symptoms remained treatable (Ross, 1997). In order to promote positive outcomes, clinicians must guide treatment with an understanding of DID and the major historical developments in treatment effectiveness. The complex details of the personality system often overwhelm counselors who lack an effective framework, and survivors of DID reveal the many inadequacies in the current counseling profession. Some of these inadequacies stem from counselors gaining misinformation through media and unreliable resources. In the past decade, limited research exploring the lives of DID survivors post-treatment, while they are trying to adjust to life outside of hospitalization, has highlighted a need to further explore the relational experiences of survivors of DID.

## **Intrapersonal and Interpersonal Experiences of Survivors of DID**

Once diagnosed, the DID client must interface with the world, not only professionally and personally, but also socially. Yet, media driven misperceptions about DID create many challenges for survivors. Societal misperceptions include false beliefs related to (a) overall functioning, (b) intimate relationships, and (c) quality of life (Bryne, 2001; Fox, Bell, Jacobson, & Hundley, 2013). Furthermore, living with DID may create inner chaos and personal challenges that are difficult to overcome while also combating external societal misperceptions. In order for survivors with DID to decrease chaos in their lives and improve relationship functioning, alters need to communicate and cooperate with one another toward an overall goal for the individual. To increase communication and overall daily connections with alters, clinicians can encourage DID survivors to strengthen self-awareness through reflection on intrapersonal interaction between alters (Middleton, 2005; Rothschild, 2009). However, little research exists (e.g., Fox et al., 2013) on the subjective experience of survivors of DID who are not currently hospitalized or in a state of crisis, or on self-reports regarding how diagnosis and treatment affect their overall quality of life. Horvath and Bedi (2002) found that exploring the client's perspective about counseling directly influenced treatment outcomes; yet most research studies about DID focus on the psychopathology perspective rather than lived experiences (e.g., Brand et al., 2013). Thus, the purpose of this study was to obtain descriptive perspectives of survivors with DID, who are not currently hospitalized, and examine their relational experiences through the lens of a DID diagnosis (i.e., relationship to self and others).

### **Method**

This study utilized a classical content analysis (Hsieh & Shannon, 2005; Leech & Onwuegbuzie, 2007) approach to collecting and analyzing data. According to Hsieh and Shannon (2005), classical content analysis is a widely used qualitative methodology for researchers "whose aim is to describe a phenomenon" (p. 1279). Therefore, the nature of classical content analysis is consistent with the goal of this study, which is to describe the lived experience of survivors with DID. Upon institutional review board (IRB) for human subjects approval, the researchers utilized a critical case sampling method to recruit participants in the study. Each participant completed an informed consent indicating the purpose of the study, anonymity, and the right to refuse participation. Additionally, the researchers discussed the sensitive nature of the questions and addressed the potential for a strong reaction to some of the questions. Finally, the researchers used semi-structured interview questions while conducting one focus group to address the following research questions: (a) What are the interpersonal experiences of survivors with DID? (b) What are the intrapersonal experiences among survivors with DID? (c) What are the misconceptions about survivors with DID?

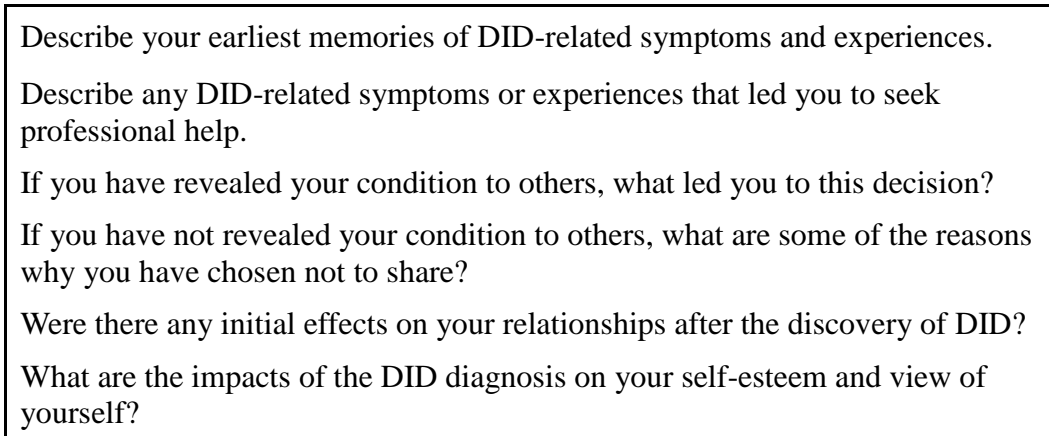
### **Sampling**

We used a critical case sampling method to recruit participants to focus on a small number of participants in order to gain specific information from survivors of DID (Creswell, 2007). The sampling method and size is consistent with phenomenological approaches in qualitative research, which suggests the need for a minimum of 12

participants when conducting this type of research. Thus, we utilized a purposive sampling method and recruited 12 participants, from various places in the United States, who have experienced the phenomenon of DID (Creswell, 2007). The focus group interview took place in a Southeastern professional organization meeting.

### **Data Collection**

Data was collected in a focus group format. The focus group remains a frequently used data collection method in clinical settings (Hays & Singh, 2012) and among qualitative researchers. We used a phenomenological-based interviewing strategy to collect data in one focus group. This method provided the participants an opportunity to re-construct their life experiences in the context of living with DID. Therefore, the interview was focused on a broad view of what the lived experience is like for a survivor with DID and not limited to certain subjective experiences. At the same time, focus group questions did address some specific areas of functioning (e.g., diagnosis, intra- and interpersonal dynamics) and addressed the following topics: (a) early memories of DID symptoms and experiences, (b) help-seeking experiences and diagnosis onset of DID, and (c) self-disclosure in relationships about DID diagnosis (Figure 1). Three researchers conducted a focus group using probing questions as a method of building rapport and encouraging participants to elaborate on their responses to open-ended questions (Hsieh & Shannon, 2005). The focus group was audiotaped, transcribed, and decoded through a data analysis process that is described in the following section.



Describe your earliest memories of DID-related symptoms and experiences.

Describe any DID-related symptoms or experiences that led you to seek professional help.

If you have revealed your condition to others, what led you to this decision?

If you have not revealed your condition to others, what are some of the reasons why you have chosen not to share?

Were there any initial effects on your relationships after the discovery of DID?

What are the impacts of the DID diagnosis on your self-esteem and view of yourself?

Figure 1. Focus group questions.

### **Data Analysis**

We utilized Hsieh and Shannon's (2005) principles of classical content analysis, which is a six-step data analysis process consisting of the following: (a) identifying key concepts, (b) determining preliminary codes, (c) compiling a list of preliminary codes, (d) adding codes throughout data, (e) evaluating all codes throughout data, and (f) finalizing codes. Additionally, we created a code book of our analysis to organize and track the development of codes and sub-codes (Moretti et al., 2011). The four researchers conducted the data analysis by meeting weekly or monthly to discuss the coding process.

### **Threats to Validity, Verification Strategies, and Trustworthiness**

Glesne (2010) suggested techniques (e.g., peer debriefing and triangulation) to promote trustworthiness and credibility in qualitative research. For the purpose of this study, the researchers used triangulation of researchers (i.e., investigator triangulation; Leech & Onwuegbuzie, 2007), to ensure inter-rater reliability during the coding process and to increase the trustworthiness of the data collection and analysis. The focus groups were conducted by three researchers. Immediately following the focus group, the researchers discussed and reflected upon the information gathered during the interview, which facilitated the provision of input on and an external check of the research process (Creswell, 2007; Glesne, 2010). During data analysis, we added a fourth member of the research team who provided a perspective to the coding that was not directly influenced by participating in the interview itself. Thus, each researcher offered an interpretation of the data and compared the responses to those of the other researchers in order to obtain the most accurate analyses.

### **Ethical Issues**

A potential confidentiality concern of this study was the protection of participant identities during the presentation of findings. Given that the purpose for using classical content analysis design is to encapsulate the significant experiences (Seidman, 2006) among survivors with DID, there was a potential risk that the small sample could be identified if pertinent information (e.g., participant names, locations) were to be released. Therefore, to maintain confidentiality, the researchers have not disclosed any identifiable information about the recruitment process or the participants.

## **Findings**

The researchers identified several overarching themes from the data. Specifically, once the researchers completed the coding process, 10 themes developed as follows: (a) symptoms, (b) symptom onset, (c) abuse and trauma history, (d) at-risk behaviors, (e) identity discrepancies, (f) impairment, (g) societal and environmental perceptions of DID, (h) self-perception and attitudes, (i) generational history, and (j) coping mechanisms.

### **Sample Characteristics and Demographics**

The focus group participants completed a brief survey containing demographic variables and sample characteristics. Overall, the participants' mean age was 39. Participants identified their ethnic background as (a) Caucasian ( $n = 10$ ) or (b) Hispanic ( $n = 2$ ). Further, participants reported the following educational backgrounds including (a) some college education ( $n = 5$ ), (b) completed a bachelor's degree ( $n = 4$ ), (c) completed a master's degree ( $n = 1$ ), (d) obtained a doctorate ( $n = 1$ ), and obtained a professional degree ( $n = 1$ ). Participants reported the following about their self-identifying sexual orientation: (a) heterosexual ( $n = 5$ ), (b) homosexual ( $n = 2$ ), (c) bisexual ( $n = 4$ ), and (d) did not report their sexuality identification ( $n = 1$ ).

With regard to sample characteristics related to mental health diagnoses, the mean age of receiving a diagnosis of DID was 32 years old. In terms of psychiatric history, seven participants received a bipolar disorder diagnosis, three participants received a borderline personality disorder diagnosis, and all 12 participants were diagnosed with

schizophrenia. These results appear consistent with previous research on co-morbidity and mental health misdiagnoses of DID survivors (Sar, 2011).

### **Symptoms of DID**

Symptoms experienced by participants covered a broad range, including missing time or a skewed sense of time (i.e., blank spells; Ross, 1997), body dissociation, fluctuating emotions, apathy, anxiety, sleep disturbances, depression, mania, unhealthy eating behaviors, a sense of multiple identities or no identity, hearing voices, and experiencing visual hallucinations. Missing time was present across participants, with one participant giving this example:

I remembered at the end of the day, looking back on the day that I had sex with three different men . . . and it was just . . . I couldn't figure out if I really had sex with three different men. . . . If it, if I was dreaming or hallucinating, or did . . . could I possibly have done such a thing . . . and wasn't that awful and, oh my God, I better go get some help.

Individuals with DID experience a lifelong adaptation to chronic complex dissociative symptoms (Sar, 2011). Dissociative clients do not report delusional explanations for hallucinations. Rather, they tend to experience these symptoms as being inexplicable and frightening and as indicators that something is fundamentally wrong with them. Accordingly, they usually attempt to hide their alters in an effort to avoid negative stigmas.

### **Symptom Onset**

All, with the exception of one of the participants, experienced the onset of DID symptoms during childhood or adolescence. One of the focus group participants reported experiencing symptoms of amnesia and not remembering her kindergarten experiences at 5 years of age. When discussing symptom onset, another participant stated, "I was 11 years old, I had a teacher pull me aside and . . . she said out of her whole teaching career she has never met a child like me . . . she would say I would be one way and . . . just minutes later 'it's like you're a completely different kid.'" Some of the participants reported noticing symptoms later in their lives after age 20 that were triggered by a major life event (e.g., having their first sexual relationship or after giving birth).

### **Abuse Trauma History**

All participants reported an abuse history; participants reported abuse occurring either from within the family or from a perpetrator outside of the family. In addition, some participants identified perpetrators within and outside of the family system. However, the majority of sexual abuse perpetrators were close family members (e.g., father, mother, stepfather, sibling, male or female relative), which allowed the abusers to be in close physical proximity to the victim and increasing the chance of perpetuating the abuse.

The focus group participants discussed a strong theme of unresolved anger about and toward their abuser(s), as well as dealing with their repressed memories. One participant specified the following:

I also was . . . sexually assaulted when I was 16. . . . And it wasn't until about two months ago that I had my part . . . finally was comfortable with my therapist, that I told her about abuse when I was younger. So, never, ever, ever, did I have recollection of childhood sex, sexual abuse until I was in my therapist's office.

When speaking about abuse by close family members, one participant stated: "As far as family . . . the only family I have is my father, and my brother, and my mother. Two of which abused me. One knew about the abuse and didn't do anything about it." Thus the memories of the abuse history and the anger that often accompanies those memories, were sometimes brought into awareness during counseling.

### **High-Risk Behaviors**

Participants reported high-risk behaviors and self-harm concerns such as (a) suicidal ideation and attempts, (b) promiscuity, (c) substance abuse, (d) self-injury, and (e) unhealthy eating patterns. It was also not unusual that participants reported being amnesic about these types of behaviors and significant events, resulting in the survivor having no memory of the high-risk behavior. This process would sometimes culminate in participants coming to an awareness of an alter identity. For example, one participant stated:

And so there's been different times in my life where I've just obsessed with killing myself . . . you know, now I see as an alter that comes out and I'm like that's the essence of that alter, so . . . but I've had that for as long as I can remember.

Another participant's high-risk behaviors manifested in indiscriminate sexual relationships: "I was extremely promiscuous, um, in my teenage years and then did not understand until later in my twenties that that was a symptom of, um . . . long-term, ritualistic, uh, child sexual abuse."

### **Identity Discrepancies**

Beyond the typical multiple alter identity diffusion, participants also reported discrepancies such as a poor sense of identity or lack of a central identity, and sexual and gender discrepancies, such as alters with different sexual orientations and/or genders. One participant stated,

you know my system obviously was really good at fooling me and it certainly did feel like a whole day and, and things were just running and little did I know, it's three or four alters doing a day and I thought . . . then it's like all of a sudden the hamster wheel stops.

### **Impairment**

Three strong sub-themes emerged under *impairment*: (a) confusion/misdiagnosis, (b) relationship difficulties, and (c) professional difficulties. Participants highlighted the lack of knowledge related to DID, which many mental health counselors demonstrated and that often led to misdiagnoses such as bipolar disorder, borderline personality disorder, and schizophrenia. As one participant described her misdiagnosis,

I had been cutting myself, but I had no idea where the cuts were coming from. . . . I had no memory of ever cutting myself, so I sought therapy and I was diagnosed with depression. Then a little later when I was diagnosed with bipolar disorder . . . I had the misdiagnosis of bipolar disorder for 7 years before a therapist even realized that it was in fact DID.

In addition to the confusion of multiple misdiagnoses, participants also reported high levels of personal confusion that resulted from symptoms such as missing time and a lack of understanding of the illness they were experiencing. DID symptoms also contributed to personal and professional relationship difficulties. Some expressed frustration attributed to relational wounds from friends and family members who distanced themselves because of participants' symptoms and the loss of support that occurred following episodes of missing time or disclosing one's diagnosis. Professionally, some found it difficult to hold jobs long-term and form professional relationships:

for me it [the diagnosis of DID] was actually a very devastating thing to hear and I rejected it for . . . quite some time. It wasn't until, um . . . I think some parts of me accepted it, um . . . more quickly than others . . . because of the consequences of having to take off work, um, three months at a time, twice over the past year . . . that's been, that's been more of a blow to my self-esteem than the actual DID diagnosis, 'cause I think now that I have a diagnosis I'm actually making strides in terms of getting better and getting some of those symptoms that we talked about before under control. But, um . . . how it's affecting . . . um . . . um . . . for me I have . . . I don't get into relationships. You know, like intimate relationships other than having close friends. Um, you know not having children . . . never being married, um, and then these . . . um . . . having to stop my career over the past year twice. . . . I'm still on a leave . . . um . . . that's been more devastating and upsetting and kind of really, really messed up my self-esteem.

### **Societal Perception of DID**

Several category sub-themes covered the larger category of societal perceptions of DID and those living with DID. These included the lack of detectability to others, lack of support and understanding (i.e., friends and family doubting the DID diagnosis or minimizing symptoms), media portrayal of DID, and attributing the DID diagnosis to character traits. Participants compared the relatively unrealistic media portrayals of DID, with their extreme dramatization of DID symptomology, with the actual experience of friends and family not knowing their diagnosis, but more often considered them moody or high-strung. One participant reported:

and I can't articulate it and so all I know is people think Sybil and I don't . . . I'm in a profession where I'm trained and teaching people. I can't, you know, and I'm trying to get customers . . . 'I want you to pay me to serve . . . you know, to train you and stuff.' And so I can't be letting people think that I'm going to be talking French all of a sudden like Sybil you know. I need to be seen as professional and that I've had depression and those kind of things but I can't let it be known that it's DID and it's . . . it's really hard.



Another participant described the lack of support from family related to her diagnosis:

I have a twin sister who won't have . . . won't at all talk about it with me and completely rejects the idea . . . out of fear is my guess, and then I've also had the response of, 'It can't be true. This is not right. You're being . . . actually being coerced into believing this . . .' and that's really hurtful so I've kinda backed off from telling people.

### **Self-Perception**

The way one views oneself, or self-perception, was reported by participants as an area impacted by living with DID. Focus group participants identified reduced self-esteem as a byproduct, often coupled with a fear of rejection, a desire for the acceptance of others, and a desire for self-acceptance. For some, they reported that the lack of research and scholarly resources about living with DID contributed to more identity confusion and lack of a clear self-perception. For others, however, the DID diagnosis increased their clarity about their symptoms and experiences, and instilled hope for a better future.

### **DID as a Coping Mechanism**

Many of the participants reframed the negative experience of having DID by praising the mind's ability to protect itself and cope with the trauma and abuse experienced in childhood. Participants also discussed an ability to be "super multi-taskers" and perform several functions at once. Several participants credited their ability to dissociate with their success at work. When commenting on her experiences, one participant stated:

it's such a positive sense of survival and the beautiful, creative thing our brains can do to keep us alive, and I would not have got through school and, you know, raised my kids the way I did and done the things I've done without it. I honestly think I would have self-destructed and died.

Another participant stated simply: "I was taught that to have DID was really a gift." It is clear from these descriptions that DID was viewed as a valuable coping mechanism and potentially enhanced their performance by enabling them to remain resilient during difficult circumstances at home and at work.

## **Discussion**

In this study, 12 participants were interviewed in a focus group to develop a phenomenology of DID. The researchers identified several themes in the data that describe the subjective experiences of survivors of DID, including: (a) symptoms, (b) symptom onset, (c) abuse and trauma history, (d) at-risk behaviors, (e) identity discrepancies, (f) impairment, (g) societal and environmental perceptions of DID, (h) self-perception and attitudes, (i) generational history, and (j) coping mechanisms. These themes presented as constructs associated with the symptomology, internal beliefs, and experiences of survivors of DID. Further, these themes describe the lived experience and includes the external and internal characteristics of coping with DID.

In regard to symptoms and symptom onset, the results of the current study identified similar findings when compared to past research. Individuals with DID and

related forms of childhood onset complex dissociative diagnoses experienced a lifelong adaptation to chronic complex dissociative symptoms. For example, these individuals may only realize in later life that not everyone has amnesia for significant parts of ongoing experiences and/or that, in most families, adults do not have sex with children (Spiegel et al., 2011). Clients experiencing dissociation do not report delusional explanations for hallucinations; rather, they tend to experience these symptoms as inexplicable and frightening—indicators that they are “crazy.” Accordingly, they usually attempt to rationalize the existence of the symptoms and may avoid disclosing them in a clinical interview due to fear and shame (Spiegel et al., 2011). In describing symptoms and characteristics, survivors reported blank spells and missing time, which remains consistent with diagnosis criteria such as amnesia (APA, 2013). In a single-case narratology, Fox and colleagues (2013) reported similar periods of lost time, and the results of the current study identified the same major characteristic of DID criterion. Symptom onset, which participants reported in early childhood, remained consistent with previous research that has identified the average age of DID onset to be in early childhood, with average onset at 6 years old (APA, 2013; Fox et al., 2013).

Next, the reported abuse histories and subsequent high-risk behaviors in response to trauma appeared consistent with previous research (Sar, 2011). In regard to abuse trauma history, the results indicated that each participant self-reported some form of childhood abuse (e.g., physical, sexual, emotional, neglect). Based on previous research (Fox et al., 2013; Sar, 2011), survivors of DID often report abuse histories that preceded their symptoms. The participants also reported high-risk behaviors, which indicate that self-destructive patterns are a common theme in survivors with DID and often the reason for inpatient admission (Ross, 1997).

In exploring identity development, discrepancies, and impairment, the results of this study provide several important findings. Identity discrepancies included the participants’ several different sexual orientations, gender identities, and other cultural identities dependent on the alters within a survivor. These identity discrepancies remain a unique characteristic to the roles that alters play and are consistent with past research. Next, participants stated that impairment included (a) confusion/misdiagnosis, (b) relationship difficulties, and (c) professional difficulties; past research (APA, 2013) identified similar difficulties and impairment in functioning.

Societal perceptions of DID include (a) lack of detectability to others, (b) lack of support, and (c) lack of understanding, thereby generating more difficulty and greater stigma of persons diagnosed with this disorder. Consistent with societal stereotypes, media portrayal and lack of knowledge by the counseling profession impede a survivor’s growth and development. As a result of negative societal perceptions, participants reported internalizing a negative self-perception and attitude toward their symptoms. These negative perceptions led to a poor sense of self-worth. Finally, from a strength-based perspective, survivors often described their DID diagnosis and symptoms as a coping mechanism, in which survival remained dependent on these skills.

### **Implications for Future Practice and Research**

Symptoms of DID remain responsive to treatment (Brand, Loewenstein, & Spiegel, 2014) when counselors use evidenced-based practices. While surviving DID presents challenges for those with the diagnosis, counselors administering appropriate

treatment can help survivors improve their relationship functioning and learn communication within their system. To increase communication and overall daily connections with others, the need exists for DID survivors to strengthen their self-awareness of interactional processes between their alters (Middleton, 2005; Rothschild, 2009). However, scant research exists that utilizes phenomenology in explaining the subjective experience of survivors of DID. Among the few studies about survivors of DID experiences, researchers (e.g., Horvath & Bedi, 2002) focused on a clinical sample of survivors who were hospitalized. Further, most research studies that measure the experiences of survivors utilized a medical model perspective rather than a humanistic perspective on the lived experience. Thus, the results from this study provide clinical insight into the lived experiences of those diagnosed with DID in order to add to the literature and better inform the counseling profession.

### **Professional Counseling Strengths-Based Philosophy in Treatment of DID**

Mental health professions need to utilize treatment of DID grounded in evidence-based practices and counselors need training in the treatment of trauma and DID. At the same time, research on professional counselors' perspectives' adds to the body of knowledge on strengths-based, holistic treatment (American Counseling Association, 2010; Erford, 2014). Thus, future research needs to focus on counselors' experiences treating survivors of DID. Compared to the medical model, which focuses on pathology and symptom treatment, a holistic strengths-based model seeks to enhance the assets of the client while also addressing symptomology. Due to the large prevalence of abuse and trauma histories in survivors with DID, establishing a trusting relationship to increase positive outcomes does present a challenge for counselors working with the DID population. However, utilizing a strengths-based model aids the formation of the therapeutic relationship and fortifies the trust between counselor and client. In fact, a strengths-based approach encompasses all of the themes found in a recent study of survivors of DID's beliefs on what types of treatments are the most effective: self-disclosed insight, a client-centered approach, a collaborative relationship, and modeling positive behaviors and emotions (Jacobson, Fox, Bell, Zeligman, & Graham, 2015). These researchers also found empathy, unconditional positive regard, and genuineness to be essential traits of effective counselors when treating survivors with DID. Professional counselor identity is steeped in the aforementioned 'facilitative conditions,' thus making a strengths-based, professional counselor approach even more appropriate for clients with a DID diagnosis. Finally, emphasizing the strengths of survivors with DID, such as innate resiliency of the mind to change in order to cope and survive abuse, is something survivors desire others to recognize, as seen in the *self-perception* and *DID as a coping mechanism* themes from this research. Professional counselors using a strengths-based approach can identify and build on these strengths to assist the client in moving forward in his or her healing process.

### **Limitations**

As mentioned, several limitations exist in qualitative research studies including the researcher's bias when interpreting the data. Inter-rater reliability becomes a concern when researchers ignore certain procedures such as peer debriefing and triangulation. Thus, we utilized these strategies to promote the credibility of data. Finally, a sample size

creates limitations in the transferability of the results of the study. On the other hand, qualitative researchers commonly utilize a small sample, which appears appropriate in using a phenomenological methodology (Creswell, 2007).

### **Conclusion**

The psychosocial history of survivors of DID often includes reported abuse histories among clients. Considering the intensive nature of abuse, symptoms of DID develop and pose major concerns with counselors working with this population including: (a) at-risk behaviors, (b) identity discrepancies, and (c) impairment in functioning. Nonetheless, recent research (Brand et al., 2014) discussed the effectiveness of treatment when focusing on decreasing at-risk behavior and increasing positive coping. Thus, research needs to continue delineating evidenced-based practices with the understanding of the phenomenology of DID as discussed in the results of this study. Additionally, societal, environmental, and self-perceptions of DID appear to influence survivors negatively, which highlights the importance of dispelling myths and misconceptions of DID to better serve this unique population.

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