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Meeting the needs of clients with dissociative identity disorder: considerations for psychotherapy

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Psychotherapy for clients with Dissociative Identity Disorder (DID) is different to therapy with most clients because these clients are multiple, comprising one or more host, and one or more alter personalities. The necessary components to be addressed in order that clients can live successfully either as a multiple or as an integrated person are outlined, discussed and critiqued. These include increasing awareness and understanding between the host(s) and the alter(s) and encouraging communication and collaboration between the identities through psychoeducation. As trauma material has not been fully realised, a key component of therapy is working through trauma events; the BASK model is introduced as a method to facilitate this process. Finally, considerations for integration are evaluated and discussed.

Keywords: counselling; dissociative identity disorder; multiple personality disorder; psychotherapy; trauma

Introduction

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

I had been seeing this client privately for about 18 months. She came to session and spoke about a trauma incident. We processed this and the client left grounded and, as far as I was aware, stable. The next day she was waiting for me outside my therapy centre having just come from hospital. She had been admitted after cutting her throat. A male alter, who did not understand that my client and him share the same body, thought cutting her throat would silence her but keep him alive. Allowing the host to talk, he felt, would lead to his father killing him and he would do anything to try and prevent this. This was a wake up call for me to adapt my therapy with this group of clients.

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What is dissociative identity disorder?

Dissociative identity disorder:

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

I find this definition is insufficient to adequately explain the concept of DID. I offer the following explanation and vignette to demonstrate how DID develops and to illustrate the observable signs practitioners may look out for.

The development of DID

The host and alters

Practitioners usually refer to clients with DID as multiple because they consist of one or more host personalities and several alter personalities. However, in the following vignette, for simplicity reasons, I have used only one host and two alter personalities. I have called the host personality Kerry and one of her alter personalities, who is a child, I have called 'someone else'. The second alter personality, a persecutory alter, I have called 'anyone but her'. At present treatment focuses on fostering communication and co-operation amongst the host(s) and alter(s), understanding and processing the trauma each alter has carried and sometimes, towards the end of therapy, there may be integration of the different identities. Following this example, I outline the main components and considerations for therapy with this client group.

Vignette

At five years old Kerry was molested by her stepfather. During the molestation she got through it by imagining it was happening to someone else. Kerry imagined this sufficiently strongly for her to separate herself from the part of her that was abused, creating an alter personality, 'someone else'. The next time Kerry was abused by her stepfather, 'someone else' just came and took the abuse which meant Kerry could get on with her life. After a while Kerry forgot about 'someone else' but when Kerry was alone with her stepfather she would become scared but did not know why; 'someone else' knew.

When Kerry was 11, her stepfather brought his friend to their house. The friend raped Kerry. Kerry pretended it was happening to 'anyone but her'. Kerry saw 'anyone but her' from the ceiling of her bedroom. Kerry believed 'anyone but her' looked nothing like her. Kerry left for a while and 'anyone but her' took her place.

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

At 14 Kerry returned, causing 'anyone but her' to retreat into the background for a while. Kerry was invited to a friend's party. She had to buy a dress, as all she could find in the wardrobe were jeans and T shirts. Unbeknown to Kerry, these had been chosen and worn by 'anyone but her'. Kerry put on her new dress, wore her hair loose and said goodbye to her mother. Her mother said she had the old Kerry back. Kerry did not know what she meant. At the party, one minute Kerry was talking with friends, the next thing she remembered was coming to, slumped in her friend's hall with her friend's parents shouting at her. She could not understand it. She never got drunk, she did not even like drink, she said her drink must have been spiked but her friend said she had left soon after arriving and came back with a bottle of vodka. Unbeknown to Kerry, 'anyone but her' had returned part way through the party, bought the drink, got drunk and had now left, leaving Kerry to pick up the pieces.

On the way home, when Kerry was trying to explain things to her mother, 'anyone but her' told Kerry to shut up, she called her a useless bag of s**t and told her she would shut her up if she did not shut up of her own accord. Kerry went quiet. Kerry began to lose time, with no memory of what happened for long spells of the day. On one occasion Kerry found herself coming to, following an overdose of sleeping pills. Kerry had no memory of taking the pills at all. When Kerry's stepfather picked her up from the hospital he told her she was a liar and of course she must know what happened. Being called a liar and making excuses for behaviour she had no recollection of performing were becoming commonplace. Other strange things happened too. She had kept a diary for years. One day when she went to write in it, she found it was full of a child's handwriting. Kerry did not know it but the handwriting belonged to 'someone else'.

General considerations for psychotherapy prior to taking on clients with DID

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

Psychotherapy tends to be long term

The length of psychotherapy is highly likely to be long term. Kluft (1985) argues anything between two and 10 years. Therapy is long term because clients have experienced repeated trauma, either related to abuse or attachment issues, or both, and throughout their childhood, often from different abusers, and tending to be particularly grave in nature. The duration of therapy is an important consideration for therapists contemplating retiring, for example.

Longer session length

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

Sessions may be more frequent

Once the initial relationship has been established, I have found that more regular sessions are often needed. Therapists who work a fixed number of client hours per week need to take these extra hours into account. Putnam (1989) argues twice weekly is ideal, sometimes three times per week, without which he states therapy may be stalemated. I have found that during the middle phase of therapy, particularly when the alters are vying for time in the therapy room and outside, clients can be left having to carry too much troubling material and become overwhelmed. During these episodes, I see clients twice a week because this can prevent them using compensatory behaviours, for example excessive drinking, cutting, bingeing and so forth, which may be used by the client as a means of coping.

Boundary considerations

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

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

Extra work

Psychotherapists working with clients with DID are also likely to need to perform extra duties between sessions. Many of these clients are part of a mental health team and liaising with the team members and the client's GP may mean letters to write and care plan approach meetings to attend and prepare for. There may also be crisis calls from other practitioners, which always seem to come on the spur of the moment and typically arrive at a busy time. In addition, if I see a client on a Friday and they seem particularly vulnerable, I will offer them the option of a therapy hour on the phone at a fixed time during the weekend. I do this because weekends are notorious trouble spots, but I say I cannot always guarantee this.

Working with self harm and clients at risk of suicide attempts

Tatarelli, Pompili, and Giradi (2007, p. 127) write that 'all the studies on dissociative identity disorder have reported a high incidence of attempted suicide ranging from 61 to 91%'. There is similarly a high rate of self harm amongst this client group. Occasionally I see clients who report being 'dumped' because their therapist was

unable to work with them due to the risk they pose to themselves. The high risk of self harm amongst this client group therefore places them at an increased risk of this. This can be a traumatic experience for any client but may be worse for clients with DID because typically they have experienced very disrupted relationships throughout their childhood. They tend not to have had a secure safe base and the belief system they have built up about relationships is one in which people abandon them, do not care or are inconsistently around. This practice carries the potential to strengthen the client's belief system that they are not worthy of care. I therefore would strongly recommend practitioners who are unable to work with complex cases, or who dislike working with clients who pose a significant risk of harming themselves, perform a thorough initial assessment.

Key elements for consideration when working with DID

Clients with DID are multiple, therefore individual therapy is inappropriate

Margaret Warner (1998, p. 375) writes:

> . . . when therapists understand dissociative process and remain empathically connected with clients, a natural process tends to develop in which dissociated memories and parts emerge on their own. Once this process is established . . . clients tend to have a finely tuned sense of timing, allowing just as much dissociated material into consciousness at any given time as they can handle . . . they seem to sense the order in which they are able to tolerate working on particular memories and life issues.

Whilst Warner (1998) describes alters and talks about their contradictory feelings (p. 380), this reference treats the client as if they (host and alters) are one unified force moving in one direction. My understanding from this passage is that Warner (1998) is here referring to the host and all the alters and arguing that we should trust the whole system (host and alters) to know what it is safe to say, when and how, and this will be only what the host and all the alters can 'handle'. Further references in her article are made to a 'client-directed style of work' (p. 368). However, the host and each alter may have different beliefs, feelings and actions to the same event. In this way therapy can resemble family therapy where all the family need to be heard and considered. Where the host and one or more alters believe it is safe to talk about 'x', other alters may disagree. Also, the host is not like a typical client in that they (host and alters) do not have access to all the information of their being. Commonly there are amnesic barriers between the alters and host(s), particularly in the early stages of therapy. Whilst I value the notion of self-directed therapy, in the case of clients with DID one or more alters may not have signed up for therapy, or where they have, may not want certain trauma incidents discussed. Therefore, permission for disclosure needs to be sought from the host and known and unknown alters in order to reduce the likelihood of harm to the body. A simple question asking if this is safe to talk about, or does anyone have any objections will suffice. Without this permission, one or more alters may attempt suicide or self harm, as in the case I referred to in the introduction. Similarly, later in her article Warner (1998) cites an incident where one of her clients also made 'serious threats to slit her throat', in this case because an alter felt frightened she would be destroyed (p. 382).

Empathy may need to be tempered

A further issue relates to empathy. Typically one or more alters have learnt they are 'bad', 'useless', 'stupid', or something similar and that they should be punished. Warner (1998, p. 375) writes:

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

Whilst empathy is important with this group of clients, they may find empathy for themselves almost impossible and empathy from the therapist may be too much for the host or one of the alters to bear. This can result in self harming if the alter, or alters, feel the care is not deserved. Therapists may therefore need to temper their empathy until they are convinced the client will not be overwhelmed. Lamagna and Gleiser (2007) state that trauma survivors struggle as much with feeling positive affect as they do with negative. These challenges to the person-centred approach to therapy raise further questions about the more widely held belief that one approach to psychotherapy is sufficient. In my opinion approaches are like one-size T shirts; they fit surprisingly few.

Talking through the diagnosis

A further difference in therapy with these clients is that talking through the diagnosis becomes an on-going part of therapy that I revisit several times. A useful starting point may be to offer an explanation of dissociation as arising out of a way of coping with overwhelming feelings. I use the analogy of people logging off, zoning out or shutting down from an experience that is too painful to face. Descriptions of how and why alters come along, commonly to protect the host from trauma, may help the host or hosts to begin to think about the alters in a more positive light. Perhaps the most crucial piece of information for all alters to grasp is that although there are several alters, there is only one body.

I have also used an analogy of the body representing a house and the alters representing the rooms. Some may have the door open, where there is communication, and some may have the door firmly closed, where there is no communication or only muttering can be heard. This can be extended to include how some alters can reach each other, through interconnecting doors, whilst others cannot.

Contracting

Several therapists recommend making contracts with clients early on in therapy (Kluft, 2003; Putnam, 1984). Whilst contracts are commonplace in some therapy approaches, greater clarity around issues of safety may warrant consideration. Some alters have the potential to be aggressive or violent; contracts can be used to set out what is not acceptable and the consequences of breaches to the agreement. Alters can be asked what they feel is an acceptable consequence for the violation of a contractual rule. Agreement over therapist availability, time constraints and limitations to the level of support on offer may also be clarified. In respect to client safety, just as you would not send a five-year-old home alone, requesting the host

always be the one that comes to therapy and leaves avoids young child alters managing this alone. If necessary, this needs to be orchestrated by the therapist.

Confirming the client's reality

Sometimes clients will be unclear about what is real and what is dreamed or imagined. They may have had aspects of their reality questioned or denied, by themselves, their abusers, a parent, or all three and over a number of years. This fosters uncertainty about what is real and, coupled with the client's amnesic episodes, for example, as the alters switch, results in a confusing existence. Aquarone argues that a lot of the work with this group of clients is 'reinforcing the reality' (R. Aquarone, personal communication, 5 May 2009, cited in Ringrose, 2010). Therefore, strategies to support the client gain clarity about events and techniques they can adopt which help to provide greater continuity of experience are useful. For example, if an alter speaks in therapy, I will always debrief the host on the content at some point, although this may need to be divulged in stages because it may be too much for the host to digest in one go. In these circumstances, a general consensus of what to do needs to be agreed with the client beforehand. I also offer clients a copy of their notes following a session. This informs them of what they may have missed if an alter was present and helps provide a greater continuity of experience. In the later stages of therapy, alters can be called upon to fill in the missing gaps left when switching occurs.

Fostering communication and co-operation between host and alters

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

Mapping the alters and getting to know them

As more alters emerge, drawing a map together in therapy aids the therapist and the host's understanding of the alters. It is helpful to see the relationship between them, who is closest to whom, who may control whom and who is accessible to whom. Sometimes alters are conjoined. Asking about their age and whether an alter has a

name makes for an easier reference. Where alters have not got a name, we make something up. This needs to be value free and neutral and may simply be something like 'the one who was afraid'.

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

Working through trauma events

Once all alters are stabilised and settled in therapy, Aquarone (2009, cited in Ringrose, 2010) recommends direct conversation with the alters. This, he argues, is necessary because they, not the host, experienced the trauma first-hand. He argues that the host will not remember trauma events and where memories are accessible these may be devoid of feelings. In recent years there appears to have been a shift from working directly with the alters to working as much as possible with only the host (Ringrose, 2010). Direct communication between therapist and alters may occur but I recommend the bulk of the work be done through the host. My aim in therapy is to focus on reducing dissociative episodes and increasing the strength of the host to manage without dissociating. I believe that direct communication between alters and therapist may strengthen, not lessen, this coping strategy. Hosts often report not knowing what happened during a period of lost time but I have found that when encouraged they can work with the alters to piece bits of information together. Boat (personal communication, 2009, cited in Ringrose, 2010) recommends encouraging the client to 'play detective' and uses various strategies to help the client stay in the room and not dissociate. For example, she has given the client scent markers to smell and clapped her hands or turned the lights on and off when the client appears as though they are about to switch.

Irrespective of which stance you favour, Van Der Hart, Steel, Boon, and Brown (1993, p. 163) write that 'experienced therapists concur that this disorder cannot be completely resolved until these traumatic memories have been successfully processed'. Similarly, Janet (1935, cited in Van Der Hart et al., 1993) believed that clients with DID have not 'realised' the traumatic event. It is through this realisation and the sharing of information amongst the host and alters that the dissociated alters can become reconnected with the host.

Clients with DID are continuously propelled backwards into their past lives as dissociated fragments of memories are repeatedly re-stimulated by current events. The process of re-stimulation keeps recurring because the material never fully registered at the time, and has not been processed (partly through the purging of emotions), absorbed and integrated. Van Der Hart et al. (1993) assert the necessity of each alter involved in the trauma event sharing their experiences with each other alter involved and eventually those not involved in the trauma, so that all alters have the same trauma story but often from different perspectives.

Sometimes different alters may recount different experiences and views on the same trauma event which need to be heard. There may also be inconsistencies and distorted cognitions (particularly with young alters) surrounding the trauma. These must be empathically challenged, just as a parent would correct a child's misunderstandings.

The BASK model

Dissociated memories are made up of four components or levels of experience – Behaviour (B), Affect (A), Sensation (S), and Knowledge (K) or BASK (Braun, 1988). Braun (1988) advocates that trauma events be explored from each of these components. Often clients report their knowledge of an incident devoid of affect, or sensations, which may be dissociated but cause the client to keep getting propelled back to the trauma experience. Working through memories beginning with any one of the BASK components, piecing together accessible constituent elements and purging the emotions attached to them takes away the memories' power and stops the cycle of re-stimulation. I have found using the BASK model for these processes extremely useful. Although I do not contest that trauma events have to be explored from each of these components, neither have I found that clients always have material associated with each component.

Pacing and trauma disclosure

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

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

Exploring somatic symptoms

Where clients report somatic or physical complaints, for example stomach ache, headache and pain in their groin, this can be the starting point of working with the trauma to which it may relate. I ask questions about where the complaint is located and how they would describe it, to begin this process. I also ask clients to use a crude scoring system, like the one mentioned above, where clients can be encouraged not to allow themselves to reach beyond a certain level of anxiety or distress. If you sense the host needs more time before working directly with trauma, I have found asking them to tell me what it would look like if they had to draw it can foster clarity without emotional charge. Clients have talked to me using various analogies. Examples include images of a black lump of tar located in the stomach, a bright red ball made up of elastic bands pinging in the chest, a dead weight tied to the client's feet like a ball and chain and the weight of a boulder weighing heavy between the

client's legs. As the host becomes more accustomed to coping, I enquire about the other BASK components, simply by asking 'anything else?' or 'any more?' until they have been drained of all they can disclose. Sometimes these pains and feelings may be accompanied by memory flashes, which can be enquired about too. Where memories have been shared, it may transpire that alters will have different feelings attached to the same family member. Hence, for example, one alter may be angry towards mum because they remember telling her about the abuse, and her not believing them, whereas perhaps the host may want to build a new relationship with mum and move on. This may cause rapid switches of emotion towards the family member and also inner turmoil with one alter feeling angry with another, or hurt by the other's reaction. Therefore, where there is a change or shift of emotions in one alter, this has repercussions for the other alters too, who will be forced to make an adjustment. It is like a rock thrown in a pool; it creates ripples long after it has been thrown.

Considerations on integration

Integration is the process where host and alters decide to merge and live as one. Not all clients choose this option. However, Kluft (1984) found that clients who elect to live as multiples often relapse under stress, or if painful material is re-stimulated by current events (Kluft, 1993a). He also strongly advises that clients with DID who are to become parents integrate because alters may exploit or persecute the host's children and the host's amnesias and inconsistencies can compromise them as parents.

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

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

Work to be completed before integration

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

Aside from the trauma work, I believe three further elements to therapy are imperative if the client is going to be able to live successfully, either as a multiple or as an integrated person. Firstly, throughout therapy, I advocate a philosophy of pulling together to fight the common enemy of the after-effects of trauma. Host or

hosts and alters must be able to work together. Secondly, it is imperative to facilitate equality amongst the alters, where competition is minimised and where alters let go of their desire or need to view themselves as unique discrete entities. Thirdly, it is important to encourage empathy and understanding amongst the alters, as well as this sense of unity. The overall aim has to be to get the host and alters to all move in one direction. For example, it would be no use having the host wanting to attend university and an alter sabotaging attendance by refusing to get out of bed. Living successfully, either as multiple or as an integrated person, can only be achieved if the host and alters work together; as Claire Schulz expressed it, like a flock of birds or shoal of fish (C. Schulz, personal communication, 9 April 2010). In the case of integration, alters may also fear being killed off, or losing talents or abilities. All of these sorts of issues need exploration.

Co-presence, fading and merging of alters prior to integration

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

Conclusion

In conclusion, working with clients who have DID poses major challenges to some psychotherapists' and counsellors' ways of practice. Clients with DID will require greater input from their therapist than is normally the case. Therapy will be long term, individual sessions may need to be longer and will be more frequent at some point. Practitioners will also need to allocate time for liaising with other professionals. These clients also pose a high risk of self harming and may attempt suicide at some point. Assessment needs to be sufficiently thorough in order that therapists not wishing to work under these conditions opt out immediately and not part way through therapy, as this can repeat the client's experiences of abandonment.

Practitioners working with clients with DID are likely to need to change elements of their ways of working. Firstly, psychotherapy with these clients means the practitioner is effectively working with a family, where initially, typically, the members will not know of each other's existence and are unlikely to want to work together. If one alter wants to talk, another may want them to stay silent. Therapists must take this difference into account.

Secondly, a major change to my working practice is that I cannot always trust the client and follow their lead. If they begin to talk about trauma, it may not be safe for them to do so. An alter may not want this and self harm or attempt suicide as a result. The whole system must always be considered.

Thirdly, a further difference in therapy with these clients is that it is often directive, instructional and necessitating a high degree of psycho-education, particularly talking through the diagnosis. Direction will also involve helping the client to co-operate and communicate with their alters. In this respect clients may need information on how to begin. In respect to direction, they are also likely to need to be given practical instructions on how to help them to regulate their emotions. It is likely that the client will not have had their emotions regulated by a supportive caregiver and thus feel easily overwhelmed. This is compounded by a lack of skills to cope and ways to self soothe. They tend to need practical instructions on this.

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

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Notes on contributor

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