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**Exploring the Consequences of Psychological
Trauma:
The View From The Swamp**

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**Portfolio for Professional Doctorate in Counselling
Psychology (DPsych)**

City University, London

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Declaration of powers of discretion

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Section A: Preface

'The world breaks everyone and afterwards some are strong at the broken places' (Fosha, 2002, p. 7)

The preface will explore each component of this Doctoral Portfolio and consider the choices that were involved in selecting and creating each component. In addition it will discuss how the parts of the portfolio are related to each other through the theme of psychological trauma and through my own personal interest in working with clients who have experienced trauma.

The portfolio begins with a piece of original research into the experiences of relationships in those who define themselves as having Dissociative Identity Disorder (DID). This research used semi-structured interviews to gather data that were then analysed using interpretative phenomenological analysis (IPA). The aims of this study were to gain an insight into the subjective experiences of those who define themselves in this way; and to explore their perceptions of the impact of DID on their relationships. Researching the concept of DID has been an experience in itself; on disclosing the subject of my thesis, I have regularly been met with confusion from family and friends, ('what on earth is DID?') and pitying smiles from professionals, ('why study something that doesn't exist?'). I cannot criticise others for their responses; my own views have evolved significantly through the process of completing this project. Initially ready to campaign for the existence of a misrepresented and misunderstood diagnosis, I now take a step back from judging a concept I can never confirm or disprove. I now focus on the experience that is described by those who define themselves as having DID and consider how this can be understood and supported by professionals.

Throughout the research process I have questioned my decision to study a diagnosis that is so controversial. During my training I became aware of my attraction to working with those individuals who are underrepresented, judged and often overlooked. Previous employment in the prison service and in substance misuse services also suggests this is true. I have learned that these individuals are experiencing extreme distress, display a complex presentation of difficulties and have often been victims of abuse or trauma in the past. I believe my attraction to this group is the reason I was attracted to exploring the concept of DID. However, I was not simply guided by my own interests but also by a need for more information about the experience of DID. Although published literature discusses the

controversy of the diagnosis (Piper & Mersky, 2004) and the possible cause for the development of the diagnosis (Liotti, 2004) there has been little literature published on the subjective experience of those who define themselves as having DID. There seemed a gap in the research and, therefore, this seemed a worthy project to pursue.

The publishable paper, section C of the portfolio, offers a review of the research study discussed above. The paper condenses the study and is written to meet the requirements for publication in the Journal of Trauma and Dissociation. The movement from writing a thesis to achieve an academic award, to writing a paper for publication that could prove valuable to other professionals is significant: it feels as though it signals a point in my training where I begin to move from being a trainee counselling psychologist to a counselling psychologist.

Section D of the portfolio is dedicated to a professional case study, which explores the work between my client, Marie, and myself. Marie attended therapy to address her Posttraumatic Stress Disorder(PTSD) after being violently raped a year previously. My work with Marie was certainly one of the most rewarding pieces of therapeutic work I have completed over the three years of my training. Although successful, the work was challenging for both Marie and myself. I have included this piece as I believe it links to the other work in this portfolio and is another example of when I have been attracted to working with those who were in extreme distress and had experienced trauma.

The work that forms this portfolio was not designed around a theme although on reflection I believe that a number of themes exist. On a surface level, psychological trauma seems a linking factor between the components. The professional case study, describing my work with Marie to resolve her PTSD symptoms could be seen to link with the study and publishable article into the experiences of those who define themselves as having DID, due to research suggesting that DID is an extreme response to childhood trauma (Scroppo, Drob, Weinberger & Eagle, 1998). Additionally all of the participants from the study shared that they had experienced a form of childhood abuse. However, I also believe there is a more subtle theme, which is my own attraction to working with those who have experienced trauma. I am unsure why I am attracted to this client group; perhaps it is a need to rescue, or

a need to reduce, in others, the feelings of being different and unheard that I have experienced myself.

The journey to becoming a counselling psychologist has been long and challenging. Although I knew that I fitted into the philosophy behind the discipline, I have often wondered which therapeutic approach I best fitted with; am I a CBT therapist or do I prefer psychodynamic interventions? I have wanted to fit somewhere, to know what values drove me and to know how best I worked. However, I never discovered where I fitted and now I have reached a space where I feel comfortable in just being me. Perhaps this change in thinking is also reflective of the process throughout my research. I wanted to fit the concept of DID into a category; I wanted to believe something, to have a position.

Through my reading I discovered the following quote from Schön:

‘A high, hard ground overlooking a swamp. On the high ground, manageable problems lend themselves through the application of research based theory and technique. In the swampy lowland, messy, confusing problems defy technical solution. ... [But] ... in the swamp lie the problems of great human concern.’ (as cited by Strawbridge & Woolfe, 2010, p. 6)

Strawbridge and Woolfe (2010) discuss this quote and suggest that practitioners have a choice to remain on the high ground where relatively unimportant problems can be resolved according to standards of rigor or to move down to the swampy lowland where important problems can be addressed but where techniques cannot be quantified or explained easily. This led me to consider whether I do have a position and it is down in the swamp. I enjoy and find it more meaningful to work in the messy swamp lands below, where important problems such as exposure to trauma and the concept of DID are not easily resolved by theory and technique; where clients' issues are not resolved in six sessions of therapy. Perhaps fitting into a model or an approach isn't so important but knowing my position as an individual psychologist is. I fit down here, struggling to make sense of an individual's problems, learning from experience and reflection and perhaps fighting own feelings of inferiority compared to those who can quantify their psychological approach.

References

- Davis, J. D. (2011). Cultural dimensions of intersubjectivity: Negotiating 'sameness' and 'otherness' in the analytic relationship. *Psychoanalytic Psychology*, 28, 4, 549-559.
- Fosha, D. (2002). Trauma reveals the roots of resilience. *Constructivism in the Human Sciences*, 6, 1&2, 7-15.
- Liotti, G. (2004). Trauma, dissociation, and disorganised attachment: Three strands of a single braid. *Psychotherapy: Theory, Research, Practice, Training*, 41, 472-786.
- Piper, A., & Mersky, H. (2004). The persistence of folly: Critical examination of Dissociative Identity Disorder. Part II. The defence and decline of multiple personality or Dissociative Identity Disorder. *Canadian Journal of Psychiatry*, 49, 10, 678-683.
- Scroppo, J. C., Drob, S. L., Weinberger, J.L., & Eagle, P. (1998). Identifying Dissociative Identity Disorder: A self report and projective study. *Journal of Abnormal Psychology*, 107, 2, 272-284.
- Strawbridge, S., Woolfe, R. (2010). Counselling psychology: Origins, developments and challenges. In R. Woolfe, S. Stawbridge, B. Douglas & W. Dryden (Eds.), *Handbook of Counselling Psychology* (3rd ed.) (pp. 3-22). London: Sage.

Section B: Research

**Interacting with the muggles:
Experiences of relationships in individuals who define
themselves as having Dissociative Identity Disorder.**

Abstract

This thesis seeks to explore the experience of relationships in individuals who define themselves as having Dissociative Identity Disorder (DID). The diagnosis of DID has been controversial for many years and the existence of the experience of multiple identities questioned. This study is interested in finding out more about the lived experience of those who define themselves as having DID.

The research takes a contextual constructionist epistemology and seeks to explore experience of relationships. Data were collected from seven women, between 30 and 50 years of age, who defined themselves as having DID. Data were collected using semi-structured interviews and analysed using interpretative phenomenological analysis (IPA).

Three master themes emerged from the data: 'the self and the diagnosis'; 'the process of relationships' and 'early experiences'. 'The self and the diagnosis' describes how the experience of DID appeared to impact on the way individuals perceived themselves and their diagnosis, as DID being a strength or a deficit. Also discussed within this master theme were difficulties in managing internal relationships; sharing the diagnosis with others; and improvement. 'The process of relationships' master theme described the experiences of being in different roles; good and bad interactions with others; and managing the beginning and the ending of relationships. The master theme of 'early experiences' explored the descriptions of interactions with early caregivers and the impact of these on the perceived development of DID.

These findings are discussed alongside published literature with particular consideration given to the differing ways individuals perceived their self-concept in relation to their experience of DID. Implications for counselling psychologists working with this client group are explored considering how internal experiences; difficulties in understanding others; and managing endings may impact on the process of therapy and the therapeutic relationship.

Introduction

Dissociative Identity Disorder (DID), previously referred to as Multiple Personality Disorder, has been a controversial diagnosis for some time. It became more widely recognised following the publication of *Sybil* (Schreiber, 1973), a novel following the journey of one woman's perceived experience and treatment of DID. The idea of experiencing multiple internal identities can appear somewhat surreal and this has led some professionals to suggest that the diagnosis is a socially created phenomenon (Spanos, 1994). However, others fiercely defend the diagnosis, describing it as a creative survival technique developed to cope with severe childhood trauma.

Through writing this thesis, I offer an insight into the subjective experience of individuals who define themselves as having DID and how these individuals make sense of their relationships in relation to their diagnosis. Although each individual's experience is different, insight can be gained through careful examination of each case and can either build on previous literature, offer suggestions for professionals working with clients who define themselves in this way or lead to further research into Dissociative Disorders.

I begin this thesis with a discussion around the concepts of dissociation and Dissociative Identity Disorder (DID) and continue by considering the controversies behind the diagnosis of DID. I move forward to discuss previous research into the diagnosis of DID, focusing on the link between DID and attachment; and qualitative research exploring the subjective experience of DID. I will finish this chapter by considering the importance of the current thesis, its aims, and my own impact on the design and implementation of the research and how I may have shaped the analysis.

Dissociation

The DSM-5 defines dissociation as 'a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control and behaviour' (American Psychiatric Association [APA], 2013, p. 291). This experience is described as resulting in a 'sense of detachment from the self and the environment' (International Society for the Study of Trauma and Dissociation [ISSTD], 2011, p. 189). Dissociation has also been

described as the experience resulting from alcohol or drug use (Van Den Bosch, Verheul, Langeland & Van Den Brink, 2003).

Although dissociation is the core feature of the Dissociative Disorders it is quite difficult to quantify. Spitzer, Barnow, Freyberger and Grabe (2006) discuss how dissociative experiences fall among the diagnostic criteria for a number of mental health disorders such as Posttraumatic Stress Disorder and Borderline Personality Disorder (APA, 2013) and Holmes et al (2005) acknowledge how the term 'dissociation' is open and can encompass a number of definitions. Dissociation can be viewed as a spectrum of experience; Livingston (2009) has suggested that most people have times when they feel disconnected from themselves or their environment, for example, driving a familiar route and arriving at a destination with little memory of the journey. However, others such as Janet (as cited in Spitzer et al, 2006, p. 82-83) suggested that dissociation was a discontinuous phenomenon which was limited to those individuals who were already experiencing mental disorder. Although more recent research has been undertaken on the experience of dissociation, there still seems debate concerning whether it is a dimensional or typological construct.

Evidence for dissociation as a dimensional process comes from studies using questionnaires and rating scales such as the Dissociative Experiences Scale (DES). Putnam (1989) describes the distribution of dissociative experiences recorded by those with no mental health difficulties and an inpatient sample with a variety of difficulties, both groups display a similar pattern of distribution of dissociative experience, suggesting that there may be a continuum from minor to major degrees of dissociative experience.

Waller, Putnam & Carlson (1996) describe a division between the non-pathological type of dissociation, which exists on a continuum, and a pathological type which is discontinuous. They also employed the DES but identified that pathological dissociation could be identified by a subset of the questions. This may suggest that there are distinct categories that an individual either belongs to or does not. Holmes et al (2005) discusses how dissociation could be divided into two types 'compartmentalization' and 'detachment', further suggesting that perhaps dissociation does not exist on a continuum.

Dell and O'Neil (2009) assert that dissociation becomes pathological and might be labelled as a disorder when there is 'a partial or complete disruption of the normal integration of a person's psychological functioning' (p. xxi). Korzekwa, Dell and Pain (2009) describe this disruption as being experienced in a number of different ways: feeling as if the world around you is unreal (derealisation); feeling detached from your own body (depersonalisation); forgetting personal information or past events which is too extensive to be classed as normal forgetfulness (dissociative amnesia); and finding evidence or receiving information about other alternative identities (identity alterations). The APA (2013) describes five categories of Dissociative Disorder: Dissociative Identity Disorder; dissociative amnesia; depersonalization/derealisation disorder; other specified Dissociative Disorder and unspecified Dissociative Disorder.

Dissociative Identity Disorder

The focus of this thesis is on the experience described as Dissociative Identity Disorder (DID), referred to by Livingston (2009) as the most complex of the Dissociative Disorders. The diagnosis of DID was previously referred to as Multiple Personality Disorder and perhaps the most well documented criterion of this diagnosis is described by the APA (2013) as a:

'Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning' (p.155).

Other criteria described include gaps in memory that are too extensive to be normal forgetfulness; and significant distress or disruptions in social and occupational functioning (APA, 2013). The APA's (2013) new publication of the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, has seen the diagnostic criteria for DID developed. An addition to the previous DSM-IV's (1994) criteria is criterion D, which acknowledges the role of dissociation in different cultures and religions and excludes these experiences from being classed as disorders (see figure 1 for full diagnostic criteria of DID).

Sar (2011) reports the prevalence of DID at approximately 1% in the general population and Sinason (2011) describes a significant gender bias: women are being diagnosed with DID much more frequently than men. There is no recommendation for medication to treat DID unless there is a dual diagnosis, and then medication will be used to treat the accompanying disorder (Cohen, 2004).

- A. Disruption of identity characterized by two or more distinct personality states or an experience of possession. This involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.
- B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The disturbance is not a normal part of a broadly accepted cultural or religious practice. (Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.)
- E. The symptoms are not attributable to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Figure 1: The DSM-5 (APA, 2013, p. 292) Criteria for Dissociative identity Disorder.

A controversial diagnosis.

McIntee (2006) describes how, historically, perceived symptoms of DID were attributed to spirit possession, but more recently two conflicting theories about the development of these symptoms have emerged: the posttraumatic theory of DID and the socio-cognitive theory (Spanos, 1994). Professionals who support the

posttraumatic theory describe DID developing as a result of severe childhood trauma; such as abuse (Kluft, 1995; Gleaves, Hernandez & Warner, 1999). Within this mode of thought, DID develops as a survival technique, where a child dissociates to mentally avoid the abuse that they are victim to. Repeated trauma is believed to reinforce this coping strategy until dissociated states become more prominent and form separate identities (Trujillo, 2009). Other researchers such as Liotti (2004) and Barach (1991) still side with the posttraumatic theory but have described DID developing as a result of early attachment and communication difficulties between the child and main caregiver, this position will be explored further later in this chapter. The socio-cognitive theory of DID, which is also referred to as the iatrogenic model (Spanos, 1994) states that the disorder is socially constructed. This perspective describes DID as either self-created by individuals with the aim of avoiding responsibility or attracting attention and resources; or developed by therapists who through suggestion and encouragement lead individuals to believe they experience the symptoms that constitute the diagnosis (Gillig, 2009).

McIntee (2006) describes the diagnosis of DID as quite unique in the arguments made against it by the socio-cognitive theory. She seeks to explore the development and basis of this theory and describes how the problem of malingering became more apparent in the 19th century due to an increase in compensation claims made for railway accidents. McIntee (2006) describes how this led individuals to seek compensation for past abuse, relying on memories that had been 'repressed' and only recently 'recovered'. This led some to question how reliable these memories were, for example Loftus, Garry and Hayne (2008) completed research into false memories and suggested that it is actually very easy for people to create memories that they have not experienced. Research of this nature left some questioning the validity of memories of extreme abuse found in those experiencing DID (Spanos, 1994). McIntee (2006) also highlighted that DID has been diagnosed most frequently in the US, leading professionals to wonder whether higher rates of diagnosis have been influenced by increased media attention prompted by the publications of books such as *Sybil* (Schreiber, 1973) and *I'm Eve* (Costner Sizemore & Sain Pittillo, 1977), or whether a small number of practitioners are over-diagnosing the disorder (Spanos, 1994).

Disagreement about the existence of the diagnosis of DID continues and has been stimulated recently by the publication of the DSM-5. Paris (2012) describes DID as a 'medical fad' (p. 1076) that should not be included in the manual and has been fading out of significance over the last few years. Paris's article prompted strong disagreement from researchers who study and work with individuals who identify themselves as having DID. They criticise Paris's arguments about DID as opinion rather than based on scientific evidence (Martinez-Taboas, Dorahy, Sar, Middleton & Kruger, 2013). However, a recent article in the New Scientist calls for DID to be rejected as an official diagnosis, quoting a case where one client's abuse memories were created through engagement in therapy (Waterhouse, 2013).

The argument for and against the existence of DID is also impacted on by the way mental health difficulties are viewed by different professionals. The medical model of mental disorder is guided by statistical manuals identifying patterns of behaviour and labelling them to give clarity on what treatment may be effective and to ensure shared understanding between professionals. Medical models can be criticized for being reductionist, reducing complex difficulties, which are shaped by culture, society and experience, down to one medical label. Further discussion about the pros and cons of diagnosis within the medical model is discussed later in this chapter. In contrast to this viewpoint are approaches such as humanistic psychology and process orientated models which do not attempt to label certain experiences. These approaches encourage viewing an individual as a whole person with a number of different influences on their behaviour. They assume that individuals are inherently good and they are striving towards self-fulfilment. In terms of DID, humanistic psychology and process oriented approaches may move away from the label 'Dissociative Identity Disorder' and the symptoms that are described within this category and instead focus on the individuals experiences of difficulties and the impact of various factors on these difficulties, both previously and currently. Like the medical model, humanistic and process oriented models can be criticised but instead of being reductionist their approaches can be viewed as too subjective and hard to define. It seems these positions offer opposite viewpoints on the subject of diagnosis and treatment of mental health difficulty. I position myself between these opposites, acknowledging that I find diagnosis helpful at times, but that there are complexities in human behaviour which are addressed more successfully by taking a humanistic approach. Based on this position, I have used the terms 'diagnosis' and 'concept' interchangeably throughout this research to acknowledge the value in

both ways of considering the phenomenon of DID. When I use the word 'concept' I refer to the ideas that are associated with the diagnosis of DID and the perceived experience of DID.

In March 2011, the first meeting of the Campaign for the Inclusion and Recognition of Multiplicity and Dissociation was held in London. This is a campaign group trying to increase awareness of DID and other Dissociative Disorders. Some of the aims of the group are: for DID to be defined as an aspect of Post-Traumatic Stress Disorder; to develop guidelines for the treatment of DID; for these guidelines to be recognised by the National Institute for Health and Clinical Excellence (NICE); for increased access to training for professionals to improve service provision for those identifying as having DID; and for funding to be provided for long term therapy for this client group (Spring, 2011). For those who support the diagnosis of DID or define themselves as having DID, it is very important that these should be met.

Interventions for working with those who experience DID appear to be in their infancy and are in themselves considered quite controversial. For example, Ringrose (2011) suggests that successful treatment includes increasing levels of communication between hosts and their alters¹ and working through trauma memories. Brand et al's (2012) survey of experts who work with clients defining themselves as experiencing DID, also recommended identifying and working directly with alters. This guidance assumes that individuals who define themselves as having DID are aware of the presence of their alters and have recollection of their traumatic memories, or perhaps it assumes that these may emerge through the process of therapy. The idea that DID could be created through engagement in therapy has been a criticism directed at the diagnosis (Spanos, 1994; Waterhouse, 2013). As mentioned previously, Loftus et al (2008) questioned the validity of recalled memories and therefore, as suggested by Piper and Mersky (2004), it is very difficult to identify whether alters and trauma memories emerge through therapy or are being created by therapy. If these experiences and memories are created by therapy, this raises a question about the ethics of therapy with this client

¹ The word alter is used, by those who define themselves as experiencing DID, to describe different internal entities; perceived to be experienced as a separate personality or identity. The alter which is perceived to be present most frequently is referred to as the host (Cohen, Giller & W, 1991).

group, as creating these aspects of experience could cause an individual significant psychological distress. It is clear that the diagnosis of DID generates extreme opinions and some passionate responses, and there is little doubt that controversy concerning the diagnosis will continue for years to come.

Taking into account the controversy around the diagnosis of DID it is important to consider my own position within these debates. As a researcher and a counselling psychologist I use diagnostic labels, but try to avoid relying on them as I believe this leads to assumptions concerning experiences, instead I try and remain focused on the reported experience of the individual. However this group of individuals are defined, it is clear that they experience difficulties and distress, and their experience needs to be explored in order to understand how and what support should be provided. I have given thought to the language used to define DID and those who state they experience the disorder. Although I do refer to DID throughout, I am considering this as a perceived experience, this avoids making judgements about the existence of DID and reflects the position offered by my participants as I did not request an official medical diagnosis from them. I will be using the phrases 'individual who defines themselves as having DID' or 'individual experiencing DID' throughout this report to describe those who identify with the diagnosis.

Overview of Literature²

Studies on professional's beliefs of DID.

Despite some professionals stating that the concept of DID is under-researched (Sinason, 2011) I did not find this to be the case and found a great deal of research in the area. I also found a lot of information and research in the field of dissociation, which appears a much more accepted experience than DID; I have considered this research as I believe it can offer insights into the concept of DID. A major theme of the research I came across was the controversy of the diagnosis, as discussed

² The literature reviewed for this study was collected through psychological and psychiatric search engines such as PsycINFO and Web of Knowledge. Key search terms used included 'dissociation', 'dissociative identity disorder', 'Multiple Personality Disorder', 'experience of dissociative identity disorder' and 'attachment'. The studies and opinions included in this review were chosen as they were deemed to offer insight into the concept of DID and the experience of relationships. Other literature about DID is referred to briefly to give the reader a context in which to place the discussed studies but was excluded from extensive exploration due to its limited relevance in relation to the current research question and aims.

above. Opinion remains divided and this has created debates between researchers such as those between Gleaves (1996) and Spanos (1994) and Paris (2012) and Martinez-Taboas et al (2013). Research has also been carried out into the beliefs and attitudes of professionals towards the diagnosis of DID. Hayes and Mitchell (1994) investigated mental health professionals' scepticism towards the diagnosis, from their sample, 24% reported moderate to extreme scepticism. Dunn, Paolo, Ryan and Van Fleet (1994) found differences between professionals who did believe in the diagnosis compared to those who did not. Professionals who validated the diagnosis of DID were significantly younger and had been employed for less time than those who did not believe in its existence. Interestingly, Cormier and Thelen (1998), in their study of 425 participants, suggested that professionals' beliefs about DID were impacted on by their therapeutic orientation: participants with a cognitive behavioural orientation were more sceptical and negative about the diagnosis than those from a psychodynamic orientation.

Disagreeing with the scepticism about DID, some researchers have spent time defending the diagnosis and creating evidence that they believe supports it. Kluft (1995) has written a number of articles about his experiences of working with clients who identify themselves as having DID. He defends the diagnosis by suggesting that literature that is sceptical of the validity of reported abuse believed to cause DID, has not considered available reports that confirm the abuse. Kluft (1995) surveyed a sample of his own clients diagnosed with DID and stated that 56% of these clients had instances which confirmed their memories of abuse. However, this percentage is still only just over half of his sample and these instances did include clients' own accounts of confirmations of abuse. Gleaves et al (1999) carried out an investigation with 446 participants into the existence of symptoms of DID prior to the individual starting therapy, assuming perhaps that if the symptoms of DID were developed iatrogenically by the therapeutic relationship, symptoms would not be present before contact with therapy. Findings showed that in 67% of cases, clinicians received some form of corroboration of symptoms prior to starting therapy.

However, the debate continues to rage on: Piper and Mersky (2004) state that the argument for the existence of DID is illogical and highlight the potential for harm should a therapist encourage a client to behave as if they had multiple identities. Piper and Mersky (2004) also describe how the criteria used to diagnose DID are open to misinterpretation due to the lack of definition around certain symptoms.

They describe how there is no real definition available for what is meant by 'identity' or 'personality state' (p. 679).

Linking trauma and DID.

Another theme of the research assumes the possibility of experiencing multiple selves and the existence of DID. This research takes a posttraumatic view of the disorder, linking it with traumatic early experiences. An early theory of the development of dissociative behaviour was provided by Pierre Janet. Janet (as cited in Scropo, Drob, Weinberger & Eagle, 1998, p. 273) suggested that dissociation was a process that served to keep traumatic experience out of consciousness. The link between dissociation and trauma has led to a body of research exploring specific early experiences and their impact on levels of dissociation, which I have considered relevant to the understanding of DID.

Van Den Bosch et al (2003) assessed levels of trauma, dissociation and PTSD in individuals with a diagnosis of Borderline Personality Disorder and suggested that higher levels of dissociation are related to extremely abusive early experiences. Findings suggested that levels of dissociation were highest amongst those with a history of sexual and physical abuse before the age of 16; those who were abused by more than one perpetrator; and those who had experienced severe maternal dysfunction. Although this study did not specifically research DID, the findings do suggest a link between high levels of dissociation (a described symptom of DID) and trauma. Scropo et al (1998) found similar results when they completed research comparing psychiatric patients diagnosed with DID and non-dissociative psychiatric patients. They found that participants with a diagnosis of DID reported more severe childhood trauma, often beginning at an early age. Lev-Wiesel (2008) suggests that early, specifically sexual, abuse is linked to the development of Dissociative Disorders in later life. Silberg (1998) explains that sexual abuse renders the body no longer safe, therefore the only way of escaping the experience is mentally, using mechanisms such as dissociation.

Trauma has been linked to a number of disorders such as Schizophrenia (Fuller, 2010), Borderline Personality Disorder (Van Dijke. Ford, Van Son, Frank & Van Der Hart, 2013) and Major Depression (Chu, Williams, Harris, Byrant, & Gatt, 2013) which begs the question why exposure to trauma is linked to the development of DID in some individuals and not others. Sinason (2011) asserts that it is the

extremity of the abuse and trauma that is linked to the development of DID, and states that ritualistic abuse has been disclosed by some individuals diagnosed with DID. However, the existence of ritualistic abuse has been questioned by Bottom, Shaver and Goodman (1996) and little evidence has been found to support the concept (La Fontaine, 1998). Sachs (2007) draws on Kahr's (2007) concept of infanticidal attachment, suggesting that this form of attachment can be subdivided into symbolic and concrete. She suggests that individuals who develop DID experience deliberate acts of violence from caregivers, intended to harm the child, which she refers to as concrete infanticidal attachment. She compares this to the violence that has been reported by those who develop schizophrenia, where danger is suggested to the child rather than acted out; Sachs calls this symbolic infanticidal attachment. Further research into the link between attachment and the diagnosis of DID will be discussed later in this chapter.

Neurological considerations.

Further research into the link between the diagnosis of DID and childhood abuse has implicated the hippocampus and the amygdala areas of the brain, which respond to stress and are involved in managing distress and regulating emotions. Vermetten, Schmahl, Lindner, Loewenstein and Bremner (2006) found that individuals with a diagnosis of DID displayed smaller hippocampal volumes than control participants. Changes in hippocampal volume are thought to be due to prolonged exposure to glucocorticoids released during stressful experiences, suggesting that individuals diagnosed with DID may have smaller hippocampal volume due to exposure to prolonged stress caused by trauma. However, this link is correlational and does not confirm that the experience of DID is caused by early trauma.

Korzekwa et al (2009) also discuss a neurological basis for dissociative behaviour that could be relevant when considering DID. They describe the role of the amygdala as identifying the threat of certain events and guiding the subsequent emotional reaction. These researchers suggest that early maltreatment can create damaging levels of cortisol and glutamate, leading to structural change in the brain (such as a reduction in volume of the amygdala) which has been found in some individuals diagnosed with DID. Therefore dissociative behaviour could develop as the brain's way of lowering levels of arousal to cope with early trauma, and DID may develop in exceptional cases where the trauma is severe. The development of brain

structures such as the hippocampus and the amygdala occurs early in life, suggesting that changes found in these areas are a result of early experiences rather than later events in adulthood (Cole & Cole, 2001).

Links between dissociation, DID and attachment.

The link between DID and childhood trauma has led researchers to consider the specific early experiences that may lead to the development of DID. A great deal of literature now assumes that DID is a result of dysfunctional attachment styles (Liotti, 2004; Barach, 1991). The word attachment refers to the relationship between a child and their primary caregiver; forming this attachment is universal among humans and important for survival (Cole & Cole, 2001). Bowlby (1988) described attachment behaviour as:

‘Any form of behaviour that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world’ (p. 29).

Attachment theory was developed by John Bowlby (1988) and suggests that infants are driven by an internal motivation to form an attachment with a caregiver, ensuring their survival. Barach (1991) appears to be one of the first researchers who drew the link between Bowlby’s concept of detachment, which is described as a form of defence in the child following a long separation from a caregiver (Bowlby, 1988, p. 37), and the diagnosis of DID. Barach noticed how individuals diagnosed with DID tended to express emotional unresponsiveness and indifference, similar to that seen in children whose attachment style Bowlby described as detached, and suggested that DID is a disorder of attachment and relational difficulties.

Childhood attachment has been measured using the Strange Situation, a procedure developed by Mary Ainsworth, which observes infant’s responses to the departure of their primary caregiver (usually their mother), the arrival and meeting of a stranger and reunion with their primary caregiver. Through this procedure different behavioural patterns are identified and labelled as styles of attachment. Three patterns are considered as organised styles as infants display consistent patterns of behaviour: secure; anxious/avoidant; and anxious/resistant. Some infants did not fit into these categories and appeared unclassifiable (Ainsworth, Blehar, Waters & Wall, 1978). From this unclassifiable category, Main and Solomon (1990) identified

a disorganised/disorientated category of attachment. Infants with attachment styles within this category demonstrated disorganised behaviour, behaving in odd and conflicting ways towards their caregiver (Liotti, 1992). Fonagy (2011) suggested that children who were classified as having a disorganised/disoriented style of attachment behaved in this way due to experiencing their caregivers as very inconsistent, behaving abusively or neglectfully at certain times and loving at others. Due to these inconsistencies in caregiver behaviour, infants are unable to develop organised ways of responding.

A number of researchers (Ogawa, Sroufe, Weomfield, Carlson & Egeland, 1997; Carlson, 1998) have suggested that early disorganised/disorientated attachment could be related to the higher levels of dissociative behaviour and specifically to the diagnosis of DID (Fonagy, 2011). Ogawa et al (1997) investigated the first 19 years of the lives of 168 young adults scored as having a disorganised/disorientated attachment style at 12 and 18 months of age. The researchers explored variables such as experiences of trauma and levels of dissociation. Findings suggested that disorganised patterns of attachment were strong predictors of later high levels of dissociation (Ogawa et al, 1997). Similarly Carlson (1998) followed 157 participants from birth to 19 years of age. Findings suggested that disorganised attachment was correlated significantly with early relational experiences such as the mother-child relationship and the quality of caregiving received by the child. Early attachment disorganisation also correlated with variables relating to behavioural problems in school, psychopathology and increased levels of dissociation in adolescence. The studies mentioned above explore dissociative behaviour rather than Dissociative Disorders or specifically DID. However, they do identify that dissociative behaviour, a described symptom of DID, is linked to early attachment difficulties, suggesting that the development of DID may also be linked to early relational difficulties.

Additional support for the idea that attachment behaviour and dissociative behaviour are connected has emerged from studies using the Adult Attachment Interview (AAI). This interview explores individuals' memories of past attachment relationships (Liotti, 2004). The scoring system categorises individuals into three organised states of mind: autonomous; dismissing; and preoccupied. Adults can also be categorised as 'unresolved' or 'cannot classify', both of which have been linked with disorganised attachment in childhood (Liotti, 2006). Liotti (2006) suggests that individuals who fall into the unresolved category seem to have unorganised

memories of traumas; whereas those who cannot be classified present incoherent states of mind about attachment. West, Adam, Spreng and Rose (2001) studied 69 adolescents who were scored as unresolved or unclassifiable by the AAI. These individuals were then compared to 64 adolescents who were classified under an organised style of attachment. The results suggest that unresolved or unclassifiable patterns of attachment are correlated with higher levels of dissociative behaviour.

Liotti (2006) has written a great deal on the subject of Dissociative Disorders, DID and disorganised attachment and takes the position that infant attachment disorganisation is a dissociative process. Liotti suggests that children who experience abuse from a caregiver are trapped in a difficult dilemma: the child is driven by a need to form an attachment bond, to create a relationship with a caregiver in order to survive, but, creating and maintaining that bond is also dangerous for the child. He states that the attachment becomes disorganised because the child never knows what to expect or how to behave as the caregiver's behaviour is inconsistent. To manage this impossible situation the child may start to collude with the parent's denial of the abuse, preserving the attachment and using dissociation to push the abuse out of awareness (Liotti, 2006).

Bowlby's theory of internal working models has also been used to explain how dissociative behaviour leads to the development of multiple identities identified in the diagnosis of DID. Fonagy (2011) suggests that due to the inconsistency of parent's behaviour, different self-representations may be created by the infant to cope with the different interactions with the primary caregiver. Bowlby (1973) had also suggested that unhappy care-seeking interactions could cause the infant to develop multiple internal representations of self instead of developing a unitary or cohesive self. Similarly Liotti (1992) has discussed multiple models of the self developing through attempts to push the abuse out of conscious awareness and suggests that each model created is strengthened by further abuse until these start to be perceived as different alters.

Blizard (1997) offers a similar theory but from an object relations perspective. She states that different internal identities can be viewed as self and object relationships. When a caregiver is inconsistent, sometimes behaving abusively and other times lovingly, a child may separate their memory of the abusive behaviour from that of caregiving behaviour resulting in internalised representations of the parent which

seem like separate people. Blizard (1997) also suggests that in some families, children may be treated as an extension of the parent, leaving the child with no unitary sense of self. This lack of a sense of self and a coherent representation of the caregiver may drive the child to form multiple identities, each of which may relate separately to one of different parent presentations.

Despite research suggesting the link between dissociative symptoms and disorganised attachment, Liotti (2006) noticed that some children experience disorganised/disoriented attachment and do not develop dissociative symptoms. This led him to consider that disorganised attachment may be a precursor to the development of Dissociative Disorders rather than having a direct causal link. He suggests that early disorganised attachment makes an individual more vulnerable to using pathological dissociation in response to later trauma or life difficulties, therefore dissociative behaviour is a result of disorganised attachment and later trauma. Liotti also suggests that instead of the self and personality fragmenting and separate internal identities being formed; trauma happens so early in a child's development that the self and personality is never able to form and remains in a fragmented state which was present at birth. Liotti's ideas challenge the theory that dissociative behaviour and DID are developed later in childhood, as defences against trauma, but also makes assumptions concerning when and how a child's personality and sense of self forms.

Other researchers (Lyons-Ruth, Dutra, Schuder & Bianchi, 2006) have focused on dissociative behaviour rather than DID, assuming the link between disorganised/disorientated attachment and dissociation but questioning whether this style of attachment is only caused by abuse or early trauma. Putnam (1997) suggests that there is more to the creation of Dissociative Disorders than exposure to trauma, as individuals who have not been traumatised sometimes displayed dissociative behaviours, and not all those who have experienced trauma dissociated. He suggested that dissociation was more of a developmental psychopathology, developed through dysfunctional early attachments. Lyons-Ruth et al (2006) supported this idea suggesting that it was not trauma that led to the development of dissociative behaviour but family factors. Dutra, Bureau, Holmes, Lyubchik and Lyons-Ruth (2009) explored the quality of early care and childhood trauma in relation to levels of dissociation in a longitudinal study of 56 young adults. Their results suggested that dissociation in young adulthood was significantly

predicted by the level of parental responsiveness experienced in childhood. Interestingly, the only type of trauma that they found to be linked to dissociation was verbal abuse. These findings suggest that it could be the early interactions between child and caregiver that result in disorganised attachment and later dissociative behaviour.

Schore and Schore's (2008) discussion of regulation theory offers a way of understanding the impact parental responsiveness and interaction with the infant can have. They suggest that attachment is more than a way of maintaining physical safety but also provides a way of regulating internal states and external relationships. Schore (2009) suggests that a secure attachment depends on the mother's ability to regulate the infant's emotions, both positive and negative, through mutual gaze and response to the infant's changes in arousal. Attachment communications can directly affect the development of the central nervous system, the autonomic nervous system and the limbic system, which are involved in processing and regulating emotional responses. Inappropriate responses to a child's expressions of emotions can induce extreme levels of arousal as no interactive repair is offered. Schore (2009) refers to this as relational trauma, which can have a lasting impression on the right brain, the area concerned with the individual's capacity to regulate and manage life stresses and to maintain a unified sense of self.

The idea that an inability to self-regulate emotions could be related to higher levels of dissociative behaviour is also supported by Briere, Weathers and Runtz (2005) who state that trauma exposure accounted for only 4% of the variance in dissociative symptoms. However, Briere (2006) suggested that difficulty in regulating negative emotional states, learned through early attachment, increased the likelihood that a trauma-exposed individual would experience dissociative symptoms, proposing that the ability to self-regulate emotions rather than early trauma per se, could be a vulnerability factor for later dissociative behaviour.

Research carried out by Carlson (1998) and referred to previously in this chapter, supports the idea that parental difficulties impact on attachment style in children and dissociative behaviour in adults. Her findings suggest that early disorganised attachment is associated with certain risk variables such as maternal relationship status (living alone with an infant), maternal risk status (such as maternal mental

health difficulties) and that those infants with high rates of disorganisation were more likely to have experienced insensitive or intrusive caregiving. Carlson discusses the role of emotional regulation in attachment, suggesting that when an infant has a frightened or frightening caregiver, they are left to manage their own emotions when their capabilities are not fully developed. Carlson (1998) suggests that this reliance on the child's underdeveloped abilities interferes with the development of emotional regulation and internal organisation, leaving the child unable to cope with expressions of emotion and perhaps leading to behaviour such as dissociation.

If dissociative behaviour is a result of poor early attachments, what creates these difficult relationships? Liotti (1992) suggests that parents of disorganised attached babies were more worried by traumatic memories or losses than parents of securely attached babies. Liotti suggests that if parents are traumatised, their own attachment system can be activated frequently, which can result in them seeking comfort from their child. The child is too young to offer the support required and therefore the parent may become angry, aggressive and frightening towards the child. Liotti suggests that this places the child in a difficult situation where they need to maintain the relationship with the parents to ensure survival but being close to the parent is also dangerous. Main and Hesse (1990) refer to this situation as 'fright without solution'. They suggest that a parent can be frightened of the child or the child's emotions and withdraw leaving the child unaware of why the parent is expressing fear, resulting in their own arousal levels increasing. Consistent with the idea that caregivers' own difficulties impact on relationships with their own children are Lyons-Ruth and Jacobvitz's (1999) findings that 80% of children whose parents are rated unresolved on the AAI develop disorganised attachment to their parents.

There has been a great deal of research exploring the link between early attachment, dissociative behaviour and DID (Liotti, 2004, Carlson, 1998). Initially it was suggested that high levels of dissociative behaviour were linked to disorganised/disorientated attachments that had developed as a result of childhood trauma or abuse (Fonagy, 2011; Sinason, 2011). However, in light of research that links dissociative behaviours with early relational difficulties it is possible that DID could be considered a 'developmental pathology' (ISSTD, p. 190) that occurs due to inappropriate interactions in the child care-giver dyad leaving the child unable to regulate emotions correctly and develop a unified sense of self (Briere et al, 2005).

The experience of DID.

Although research into attachment, neurology and trauma are useful in considering factors that may lead to a diagnosis of DID, they don't offer much information about what it is like to define yourself as experiencing DID. A search for more information about individual experience results in four main categories of information within this theme. There are the stories of people who have experienced childhood trauma, been diagnosed with DID and are now writing from a place of recovery. These stories include an article by Olga Trujillo (2009) who describes her experiences of childhood trauma and how she believes she mentally left her body during the abuse and 'broke down' the attacks by placing different elements of the abuse into separate imaginary drawers, which later developed as different identities (Trujillo, 2009). Another article offering access to experience and meaning-making around DID is written by Coyle and Thobaben (1995). In this article Rhonda Coyle describes how she was diagnosed, her experience of living with DID and how she believed her different identities were formed.

Many books have also been written in this style, perhaps most well-known are *Sybil* (Schreiber, 1973) and *I'm Eve* (Costner Sizemore & Sain Pittillo, 1977); others include *When Rabbit Howls* (Chase, 1987), *The Flock* (Casey, 1991), *A Fractured Mind* (Oxnam, 2005) and *Today I'm Alice* (Jamieson, 2009). These books are either written by the individual themselves or in the case of *Sybil* by Flora Rheta Schreiber who states she had spent seven years with Sybil and her therapist Dr Wilbur before writing this book (Schreiber, 1973). Although an interesting way of accessing experience, these articles and books only present one person's perspective and the meaning this individual makes of the diagnosis. Most of the books include descriptions of past abuse and could be criticised for sensationalising the disorder by making it appear dramatic and extreme (Piper & Mersky, 2004). Also these books have been written from a position of reaching recovery, which could alter an individual's perception of what the experience was like at different points in their lives. A common theme across these articles and books is the meaning that is given to the experience of DID as a creative survival technique. Trujillo (2009) states that DID 'allows an individual in hopeless circumstance to preserve some areas of healthy functioning' (p. 2), suggesting that despite the distress and chaos that is linked to experiencing this disorder, most individuals prize and value their experience. The idea of the diagnosis of DID as being valued by individuals is

echoed by Saakvitne (2008) who states that 'more than many diagnoses, the diagnosis of DID creates an identity in and of itself' (p. 257).

Other sources of information about experience are poems and short stories written by individuals diagnosed with DID. *First Person Plural* is a survivor led charity for individuals diagnosed with DID and publishes a quarterly magazine called *Rainbows End*; another organisation called *Positive Outcomes for Dissociative Survivors* (PODS) publishes a magazine called *Multiple Parts* three times a year. Each edition of both magazines contains a number of poems and short stories written to express the difficulties of living with DID. A book edited by Cohen, Giller and W (1991) called *Multiple Personality Disorder from the Inside Out* also offers short stories, comments and poems from individuals who are diagnosed with DID about their experiences and difficulties.

One of the most common ways of exploring the experiences of individuals diagnosed with DID is through case studies written by professionals. For example Baker (2010) discusses the case of Jackie and how through therapy she was able to restore a sense of self. Rothschild (2009) discusses her work with Sarah and how together they helped Sarah restore a sense of herself as a continuous entity. Stickley and Nickeas (2006) take a narrative approach to discussing the experiences of Rachel offering a review of Rachel's journey from early abuse, to a later diagnosis of DID. These case studies often demonstrate how a professional worked with a client with DID and how successful this was, although because they are written in the third person by researchers who have worked with the individual discussed in the case study, they offer limited insight into what the experience was like for the individual themselves.

The fourth category of information around the experience of DID is through investigations of individual's subjective experience using qualitative research methods, although I have only discovered one example of a study which seeks to explore the experience of living with DID by interviewing individuals with the condition and analysing the results. Cannon (2010) wrote her Masters dissertation to explore the question 'what is it like living with Dissociative Identity Disorder – and what has helped or hindered on the journey?'. She used interpretative phenomenological analysis (IPA) to analyse semi-structured interviews with seven individuals who had been diagnosed with DID. Cannon's (2010) findings

emphasised the individuality of people's experiences and acts as a reminder of the importance of considering the individual's experience of living with any mental health problem. However, she does highlight some common themes between interviews: for example, participants believed that problems accessing appropriate services and treatment had exacerbated the difficulties of living with DID. They also reported a general lack of understanding about the disorder, not only from professionals but also from friends and family, which led to strong feelings of isolation. Support from therapists and support workers was described as very valuable. Another common thread was the difficulties participants experienced when relating to others. This finding could link with the research relating dissociative behaviour with disorganised attachment patterns in childhood and ability to self-regulate emotions. Cannon (2010) suggests that the experiences of relationships for those who define themselves as having DID require further investigation.

Linking the perceived experience of DID, early attachment and relationships.

Consideration of the literature around dissociative behaviour and DID suggests that early dysfunctional attachment has been implicated in the development of both experiences (Liotti, 2004) and that individuals who have been diagnosed with DID report difficulties in their adult relationships (Cannon, 2010), but there is a lack of information and knowledge about individuals' specific experiences in their relationships.

If we are to assume that early attachment impacts on development, then it is possible that poor early attachment and the experience of dissociative behaviour would impact on the way an individual conducts their adult relationships. Blizard and Bluhm (1994) suggest that the child's internal model of the environment and those in it will create a template for later relationships. Fonagy (2011) suggests that if the infant has negative experiences with their caregiver, they will develop negative representations of others.

Research into the impact of early abuse can give an insight into how individuals' relationships are impacted on by their early experiences. Dorahy (2010), a researcher in New Zealand, has carried out a number of investigations into feelings associated with the experience of childhood abuse, most frequently shame and guilt. In one study he examined the impact of shame, guilt and dissociation on

interpersonal relationships by assessing 81 participants, using the *Structured Interview for Disorders of Extreme Stress*, receiving treatment from a trauma service. Results suggested that levels of lifetime shame and current dissociative behaviour made significant contributions to individuals' relationships. Higher levels of dissociative behaviour were linked to feeling disconnected from others, and served to dissolve interpersonal relationships. Dorahy suggested that this was due to the degree to which dissociation was felt to be uncontrollable, and how this could create feelings of shame that impacted on the individual's relationships.

In a later study, Dorahy and Clearwater (2012) investigated feelings of shame and guilt in adult men who had been sexually abused as children. Data were collected from a focus group of seven participants and analysed using IPA. Findings from this study suggested that childhood sexual abuse impacted on the way individuals viewed themselves which then impacted on how they interacted with others. For example, those viewing themselves as shameful believed others would also judge them in this way. Findings also suggested that feelings of shame and guilt impacted on individuals' sense of worth and how worthy they felt of support from others. One participant described how his feelings about himself impacted on his ability to disclose his abuse history to others: he reported anxiety in sharing his history due to perceived stigma from others and feeling unsure how they would response to his disclosures. This anxiety led him to withdraw from others and avoid their questions, but this left him feeling isolated. Another participant reported feeling as if he never fully understood the internal perceptions of others, leading to feelings of uncertainty around how to react around people.

In another study by Dorahy, Corry, Shannon, Webb, McDermott, Ryan and Dyer (2013), 65 adults receiving treatment for trauma were assessed for PTSD, dissociation, and the impact of these on intimate relationships. Complex PTSD was found to predict three main relationship difficulties: relationship anxiety, relationship depression and fear of relationships. Those participants with higher levels of dissociation were more likely to experience relationship uncertainties; feeling fear and engaging in excessive rumination to try to make sense of their relationships; being more self-critical; and directing inwards feelings of anger about their relationships.

Other research considers how trauma can impact on the way a person positions themselves socially. Dorahy et al (2009) suggest that if an individual feels similar to those in their social group, they can be protected from distress by feeling a sense of connectedness and acceptability as a member of the group. However, in complex PTSD, the authors assert individuals feel disconnected from others and therefore they do not experience this protection. This could also be true of those defining themselves as experiencing DID; alternatively the diagnosis of DID itself may create a social identity for some, allowing them to experience connectedness with others who have the diagnosis.

A study by Barlow, Cromer, Prairie Caron and Freyd (2012) suggests that individuals who define themselves as having DID display higher levels of attachment to companion animals and stuffed animals than student groups who experienced high or low levels of dissociation measured by the *Dissociative Experiences Scale* (DES). Barlow et al suggest that a human-animal bond could serve as an attachment to compensate for lack of attachment from early caregivers; however, it also could be that due to difficulties in relationships with people, individuals who define themselves in this way seek attachment from other sources.

Koral (2008) describes how familial and social support can be protective factors against the development of DID, emphasising the importance of relationships. However, she also considers how children with disorganised attachments may be less likely to seek social support networks, impeding the development of social skills and impacting on their ability to create and maintain relationships later in life. Hoyt (2002) suggests that dissociation is a defence against pain and danger and therefore considers that the use of dissociation later on in life can impact on the awareness of danger cues, leaving the individual vulnerable to dangerous situations and unhealthy relationships. Barker (2010) discusses 'traumatic bonding' (p. 9) where an individual may hold tightly onto a relationship that seems harmful. Barker explains that if a child experiences fear they may seek attachment: the more frightened they feel, the more tightly they will hold onto the attachment they have, even if it is causing them distress. This pattern can continue into adulthood leaving individuals maintaining relationships that are harmful. Therefore, depending on an individual's past experiences, those who define themselves as having DID may find themselves in relationships that could be unhealthy. Olio and Cornell (1993) suggest that the violations that are involved in early abuse, especially from those in

positions of authority within the family, may create difficulties with trust, intimacy and dependency later on in life.

Qualitative research has been carried out with those who report sexual abuse allowing access to the experience of relationships in this sample of individuals, however, no research has been carried out specifically to look at the relational experiences of those who define themselves as having DID. A few insights can be gathered through Cannon's (2010) investigation of 'what is it like living with DID?' Her findings suggest that individuals who define themselves in this way experience difficulty making friends; one of the reasons for this was described as the struggle to balance the needs of friends with the needs of internal identities. Other difficulties included the feeling that others did not understand or believe their experience of DID and therefore participants reported feeling as if they were hiding their real selves from others. Participants also reported problems with mentalisation, feeling as if they were unable to hold another person in mind when they were out of their sight, this meant participants had the ability to leave friends and end relationships with ease. Missing out on developmental stages was also reported, leaving individuals feeling as if they did not have a secure attachment figure in childhood, which created difficulties in connecting to others in adulthood.

Trujillo (2009) offers a glimpse into the impact she believes developing DID has had on her relationships. She describes feeling and behaving differently depending on the person she was with and this only becoming apparent when talking to others and getting feedback from them. She stated that she found trusting others to be very difficult, due to her belief that others would never love her or be honest with her. She stated that she managed these difficulties by often hiding herself from others, building new relationships very slowly and carefully.

The importance of the present study

There has been some research into the lived experience of those who define themselves as having DID but this has been limited and there appears to be little information about the experience of adult relationships in this population. This stands in contrast to the wealth of research linking dissociative behaviour with dysfunctional early attachment (Liotti, 2006) and the impact that early attachment patterns have been shown to have on later relational functioning (Reuter & Maryann, 2011). It is this gap in the literature that I hope to address in the following

research exploring the experiences of relationships in individuals who define themselves as having DID. Counselling psychology, as a discipline, seeks the latest research and approaches to guide interventions; further research into the lived experience of DID would be useful to guide therapeutic interventions with this client group.

I believe finding out more information about the experiences of relationships in individuals who define themselves in this way can be beneficial to the individual themselves, the professionals working with that individual and the healthcare system.

DID continues to be considered as a rare diagnosis, and controversy still remains about its existence (Piper and Mersky, 2004; Paris, 2012). This can lead to confusion about diagnosis and how best to help individuals who perceive themselves as having DID. Individuals who are given this diagnosis describe spending on average six to seven years in the treatment system before receiving appropriate support (Gleaves, 1996). The link between the diagnosis of DID and childhood trauma suggests that individuals are vulnerable and therefore accessing appropriate treatment quickly would be very beneficial. Feeling abnormal can lead an individual to withdraw from others, feeling misunderstood and isolated. An increased understanding of their own and others' experiences may reduce loneliness, isolation and distress in those who define themselves in this way.

The ISSTD (2011) state that difficulties in diagnosing DID may be due to the lack of education among professionals concerning dissociation in general. Dell (1988) completed a survey on professionals' experiences of working with individuals who defined themselves as having DID. His findings suggested that more than 80% had experienced negative reactions from colleagues, including refusals of admission to hospitals for their clients. More recently, Gillig (2009) suggested that clients who defined themselves as experiencing DID evoked anxiety in professionals due to their unusual clinical presentation. She also suggested that the fear of individuals evading responsibility, especially from criminal offenses, also caused professionals anxiety working with DID. Warner and Wilkins (2003), however, highlight that in reacting negatively, services can re-enact earlier abusive relationships, making treatment more difficult.

Dell (1988) states that the common image of DID is inaccurate and that switching and amnesia, commonly assumed to be the main symptoms of DID, occur for less than a half of a percent of the time (as cited in Trauma and Abuse Group, 2002). Instead, Dell describes the main difficulties as regular intrusions that interrupt functioning, and the development of a sense of self. These comments suggest that very little is actually known about the experience of those who perceive themselves to have a diagnosis of DID and more knowledge on the subject would be helpful.

Gaining a greater understanding of the experience of relationships in this client group would also help to inform therapeutic work, especially in terms of building and maintaining the therapeutic relationship. Perhaps knowing the difficulties clients may face and which relationship dynamics may be enacted within the therapeutic relationship would be helpful for therapists. As a trainee counselling psychologist my work is very much centred on the therapeutic relationship and my interventions are based on empirical evidence. From the perspective of a counselling psychologist, more information concerning experiences of relationships in this group of individuals would give findings which can then be used to guide therapeutic interventions.

Receiving appropriate treatment is not only beneficial to the individual but also to the health service. Lloyd (2011) explored one client's treatment journey before she had been diagnosed with DID. The client had been engaged with the health service for 13 years before receiving the diagnosis that enabled her to gain access to long-term therapy. Lloyd presented evidence that the clinical cost of the 13 years of crisis management was far higher than the long-term therapy which was proving to be much more helpful. Research by Brand et al (2009) has suggested that appropriate therapeutic treatment for individuals who define themselves as being diagnosed with DID can be very successful. By studying individuals who had engaged in long-term therapy she noticed that clients in the later stages engaged in fewer self-harming behaviours, had fewer hospital admissions and displayed increases in levels of functioning and decreases in levels of distress.

This discussion suggests there are many benefits to learning more about the experience of those who define themselves as having DID. Although some professionals such as Paris, (2012) state that there is no justification for including the diagnosis of DID in DSM-5, individuals who define themselves in this way clearly experience difficulty and distress. With this in mind it is important to have more

information about their experiences in relationships in order to provide appropriate support to reduce distress and work towards improving their quality of life.

Research aims

Research question:

What are the experiences of relationships in individuals who define themselves as having Dissociative Identity Disorder?

Research aims:

1. To gain an insight into experiences of relationships in individuals who define themselves as having DID.
2. To explore the meaning that these individuals make of their relationships, considering the perceived impact of experiencing DID on their relationships.

Entering into the debate

But how do we study a concept that is so questionable? In studying the concept, am I assuming that individuals can experience alternative identities and that DID does exist? Also by using the diagnostic label of DID, am I entering into the debate concerning the accuracy and value of diagnostic labelling?

Debates and controversies have always existed around the value of diagnostic labelling and the publication of manuals of mental disorder. Mayes and Horwitz (2005) explore the history and controversies behind previous versions of the American Psychiatric Association's Diagnostic and Statistical Manuals and more recently the publication of DSM 5 (APA, 2013) has again provoked these debates. For six months letters were written into *The Psychologist*, the *British Psychological Society's* monthly publication, regarding the positives and negatives of using diagnostic categories and certainly among psychologists there are passionate and divided opinions on the subject.

Those concerned about the use of diagnosis in mental health suggest that labelling people can depersonalise the individual and their experience, and reduce complex difficulties to a simple category (Poland, Eckardt & Spaulding, 1994). There is also

some stigma attached to certain diagnoses which may cause an already vulnerable individual further distress. In addition to this is the fact that medical theories of mental disorder are far from being proved and that due to overlaps of symptoms between diagnoses individuals can often be given a label which may not be accurate.

Applying these difficulties to DID, Warner and Wilkins (2003) suggest that making diagnostic constructs appear 'real' imposes formulations on certain disorders, which can then shape individual's actions and the way they perceive themselves (p.170). This is supported by Hegeman (2009), who suggests that individuals experiencing DID may come to cherish their various parts rather than needing to escape the trauma that led to their development. This creation of an identity based on a diagnosis could be true of DID.

The opposite opinion on this topic is presented by Brewin, Lanius and Novac (2009) who suggest that diagnostic labels are descriptive and are helpful for professionals as they use a commonly understood language. Regier, Narrow, Kuhl and Kupfer (2009) also describe how diagnostic manuals do not ignore the individual and their experience taking into account cultural and societal influences.

I believe there is truth in both of these opinions. Client's issues are complex and reducing them to one label can seem simplistic and additional difficulties, symptoms or experiences can be overlooked. However, I believe there is a need for diagnoses if they are used carefully. A diagnosis can help to guide interventions, both psychological and medical and in this way can be extremely valuable. Some of my own clients describe feeling as if they have benefitted from receiving a diagnosis, perhaps finding comfort in having a name to put to their experience and feeling relieved that they are not alone. However, this is very individual and the use of diagnostic labels relies on professionals not holding them too tightly, explaining them properly to clients, being aware of other influences and difficulties which could be impacting on a client's experience and understanding their limitations. Wessely (2013) summarizes this by stating 'a classification system is like a map. And just as any map is provisional, ready to be changed as the landscape changes, so is classification' (p.1).

Cohen (2004) presents a different and interesting perspective on DID and the issue of diagnosis. He is against diagnosis, and states that 'calling this cluster of experiences a disorder suggests some kind of verifiable pathology that has its basis in something that is malfunctioning within the person' (p. 218). He goes on to debate how this attitude can exacerbate feelings and thoughts in the client that there is something wrong with them that they cannot control, leaving individuals continuing to feel isolated and alone in their experiences. Lawler- Fahey states:

'Instead of arguing about the existence of Multiple Personality Disorder or dissociation we should recognise that dissociation exists in different degrees and treat the individual who is traumatized, rather than leave him or her without treatment' (as cited in Cohen, 2004, p. 219).

If I believe the diagnosis of DID is useful am I assuming that the symptoms that fall under the category of DID are real? That individuals can experience alternative identities? Spanos (1994) argues that DID is a socially created phenomenon, created by clients who desire the attention that is associated with the diagnosis or by therapists who encourage, consciously or unconsciously, the symptoms to emerge. McIntee (2006) describes how more clients have been diagnosed with DID in America compared to other countries and that there was a significant rise in individuals being given this diagnosis following increased media portrayals of DID such as the release of *Sybil* (Schreiber, 1973). These comments support Paris (2012) who states that DID is a medical fad.

Those, such as Kluft (1995), who state that DID is a real diagnostic criteria consider it to be a creative technique used to survive severe childhood trauma. Kluft (1995) has written a number of articles about his experience of working with those who define themselves as experiencing DID and has worked to provide evidence that the experience and memories associated with the diagnosis are not fabricated through client-therapist interaction but were present before therapy started. Sinason (2011) links the development of the experience of DID with extreme childhood abuse and Liotti (2006) considers the impact of early disorganised attachment. The recent development of the Campaign for the Inclusion and Recognition of Multiplicity and Dissociation suggests that this diagnosis is not a medical fad or something that is fading away.

I am unsure whether the diagnostic criteria of DID is real and I don't know if people can experience alternative identities or whether this is just an individual's perception of what they are experiencing. Scropo et al's (1998) comparison between inpatients diagnosed with DID and inpatients without the diagnosis highlighted that those diagnosed with DID reported a number of distinctive traits that separated them from the other inpatient group. These included greater imaginative activity; a reduced ability to integrate mental contents; an increased tendency to access different states of consciousness; and an unusual view of reality. Studies such as this suggest to me that there is a set of characteristics that is common to this client group which differentiates them from others experiencing mental health issues and implies that there is a phenomenon that exists or develops as a result of a specific experience.

However, the time I have spent with participants and their interview data has led me to believe that the perceived experience of DID is different between individuals, perhaps true of most mental health difficulties, and is not reflective of the diagnostic criteria offered by DSM-5 (APA, 2013). I do not believe the experience that is stated by individuals who define themselves in this way is fabricated or created through the therapeutic relationship but I do acknowledge that society and cultural influences have an impact on and can shape the use of diagnoses. Therefore maybe there is truth in both arguments for and against the diagnosis of DID. If a phenomenon exists, that is currently labelled as DID, I find I am drawn to Dell (1988) who states that the common image of DID is inaccurate, that switching and amnesia occur less than half a percent of the time and that the main problems for the client group are regular intrusions and the difficulties around the development of a sense of self. Dell's description is the closest I can find which reflects my own experience of meeting with those who define themselves as having DID.

Personal relationship with the research

Hegeman (2009) describes how the therapist of a client who presents as experiencing DID is caught in a dilemma, experiencing 'a culturally induced pull towards disbelief' (p. 190) created by the controversy towards the diagnosis, but at the same time feeling empathy towards her client. The dilemma described by Hegeman (2009) is one that I experienced as I embarked on this research. Initially it was important for me to believe in the existence of the diagnosis of DID and that individuals can experience 'two or more distinct personality states' (APA, 2013) but

on reflection this is something I can never prove. I wonder if it was important for me to believe in this diagnosis because it validated individuals who defined themselves in this way. I have no personal connection with any individuals diagnosed with DID or any experience of a Dissociative Disorder myself. I have, however, noticed in my clinical work that I am drawn to working with individuals who are often overlooked by society such as offenders, those who misuse substances and also to deeply traumatised individuals, perhaps there is a desire to rescue or defend these clients and this is activated when I consider the diagnosis of DID.

I have noticed that I have been strongly influenced by the reading I have completed around the subject of DID and my interviews with participants. Hegeman (2009) suggests that a theme of 'do you believe me?' (p. 192) is common between client and therapist when working with extreme trauma. She suggests that feelings of disbelief are sometimes a defence in the therapist to protect against the horrors of abuse. I experienced this theme during my interactions with participants and felt as if they wanted me to believe and invest in their experiences. This experience may have also influenced me in feeling as if I needed to believe in the existence of DID.

Considering my choice to explore relational experiences, I am aware of being attracted to thinking in terms of early attachment patterns among my clients and believe, based on my own experience, that early attachments have a huge impact on the development of the individual and their later relationships. These beliefs about the importance of attachment will shape this research, perhaps it already has in deciding to explore this subject, however, I cannot eliminate these feelings but I can remain aware of them and how they may impact on data collection and interpretation.

Although my personal relationship with this research has changed: I am now more comfortable stating 'I don't know' rather than fighting for my participants, my interest in understanding experience and the meaning given to this experience by those who perceive themselves to have DID has not. Although I now consider the disorder in a more critical way it still seems a fascinating and worthwhile area to explore.

Methodology

Overview

The previous chapter introduced the research question and explored previous literature in the area of dissociation and DID. Within this chapter, I discuss the methodology used to explore the research question. I start by offering a short summary of the research design, allowing the reader to understand what actually occurred, before breaking down the steps and decisions made that led to conducting the research. Following this, I will offer a rationale behind the choice to use a qualitative perspective and will then focus in more depth on interpretative phenomenological analysis (IPA), the specific methodology selected. I will also consider my own understanding of knowledge and how this impacted on the research design and findings.

The chapter continues by describing the way in which participants were recruited and data collected, leading to a detailed description of how the data were transcribed and analysed and the ethical considerations that were held in mind throughout the procedure. There will then be a brief discussion around evaluation of the findings, and I will conclude the chapter by considering my own role in the methodology process.

Research Design

Data were collected using semi-structured interviews. Interviews were carried out on a small, homogenous sample of seven participants³. Data were approached using a qualitative methodology and analysed using interpretative phenomenological analysis (IPA).

Rationale for a Qualitative Perspective

There were four main reasons behind the decision to use a qualitative perspective to explore the current research question.

³ Please note the use of the word 'participant' will be used throughout this report to refer to individuals who volunteered to take part in this research. I was guided by the code of human research ethics (BPS, 2010) in my decision to use this term as it acknowledges individual's 'active role' and their 'autonomy and agency' in taking part in research (p. 5-6).

The principal reason was the type of answers provided by this approach. Willig (2012) states that a search for meaning is the concern of qualitative research, achieved by exploring participants' experiences and how these experiences are made sense of. My research question sought to explore individuals' subjective experience of relationships and the meaning they attached to this in relation to their perceived experience of DID. I was not searching for a causal link or a correlation between described qualities of DID and relationship experience, which may have been more appropriately explored by a quantitative perspective. So little appeared to be known about the perceived experience of DID that quantifying the phenomenon seemed premature; therefore I sought a methodology that allowed flexibility and space to capture aspects of the experience that had not previously been considered. As described by Patton (1990) the strength of qualitative research is in its ability to collect detailed information from a smaller number of participants, however, this reduces the generalisability of the findings. Due to the lack of information about the experience of DID, this research did not aim to collect findings that could be generalised to every individual with this diagnosis. Instead it aimed to take a curious approach to explore specific individuals' experiences, which may offer suggestions about the concept of DID that can be researched further in the future. Taking a qualitative perspective therefore allowed for this collection of rich and detailed data about participant's subjective experiences and therefore seemed the most appropriate approach to explore this research question.

The second reason behind the decision to use a qualitative methodology was my own belief, that I, as researcher, would have an impact on the data collected. Working as a trainee counselling psychologist, I am acutely aware of my own role in the process of therapy and therefore felt that my role in this research could not be ignored. Willig (2008) describes the way in which qualitative research allows the researcher to be reflexive and acknowledge their own contribution in constructing meanings from the data. Using a qualitative methodology allowed the opportunity for my own role to be explored throughout the research process.

Political issues were the third reason that guided the decision to use a qualitative approach. Willig (2012) discusses political aspects of research and how some researchers are motivated by wanting to give participants a voice, especially those groups who are under-represented. Before embarking on this research, I had a strong interest in the diagnosis of DID and read a lot around the subject. As

mentioned previously, I am aware of my attraction to client groups who are underrepresented and due to the controversy around the diagnosis of DID, the experiences of those who define themselves in this way seem to be overlooked. Despite my reading, I continued to be left without a firm understanding of what the diagnosis of DID was or how I positioned myself in relation to it. From books and magazines written by individuals defining themselves in this way, I gained a sense of how unheard individuals felt and how difficult this could make access to treatment that was perceived to be essential in reducing distress. I believed using a qualitative perspective would offer individuals identifying with the diagnosis a voice, and through their voice some access to their perceived experiences of DID and the impact it had on their lives. This knowledge would ultimately improve my own and other professionals' understanding when working with clients who defined themselves in this way.

Lastly, the compatibility between a qualitative perspective and counselling psychology could not be ignored. Counselling psychology is a discipline that combines scientific knowledge with philosophical understanding and is underpinned with humanistic values: its focus is on the individual in context. The division of counselling psychology website summarises perfectly the values and focus of counselling psychology:

'So we meet people. Not problems, not cases, not patients, we relate with people. And through that relationship - derived from our values and embedded in the mixed traditions at our roots - we try to help people. In the end it's not the suffering or dysfunction that we meet, it's the people who are struggling. We see people.' (Frankland & Walsh , 2000)

This focus on the individual is consistent with the interests of qualitative research: that it is the individual's experience and their meaning-making that is important in understanding a phenomenon in greater depth.

Epistemological Framework

'Epistemological positions are characterised by a set of assumptions about knowledge and knowing that provide answers to the question "what and how can we know".' (Willig, 2012, p. 9)

An epistemological framework is the position that is taken when considering what it is possible to know in the world. Harper (2012) describes how our epistemological position impacts on the assumptions we make about the relationship between our data and the world, and therefore how important it is to be aware of the position that we, as researchers, take. To identify my own epistemological position I have considered my answers to Willig's (2012, p.10) three questions:

1. 'What kind of knowledge do I aim to create?
2. What are the assumptions that I make about the (material, social and psychological) worlds that I study?
3. How do I conceptualise the role of the researcher in the research process?/What is the relationship between myself and the knowledge I aim to generate?'

Initially, I considered the type of knowledge I wished to create. As discussed in the previous section, my desire was to collect knowledge about the subjective experience of participants. Willig (2012) states that in seeking this type of data, the researcher is making the assumption that there is something 'out there' to research, that there is some form of reality. However I knew I did not place any judgement on how this reality related to other aspects of the world or the accuracy of the reality. I assumed that the reality that was shared with me by participants was important and accessed some level of their experience. This position is very similar to how I work as a therapist, working with what the client brings me and reserving judgement. However, I also was aware of considering the reality shared with me as something very context specific, as suggested by Madill, Jordan and Shirley (2000). This reality was to an extent constructed between myself as the researcher and the participant through our interactions and their interpretations during data collection and my own interpretations during the analysis.

When considering Willig's (2012) second question I acknowledged that my tendency was to focus on an individual's subjective experience at the expense of thinking about their material and social worlds. However, I did believe that the latter are important elements in developing an understanding of an individual's experience. Each individual has a very different involvement with the world due to their past experiences and current context therefore I also sought to consider 'what is the world like for this person?' as suggested by Willig (2012, p. 14).

In answering Willig's (2012) final question I concluded that my role as a researcher was initially to aim to create an environment where participants felt safe and comfortable enough to discuss their experiences openly. Once interviews had been completed, my role was to get as close as possible to the experience described by participants, through careful and systematic analysis of the data. However, I recognised the limits of this closeness and that I needed to take my own relationship with the diagnosis of DID and the process of the research into account.

Through consideration of Willig's (2012) three questions I developed a clearer understanding of my own approach to knowledge and how this impacted on the process of this research. I concluded that I sought phenomenological knowledge as described by Willig (2012), by taking a contextual constructionist epistemology as described by Madill et al (2000). Willig (2012) describes phenomenological knowledge as 'knowledge of the quality and texture of experience' (p. 11). In seeking this knowledge I took an interpretative approach, accepting the data, but using my own knowledge to consider the impact of social or psychological factors that may impact on the participant's experiences. Willig (2012) suggests that contextual constructionism 'accepts the inevitability of bringing one's personal and cultural perspectives to bear on research projects' (p. 10) and therefore this allowed me to consider myself in the research process while taking an interpretive stance. Contextual constructionism also was a good fit with my own belief that experiences described by participants were dependent on their own individual life context and that in which data were collected. Jaeger and Rosnaw (1988) summarise this by stating 'human acts or 'events' are active, dynamic and developmental moments of a continuously changing reality' (p.3). This perspective encouraged me to consider the wider social and psychological context for participants; how this may have impacted on the data that were constructed through the interview procedure; and the context in which I was located while analysing the data.

Interpretative Phenomenological Analysis

Smith, Flowers and Larkin (2009) describe interpretative phenomenological analysis (IPA) as a qualitative methodology that is committed to the exploration of lived experience and the meaning that is given to that experience by the individual.

Mainstream psychology has often been preoccupied with producing research results that can be generalised to a wide population, collecting data through quantitative

methodologies, which some researchers have suggested neglects the study of individual experience (Eatough & Smith, 2008). IPA is described as moving away from looking for general theories to the more specific, it has an idiographic commitment and its interest is in the variability of human experience (Smith et al, 2009). Eatough and Smith (2008) describe experience as subjective and therefore a phenomenon instead of a direct reality. It is influenced by our past experiences, our societal influences, our culture, and the meanings we attach to these. IPA's interest is in this subjective experience. Smith et al (2009) describe how life is often lived without explicit awareness of the flow of experience but how, when something major occurs, our attention is drawn to the experience and the significance of it. It is this significant event and the meaning created from it that is explored using IPA.

Smith et al (2009) describe IPA as a recently developed methodology, however, the philosophical roots of the approach can be traced back further in time. The methodology was originally developed for use in psychology and has been used across the discipline, as well as starting to be introduced in other health professions such as nursing and physiotherapy (Steward & Rae, 2013; Cassidy, Reynold, Naylor & De Souza, 2011). Despite IPA's development for use in psychology, Smith and Osborn (2008) suggest that IPA and mainstream psychology come together in terms of their interest in exploring how people think about their experiences but diverge in deciding how this thinking should be best investigated. This suggests that psychology remains concerned with quantitative data and the desire for generalisable results, leaving IPA still fighting for its place as a valued research methodology.

IPA is described by Smith et al (2009) as having three main theoretical underpinnings: phenomenology; hermeneutics; and idiography. Eatough and Smith (2008) state that phenomenology is a philosophical approach that was introduced by Husserl in the early 20th century. The approach is concerned with the idea of what it is like to be human and especially focuses on what it is like to experience events that are important to us. Husserl's ideas, as described by Smith et al (2009), involved stepping out of our everyday experience, where there is often no explicit awareness of this experience, to a 'phenomenological attitude' (p. 12) where focus is directed inwards, allowing reflection on particular objects or events. The difficulty in adopting this attitude is, as Smith et al (2009) state, 'disengaging from the activity' (p.13) and moving away from our tendency to attribute meaning to the activity. To

be able to do this Husserl described a need to 'bracket off' our preconceptions and previous experiences and put these to one side, enabling access to the core of the experience (Smith et al, 2009, p. 13). Smith et al (2009) describe how phenomenology has been developed by other scholars such as Heidegger, Merleau-Ponty and Sartre. Heidegger's approach is particularly interesting when considering IPA. Heidegger was initially a student of Husserl's, who in time grew to disagree with the idea of 'bracketing', believing that it wasn't possible for knowledge to exist without some form of interpretation and therefore putting to one side preconceptions and previous experience was simply not possible (Smith et al, 2009). IPA acknowledges that objectivity is not possible and this leads onto another underpinning of IPA, hermeneutics.

Smith (2008) describes IPA as taking two different stances: an empathic stance, where the researcher is trying to understand what it is like for an individual to have the experience; and a questioning stance, where the researcher is interpreting the meaning behind the individual's behaviour. Hermeneutics, described by Smith et al (2009), refers to the theory of interpretation, how phenomena are interpreted, and, in the case of IPA, how experience is interpreted. Eatough and Smith (2008) describe hermeneutics as not just a method of thinking but rather how 'the very nature of being-in-the-world is hermeneutic' (p. 180), therefore we are interpreting on some level every moment of the day. Smith et al (2009) discuss interpretation as a process moving between the part and the whole. They use the example of a word (a part) that can only be understood fully by looking at the sentence (the whole) in which it appears; however, to understand the sentence, individual words need to be examined. This is referred to as the hermeneutic circle (p. 28). An additional dimension is added when we consider that our understanding of an event is influenced by our existing knowledge. Smith and Osborn (2008) describe IPA as involving a double hermeneutic or a 'two stage interpretation process' (p. 53). They state that 'as participants are trying to make sense of their world the researcher is trying to make sense of the participants making sense of their world' (Smith & Osborn, 2008, p. 53). Therefore a consideration in using IPA is how the researcher is interpreting participants' data and what could be impacting on this interpretation, such as their preconceptions based on past experience. Smith et al (2009) emphasise the importance of being aware of preconceptions, both before starting analysis, and allowing them to emerge through the reading of the data.

Eatough and Smith (2008) describe idiography as a focus on 'the particular rather than the universal' (p. 183). In terms of IPA, this refers to the focus on the individual's subjective experience. Allport (1940) noted a decline in interest in the individual experience, stating that over time the idiographic use of case studies had reduced. This is perhaps consistent with the desire of mainstream psychology for results that can be generalised. However, the advantage of focusing on the individual is that one can learn a great deal about that person and their experience. Fade (2004) states that 'IPA can be used to develop 'thick descriptions' (p. 647) that may help illuminate human experience'. Alongside this, Warnock suggests that idiographic knowledge can also be helpful in understanding more universal phenomena, either by affirming previous knowledge collected about humanity, or by drawing attention to new and previous unnoticed experiences that could be explored further with other participants (as cited in Eatough and Smith, 2008, p. 183).

Rationale behind choosing IPA.

There were several reasons why IPA was selected to explore the experience of relationships in individuals who defined themselves as having DID. Smith et al (2009) state that the primary reason for selecting to use IPA should be that it is consistent with the epistemological position of the research question. As discussed in the previous section, my research question was considered in a contextual constructionist framework. Harper (2012) describes how researchers from different epistemological positions can use the same methodology; however, Smith et al (2009) describe certain assumptions made specifically by IPA. It assumes that our data can tell us something about people's experiences and therefore takes a more realist than relativist position. However, IPA also acknowledges the role of interpretation from the researcher and considers the social, cultural and psychological impact on experience. Willig (2012) suggests that IPA's epistemological position sits between the two extremes of realism and relativism. In reviewing whether IPA is compatible with a contextual constructionist position: both acknowledge the influence of the researcher; both consider other impacts, social, psychological and cultural, on the data; and both suggest that if these influences and impacts are recognised, the data collected could tell us something valuable about participants experiences.

Another reason guiding the choice to use IPA was the findings that it produced and the flexibility of the approach. Smith et al (2009) describe IPA as 'committed to the

examination of how people make sense of their major life experiences' (p. 1). Defining yourself as having DID seemed to fall into the category of a major life experience. A lack of knowledge about the perceived experience and impact of living with DID encouraged me to seek more information through asking individuals directly, and IPA's focus on exploring subjective experience seemed a perfect way of gaining access to this lived experience. Smith and Osborn (2008) state that the most common method of data collection used for IPA is semi-structured interviews. Using semi-structured interviews provides the opportunity to engage in a conversation with participants that allows original questions to be modified if unexpected topics emerged (Smith & Osborn, 2008), which was likely to be the case for the present study, given so little research has previously been conducted into the subjective experience of individuals defining themselves as having DID.

Smith and Osborn (2008) describe how IPA is considerate to the active role of the researcher, and this was also a quality that attracted me to the approach. As a trainee counselling psychologist, I work in a way that prizes the therapeutic relationship and acknowledges my own role in the process of therapy. Therefore I felt drawn to IPA as a methodology that explicitly acknowledges the researcher's role in the process of research, and encourages openness in considering how their own preconceptions and past experiences may influence and impact on every step of the research process.

While considering qualitative approaches to use in exploring the current research question, two other methodologies stood out to me: discourse analytic approaches and narrative methods. Smith et al (2009) categorise discourse analytic approaches into Foucauldian discourse analysis and discursive psychology but state that both approaches share their roots in social constructionism. Willig (2008) describes how discursive psychology is concerned with the ways in which people use language to achieve interpersonal objectives in social interaction. In contrast, Foucauldian analysis 'focuses upon what kind of objects and subjects are constructed through discourses and what kinds of ways-of-being these objects and subjects make available to people' (Willig, 2008, p. 96). Coolican (2009) describes how in these approaches, a more constructive position is taken, and language is considered to be used not as a way of describing reality, but as a way of constructing reality. Willig (2012) explains that by seeking social constructionist knowledge the researcher can take a more sceptical view of the data, looking past how events or objects are

experienced to how people talk about the world and construct reality through their language use.

Of the two, Foucauldian analysis, developed by Michel Foucault (1965), seemed the more appropriate way of exploring the current interview question, as it would have allowed consideration of the impact of language on subjectivity. It also considers, as Parker (1992) states, how 'language is structured to mirror power relationships' (p. 11) which could be relevant to individuals who define themselves as having DID. My original reason for selecting a qualitative approach was to allow participants an opportunity to discuss their experiences and be heard, and the compatibility of this position with the ethos behind counselling psychology. Smith (2011) describes how IPA uses language to understand how participants make sense of their experience compared to discourse analysis approaches which considers experience to be constructed through language. IPA also believes in the primacy of cognition and emotional reactions, whereas these are considered to be constructions of language in discourse analysis. For these reasons I felt that discourse analysis would not be appropriate in exploring this research question.

Narrative approaches, as described by Willig (2008), explore the way in which individuals tell stories of their experiences, and how this allows them to organise and give meaning to these experiences. Smith et al (2009) suggest that different researchers focus on different aspects of participants' story telling. For example, Crossley (2000) focuses on the content of the stories told by participants. By specifically focusing on a trauma narrative Crossley discusses how individuals who have been exposed to trauma create accounts that can be shared with others, but are also true to themselves, and she seeks to understand how this self-account is created. Gergen and Gergen (1988) are interested in the structure of the narrative, suggesting that events 'will acquire the reality of "a beginning," "a climax," "a low point," "an ending," and so on' (p. 18) and this understanding will impact on how such events are experienced in the participants lives. Smith et al (2009) describe how other researchers such as Andrews, Sclater, Squires and Treacher (2000) are interested in the stories that are present in the cultural domain and how these relate to the stories participants tell about themselves. I found the idea of using a narrative approach very interesting, but I also wondered whether the method of data collection would be too limited in the access it would give me to the data that I desired. The questions asked in the interview were very open and involved

discussion of different experiences of interactions with others rather than a narrative of experience of one particular relationship, or how relationships had changed over time.

Despite deciding to use IPA, I did not ignore the limitations of the approach. Willig (2008) describes limitations including the approach's reliance on language, how reliable participant's accounts can be and IPA only accessing descriptive information rather than explanations of why things occurred. In IPA, participants' experiences are accessed through language; therefore, Willig (2008) suggests that this assumes that language has the capacity to capture and explain an experience. If, as is assumed in other approaches such as discourse analysis, language actually constructs rather than just describes experiences, then perhaps the data collected through using IPA actually tells us more about how experiences are described rather than what they are actually like to experience (Willig, 2008). If we are to assume that language does have the capacity to access an experience, there remains the question of whether participants are able to put their experiences into words to the depth that is needed for an analysis using IPA. Willig (2008) describes experience as a complex concept and suggests that it may be very difficult or in fact impossible to describe our experiences. However, this could be a criticism that is true of all qualitative research which all rely on participant's ability to describe experience. Willig (2008) also questions how much information and understanding IPA actually provides. She describes IPA as being concerned with describing the world as it is experienced rather than providing any understanding to as why it is experienced in this way.

Following the decision to use a qualitative approach to explore this research question there were a number of different methodologies to consider. Despite the limitations described by Willig (2008), IPA was believed to be the best fit with the chosen epistemological position and with the information sought by this research.

Research Plan

Choice of data collection method.

Smith et al (2009) suggest that due to IPA requiring rich and in-depth data, a collection method that offers participants the opportunity to provide this kind of data is preferable. Options of data collection methods suggested by Smith and Osborn

(2008) included interviews, diary entries and personal accounts. The choice of using interviews was based on the flexibility this method provided. Interviews allowed the researcher to explore and probe topics in a way that a written record would simply not allow.

An awareness of the link between DID and childhood trauma made by several researchers (Coons, 1994; Kluft, 1993) also guided the decision to use interviews as a data collection method. I considered that discussing relationships, especially early relationships, could be difficult for some participants and there was the possibility that some individuals may become upset. Due to my training and experience of working with people in distress, I felt confident to manage and contain this in an interview setting but was aware of having less influence if a participant were writing in a diary at home. My final reason for choosing to use interviews was purely practical. My research was time-limited and therefore it seemed more practical to collect all the data needed in one meeting with the participant.

Kvale (2007) states that an interview is 'a conversation that has structure and a purpose' (p. 7); however, this structure can vary greatly. In considering the form of interview to use, semi-structured interviews seemed to be the most appropriate choice as a data collection method for this research. Eatough and Smith (2008) describe how semi-structured interviews sit between structured and unstructured interviews. Structured interviews are described as standardised and therefore often inflexible; this method is more commonly used to collect quantitative data. Alternatively, unstructured interviews are often open-ended and may begin with a single question allowing the participant freedom in guiding the discussion (Eatough & Smith, 2008).

Semi-structured interviews collect data in an informal manner, allowing space for exploration of what is brought. However, they also have a schedule, which Smith et al (2009) describe as allowing the researcher to prepare what the content of the interview is likely to be. Kvale (2007) discusses the need for a sense of reciprocity between researchers and research participants. Although participants are offering their knowledge and experience to the researcher, the process of discussing these experiences for a significant period of time, with an interested other, can be positive. I believed this could be true for those who perceived themselves as experiencing DID where, through reading about the experience, I had learned that individuals

who defined themselves in this way often described themselves as feeling unheard. I considered that participants may wish to take part in this research to share their experiences with a greater audience and feel heard. Semi-structured interviews offered participants this opportunity and therefore this method seemed the best way of collecting data to explore the present research question.

Initial interview structure.

There are conflicting views over the necessity of an interview schedule for use in semi-structured interviews, with Fade (2004) stating that a structure is not needed as it may interfere with the exploration of what the participant believes is important. Smith et al (2009) however, suggest that a schedule helps the researcher to have a list of relevant topics in mind and allows them to prepare for any potentially delicate subjects and warn the participants in advance. As I had not collected data using this method before, I believed it would be beneficial to have an interview schedule. Smith and Osborn (2008) also state that having a schedule offers some useful questions and topics to discuss if conversation is difficult, and I believed it would also allowed me to focus on what the participant was saying instead of being concerned over what needed to be asked next.

The development of an interview structure was guided by Smith and Osborn (2008). Initially, I explored my own understanding of the concept of a 'relationship' and considered the different elements that would be helpful to cover in the interview. The term 'relationship' was very broad and I believed there was a risk that participants may refer to only one type of relationship for the whole interview, thus narrowing the data down to focus on only one part of their experience. However, I also felt unable to define specifically the type of relationship to discuss, as I believed this would exclude individuals who had not experienced this form of relationship, such as intimate relationships. I wished to enable participants to feel able to discuss a number of different relationship experiences they had engaged in, and to trust them to identify their own significant experiences.

The interview began with a question asking the participant to describe their understanding of a relationship (please see Appendix 1 for the full interview schedule). The aim of this was to start with a general question allowing rapport to develop, as suggested by Smith and Osborn (2008), and for the participant to begin to feel more comfortable. In addition, this question allowed me to assess

participant's understanding of the term 'relationship'. A relationship is defined as 'the way in which one person or thing is related to each other' (Oxford Reference Dictionary, 1987, p. 697). Through this initial question I sought an answer that was similar to this definition.

Through conversations with colleagues and my supervisor, I decided to use an activity early on in the interview. Using a diagram of a series of four circles growing in size (please see Appendix 2 for an example of the activity), participants were asked to choose pebbles to represent three of their relationships. Participants were then asked to consider themselves as the dot in the centre of the circles and position the pebbles on the diagram in relation to themselves. The four circles were chosen for clarity in seeing where the pebbles had been placed. Following this, I asked more about who the pebbles signified, why they had been selected and why they had been positioned in this way. Smith et al (2009) describe starting interviews with a descriptive experience, which can help participants get used to talking and feel more comfortable in the interview setting. This activity was selected to allow participants to get used to talking to me but also to allow them to consider their different types of relationships.

Following the activity, participants were asked to choose one of the previously selected relationships to speak about, allowing them to select a relationship that felt comfortable to discuss. This technique of funnelling is described by Smith and Osborn (2008) and was employed to move away from the general topic of relationships to participants' more specific experiences within one relationship. Questions moved back to a more general level by inviting the participant to compare this relationship to others that they had experienced, offering another opportunity for different relationships to be discussed. Three questions were then asked, specifically about the process of relationships. Questions asking specifically about the perceived impact of DID were left until the end of the interview as it was assumed that the way in which participants perceived their relationships would be naturally impacted on by their experience of DID. However, I believed that there was a need to ask specifically, as it allowed participants to be explicit about their perceived impact of DID. At the end, questions were asked allowing participants to consider the experience of taking part in the interview and whether they felt there was anything else I should have asked them. Prompts were used throughout the schedule to encourage further discussion if necessary.

Pilot studies.

When considering the use of pilot studies, I was guided by Yin (2009) who distinguishes between pilot tests and pretests. Pilot tests are considered to be an arena where different questions can be tested and different approaches experimented with. In contrast, a pretest is described as a trial run where an interview schedule is followed closely to highlight any difficulties that may arise, so these can be addressed before the interview is conducted with participants. My pilot studies took the form of pretests; I conducted two with colleagues and one reflective interview on myself. There were several areas that were explored: whether the chosen questions would elicit enough information; that the information gathered was of sufficient depth; whether questions made sense; if the order of questions was appropriate; and how long the interview would take to complete.

Colleagues were selected to complete the pilot studies rather than those who defined themselves as having DID. This decision was made due to the small number of individuals defining themselves in this way, and difficulties anticipated in recruiting for the main study from such a small sample. However, carrying out pilot studies on colleagues was limiting. The experiences of relationships shared was very different to those reported by individuals who defined themselves as having DID, as highlighted from the interviews carried out for the main study. Therefore although the pilot studies allowed exploration of the structure of the schedule and time limitations, they did not offer any insights into what the interview would be like, what material it would generate or prepare me for any unexpected areas of conversation that may emerge when conducting the interviews with those who defined themselves as having DID.

Feedback from the pilot studies suggested that taking part in the interview had been an interesting and thought provoking experience. Participants had been able to answer all questions, and the data collected were rich and detailed enough to reassure me that the interview would address the research question. Two changes were made following the pilot studies. Originally in the activity, small dolls were used instead of pebbles. However, using dolls did not allow for much distinction between chosen relationships, as they all appeared very similar. Following the pilot study I decided to use pebbles as these allowed participants more choice in selecting a pebble to represent the chosen relationship. This also allowed me the opportunity to inquire why specific pebbles had been chosen, eliciting more information about

certain relationships. In the original interview schedule, I also asked participants to think of four relationships to use in the early activity. Following the pilot studies I reduced this to three, as the interviews were running over the time limitation of an hour and a half.

During my reflective interview I took the role of the participant and a colleague followed the interview schedule for me. This experience reminded me that the questions were not easy to answer and required some thought, helping me to allow participants space and time during the interviews. I enjoyed taking part in the activity and I felt that it would be useful to keep for the main interviews. Smith et al (2009) state that interview schedules evolve through the data collection process, and I kept in mind that elements might change within interviews and also between interviews as unexpected difficulties or areas for discussion arose.

Sampling and participants.

Smith et al (2009) state that a homogeneous sample is sought for an IPA study. The idiographic focus of IPA on a detailed examination of an individual's experience means that samples are chosen purposefully, guided by the insight participants can offer. Therefore, as Smith et al (2009) suggest, participants 'represent a perspective, rather than a population' (p. 49). This research sought to explore lived experience of relationships in those defining themselves as experiencing DID. Smith et al (2009) suggest that in some cases, the rarity of an experience provides the boundaries of the sample used and this was true of the current study. The initial criteria for recruitment of participants was that they defined themselves as experiencing DID. The word 'experience' rather than 'be diagnosed with' DID was used due to the scarcity of individuals with an official diagnosis: it was deemed that requiring a diagnosis would limit the sample I could recruit from⁴. There were additional difficulties in assessing what an 'official diagnosis' would consist of as I was not recruiting from a medically based organisation. Additionally, due to the controversial nature of the diagnosis of DID, recruiting participants who defined themselves in this way avoided making assumptions about the existence or

⁴ Please note the 'diagnosis of DID' has been referred to in my recruitment material and information given to participants. This reflects my own evolving views of the concept of DID which have changed from recruitment to writing-up of this project and my movement away from diagnosis towards focusing on subjective experience. The word 'diagnosis' is also used for clarity and to ensure shared understanding when speaking to participants.

nonexistence of the diagnosis. I was also attracted to the word 'experience' as it felt consistent with the epistemological stance taken by the research question and by IPA.

The second inclusion criterion for participants required that they were members of the organisation *First Person Plural* which is a charity run by individuals who have lived experience of DID. The organisation is nationwide and has approximately 80 members who experience a Dissociative Disorder. I recruited through this organisation because it provided access to a greater number of individuals defining themselves as having DID than did any other organisation in the country. After making initial contact with one of the leaders of the organisation, I was encouraged by the enthusiasm and support they offered me. By limiting recruitment to members of *First Person Plural* I recruited participants who were more informed about Dissociative Disorders and who had actively sought out and paid for support. Being part of this organisation also ensured that participants had access to a group of people with shared experiences, should they need additional support following engagement in this research.

The sample was also defined by exclusion criteria. *First Person Plural* is a nationwide organisation therefore I knew that members could be located anywhere in Britain. I considered how easily people could be reached, and concluded that I could reach all areas of England but would exclude from the research individuals based in Scotland and Wales due to the travelling distance being too great. The interactive nature of the activity also limited alternative ways of conducting interviews, such as on the telephone or using Skype. Another practical consideration was the need for participants to be able to speak and understand English.

Ethical considerations were also taken into account when selecting a sample. Individuals defining themselves as having DID may lead very chaotic lives, experiencing feelings, thoughts and memories that they do not understand, perhaps leaving them vulnerable. Although it was hoped that individuals who did not feel able to safely take part in the research would not volunteer, it was still important to assess whether a participant would be able to sit and complete an interview lasting up to an hour and a half, about a subject that may be distressing. For this reason, I decided to exclude individuals whom I deemed too vulnerable to complete the

research. Vulnerability was assessed by the ability of the individual to engage in an initial phone conversation with me and a follow up call a week later. This process is discussed further in the procedure section of this chapter.

Smith et al (2009) suggest that between four and 10 interviews provide an adequate sample for analysis using IPA. This sample size provides enough data to be able to highlight similarities and differences between participants, but not too much to make analysis overwhelming (Smith et al, 2009). Following these suggestions, I recruited seven women aged approximately between 30 and 50 years of age. Demographic data was not formally collected, but information was gathered throughout the interview procedure that helped provide a sense of who the participants were. All seven participants were female; of these, four reported being mothers, two were presently married and one was living with her partner. All participants appeared to be functioning well within their lives; four described having full time employment, another stayed at home to raise her three children. Only two participants described not working due to struggling with their experience of DID and for one this was complicated by a number of physical illnesses. However, both of these participants described volunteering work they took part in as well as a number of social activities. Four participants shared that they had previously been married but were now divorced and of these, two shared they had experienced domestic violence in their marriages. All participants reported difficult early experiences, five had been abused by members of their family, one had experienced neglect, and another participant shared that she had experienced childhood sexual abuse but did not disclose from whom.

Although consideration of inclusion and exclusion criteria is vital in carrying out research, Smith and Osborn (2008) also point out that 'one's sample will in part be defined by who is prepared to be included in it' (p. 56). This emphasises the importance of considering the individuals who volunteered to take part, those who did not come forward and what this may tell us about the findings of the research.

Procedure

Recruitment and preparation.

First Person Plural keep in contact with their members through a magazine called *Rainbows End*, which is published quarterly. I contacted the chair of the organisation, initially by email and then by telephone, before designing this

research. She was confident that I would be able to recruit enough participants among their members, and on my behalf contacted the co-ordinator of the charity, who sent me email confirmation that I could recruit through their organisation (see Appendix 3 for my initial email to the organisation and Appendix 4 for email confirmation from the organisation that I could recruit through them). It was suggested to me that placing an advert in *Rainbows End* maybe a good place to start recruitment, and if I needed further participants, the organisation stated they would approach members directly.

I placed an advert in *Rainbows End* (see Appendix 5) asking people to contact me by phone or email if they were interested in taking part in the research. The magazine was published in black and white, therefore I decided I would include a photo of myself to draw attention to the advert and 'put a face to the name', thereby encouraging people to make contact. This approach seemed successful and one participant actually sent me a photograph of herself allowing us to recognise each other when we met. I received all expressions of interest by email and through this method of communication arranged a time for a telephone assessment. This initial telephone contact was an opportunity where participants could find out more about the research; I could complete a basic assessment of vulnerability and risk; and we could discuss places where participants would feel comfortable meeting (please see Appendix 6 for the prompt sheet used for the telephone interviews). Following this discussion, I emailed participants an information sheet (please see Appendix 7) and invited them to take a week to ensure they wished to take part in the research. A follow-up telephone call was arranged for a week later.

Once I had spoken to individuals on the phone and identified their location, I sought places that would be suitable to use for conducting interviews. Libraries and universities were often very generous in allowing me to borrow a room for two hours. Smith and Osborn (2008) describe conducting interviews in places where participants feel most comfortable and, keeping this in mind, I asked participants whether they knew of anywhere we could conduct an interview. This proved to be a useful question as one participant was able to use a room at their GP surgery, and another, a previous therapist's room. A week after our first telephone contact, I called the participant to clarify whether they were still willing to take part in the research. All participants confirmed that they were; a date and time to meet was set and a location selected. As I was often travelling to unfamiliar places, I ensured that

I had the contact details of the local Accident and Emergency departments and Community Mental Health Teams in case I was concerned for the welfare of any of the participants during or after the interviews. I maintained my own safety by ensuring my family were aware of where I was going and using interview rooms that were in public buildings.

A few days before each interview, I emailed participants to ensure they were still able to attend and that they knew where we were meeting. Additionally, on the morning of each interview, I sent a text message to check participant's attendance. These contacts were made for practical reasons: I was travelling up to four hours to meet some of the participants. However, I believed they also served to help build a relationship between myself and the participant, which I hoped made the interview process feel more comfortable for us both.

Pre-interview discussion.

Each interview setting was very different and I arrived early to ensure that I could find the room and set up the recording equipment before the participant arrived. This arrangement worked well for all the interviews but one. For one interview, I could not access the room before meeting the participant and she had to wait for me to set up the equipment. This felt quite awkward and I felt flustered, which may have impacted on our interview experience. On meeting with each participant, the purpose of the interview was reviewed as was the information sheet, and participants were invited to ask any questions. Due to meeting in an unfamiliar place and interviewing individuals who could be considered vulnerable adults, I also asked participants for the number of a support worker, GP, family member or friend that I could contact should I become concerned about them. Following these steps, I asked participants to sign a consent form (Appendix 8) confirming that they understood what the interview involved and that they were willing to take part.

The interview schedule.

As discussed previously an interview schedule was developed based on guidance from Smith and Osborn (2008). The interviews were conversational in nature, which allowed me to probe for more information when deemed appropriate to gain a richer quality of data.

Post-interview debrief.

Each interview was concluded with a verbal debrief, allowing participants to share their experiences of taking part in the research and to explore how they felt afterwards. Participants were also given a debrief sheet (Appendix 9) which thanked them for taking part and provided them with helpline numbers should they later feel distressed about the interview content, and website addresses should they want any further information about DID and attachment. The sheet also reminded participants of my own contact details and those of my supervisor should they wish to discuss anything further about the research.

Analytic strategy.

Smith and Osborn (2008) state that approaching the data can be adaptive and dependent on an individual's own personal way of working, therefore allowing flexibility to work in a way that makes sense to the individual researcher. I was guided by Smith et al (2009).

Each interview was transcribed with large margins each side of the page to allow for coding and using double spacing allowing for comments to be added within the text if necessary (please see Appendix 10 for an sample of transcription identifying initial notation and emergent themes⁵). Following transcription of the interviews, Smith et al (2009) emphasise the need to become immersed in the data. Transcribing the interviews had already helped me with this step and I was starting to feel as if I had an understanding of the participants. Following initial transcription I listened again to the recording while reading the transcript to ensure I had typed up the interviews correctly and to immerse myself further into the data. As stated by Smith et al (2009), the beginning of the analysis stage is the time to ensure that the participant is the focus and attempts should be made by the researcher to bracket off their interview recollections or observations. Following each interview, I had written down my observations in a research diary so that I was able to refer back to these and be aware of their influence at the analysis stage.

Following transcription of the interviews, the next stage was to complete initial noting. Smith et al (2009) state that at this stage, the analyst maintains an open

⁵ Please note that appendices 11-14 are included as examples to illustrate stages of the analysis and do not demonstrate a step-by-step guide of the process of analysis.

mind and jots down anything of interest. I made my notes on the left margin of my transcripts and carried out this process three times with each interview. Guided by Smith et al (2009) I monitored three different levels of meaning: descriptive comments; linguistic comments; and conceptual comments. Throughout the analysis process, I was aware of my own role in making sense of the data and worked to distinguish my own perceptions from those of the participants by speaking with my supervisor about the process and findings, and regularly revisiting and challenging my comments. I also regularly employed Smith et al's (2009) concept of deconstruction, moving in to focus in detail on certain sections of the text and sometimes reading sections backwards.

After completing the initial noting, work was carried out to condense these comments and identify emergent themes within the data. Smith et al (2009) describe these themes as capturing the researcher's own interpretation of what the participant is trying to express. I recorded these themes in the right margin of my transcript. To ensure I was monitoring my own role in the analysis, I went through each interview twice to identify emergent themes and then created a list of emergent themes for each interview. I found that due to the amount of data I had collected, six out of seven participants spoke for an hour and a half, I had a large number of emergent themes. Time was taken to reduce these by combining similar themes or creating early clustering of similar themes (please see Appendix 11 for Lauren's theme list). I ensured that I remained close to the data by continually referring back to the transcripts.

Once I had reduced each list to 60 themes or fewer, I worked to identify connections between emergent themes and cluster them. At this stage I continued to cluster similar emergent themes together. Working in a visual way, I wrote each theme on a piece of coloured sticky notepaper which allowed me flexibility in physically moving themes between clusters as the analysis developed. From this, a database was created for each interview showing the clusters of themes and supporting quotes, which ensured I still remained embedded in the data and the participant's words (please see Appendix 12 for the table illustrating how themes from Lauren's interview were clustered). I repeated the process with coloured paper to cluster the themes between participants (please see Appendix 13 for a table illustrating the early stages of clustering between cases). At this stage, I considered the strength of the theme; defined by the amount of time allocated in the interview to the topic by

the participant; and its relevance to the research question. I was aware that the frequency of the theme occurring was not enough on its own, and also considered the originality of the theme in light of previous research. This stage resulted in the development of three master themes, each containing a small number of emergent themes.

Following this, the analysis was written up; please refer to the analysis chapter for the findings of this research.

Ethics

When conducting any research, it is vital to consider the ethical impact it may have. The British Psychological Society's (BPS) Code of Human Research Ethics (2010) defines research ethics as 'the moral principles guiding research from its inception through to completion and publication of results' (p. 5). Guided by this policy, ethics were considered at every stage of the research process.

In the initial research proposal stage, an ethical approval form was submitted to City University London to explicitly explain how ethical issues would be addressed. Issues included considering risks to participants; how these could be justified and managed; and risks to the researcher; these will be explored further below. Ethical approval was given from City University to conduct this research (please see Appendix 14).

I believed that the risk to participants in taking part in this research was minimal; however, I acknowledged that participants might experience some psychological harm through becoming distressed during or after the interview, due to the nature of the topics discussed. I worked to exclude vulnerable individuals from the research through assessment during our initial telephone contact. However, I was also aware of the limitations of this mode of assessment and of the nature of DID. Barlow (2007) highlights the possibility of individuals becoming distressed and dissociating within interviews as a response to the material discussed. To attempt to manage this situation, a question was incorporated into the telephone assessment that asked about the participant's current levels of dissociation and how we would know if they were dissociating. Some participants were confident that they would not dissociate, others stated that they would reduce this possibility by avoiding speaking in depth about certain topics, and others described being co-conscious when they

dissociated so would be able to share with me what was happening. During the interviews themselves, I followed Barlow's (2007) suggestion of planning for individuals' distress by being aware that certain topics may be upsetting, and having regular check-ins. Throughout the interview, I remained vigilant to signs of distress from participants and half way through the interview I offered a short break. Participants were also invited to bring a support worker, family member or friend to the interview. This offer was accepted by one participant who brought a friend to support her. No participants expressed any signs of distress during their interview.

Ensuring that participants were aware of and prepared for the requirements of the interview was also an important part of managing distress. Each participant was given a week between our initial telephone contact and my follow-up call to read the information sheet and make sure they wished to take part. This information sheet was also reviewed at the start of each interview and a consent form signed, which confirmed understanding of what the research involved. Opportunities for questions were offered at all stages and participants had the right to withdraw from the research at any time which was emphasised in the information sheet. This research did not attempt to deceive participants, the aim was to be transparent about the process; I hoped this would also help me to build rapport with participants, which Smith et al (2009) suggest aids the collection of rich data. Each participant was offered, and each accepted, the opportunity to receive a summary of the findings following write-up.

At the end of each interview, participants were asked about their experiences of taking part. This question served three purposes: to ground participants before they left the interview and returned to everyday life; to gain feedback that I could use for other interviews; and for assessing and managing any distress. In addition to a verbal discussion, participants were also given a debrief sheet.

Maintaining participants' anonymity was vital as individuals were discussing sensitive, personal information and needed to be sure they could not be identified. I made explicit my intentions about how this would be achieved, in both the information sheet and the consent form. I limited the amount of personal information collected from participants to their name, telephone number, email address and the rough area of the country in which they lived. The contact details for participants' GP, support worker, friend or family member requested at the beginning of each

interview was offered back to participants at the end of the interview, to be either taken with them or destroyed by me immediately, as per their preference.

Notes made before and during interviews were coded with the initial of the participant's first name and the interview number; these were stored in a locked filing cabinet in my home. Recordings were stored on a personal, password-protected computer, labelled with the initial of the participant's first name and the interview number. Transcriptions of the interviews were labelled in the same way and when printed were again stored in the locked filing cabinet. It was only when I wrote up the analysis chapter that any initials used were replaced by pseudonyms that I selected. All information related to this research will be stored as above, dictated by the *British Psychological Society* (2005), for the recommended five years before being destroyed.

Despite emphasising the importance of confidentiality I was also aware of its limitations. I had asked participants about experiencing suicidal thoughts during our initial telephone contact, which I hoped had allowed me to assess levels of vulnerability. However, I was also aware that this was a brief telephone assessment and I remained mindful that should any of the participants have disclosed plans of suicide in the interview or become extremely distressed, I would have needed to breach their confidentiality and seek support, initially using the contact details they had provided me with or, if these individuals could not be reached, from other local mental health professionals.

As stated by the BPS (2010), ethical principles are not just relevant for the data collection stage of research but through to 'completion and publication of results' (p. 5). I kept this in mind throughout my write-up and remained concerned about respecting participants' meanings and remaining alongside the experiences they described. Through the transcription and analysis process, I spent a great deal of time reading and re-reading the data, attempting to draw out the richest experiences that would address the research question. However, I was also aware of a need for the data to be inspected by others to allow a different perspective, and to ensure that what I was discovering originated from the participants and was not influenced by my own perceptions. This is consistent with Yardley's (2000) description of the need to be transparent in order to evaluate the value of qualitative research. I sought peers to inspect the data and analyse small samples of the interviews, which

were then compared to my own analysis; this proved to be very helpful. A mini-audit was also completed by my supervisor to ensure that my analysis remained embedded in the data.

In considering the impact of research on participants, it is easy to forget the impact it may also have on the researcher. I was aware that listening to difficult experiences of relationships could have an impact on my own feelings. I was also aware of the severity of childhood trauma that has been linked to the development of DID by some researchers and professionals (Sinason, 2011; Kluft, 1995) and that although I was not asking specifically about early relationships, these experiences may emerge through our discussions. During data collection and the early stages of analysis, I continued to engage in personal therapy, which allowed me the time and space to process and acknowledge the impact of the data on my mood and vice versa. Later through the writing up of this report, I used my supervisor and peers for guidance and support.

Evaluation of Research

Traditionally, the value of research has been assessed by measuring the validity (the extent to which the desired construct was actually measured) and the reliability (the ability to be consistent and dependable) of the method used to collect data (Coolican, 2009). Yardley (2000) states that although these measures are useful in assessing quantitative research, they are not appropriate for use when taking a qualitative perspective. For example, a large representative sample that would be needed to measure validity and reliability could not be collected for use in qualitative research due to the quantity of data that then would need to be analysed. Similarly, consideration of replicability is inappropriate, as qualitative research acknowledges that it offers only one way of considering a certain phenomenon, and therefore findings are unlikely to be recreated exactly, even in similar investigations (Yardley, 2000). These measures are also inappropriate as qualitative research acknowledges the difficulty in knowing what the 'real' truth is and what can actually be captured by research.

For qualitative research not to be dismissed, there must be some measure of its value. Willig (2012) describes the importance of considering the study's epistemological position when evaluating qualitative research, as this can inform us of what the researcher aimed to discover and what sort of knowledge they wished to

create. As identified previously, this research takes a contextual constructionist position and Willig (2012) suggests that an evaluation of this perspective involves 'scrutiny of the study's use of reflexivity' (p. 18), exploration of how the study theorises between accounts (the participant's accounts and the researcher's analysis) as well as the context in which the accounts have been created. The concept of reflexivity can be considered in different ways by different researchers but Willig (2012) suggests that the IPA researcher draws 'on his or her own thoughts and feelings about what the participant is saying to uncover meanings within it that are not immediately obvious to the participant' (p. 18). In assessing my own research, I refer to Yardley's (2000) criteria as all four are consistent with the epistemological position taken by this research.

Yardley's (2000) first criterion is 'sensitivity to context'. This refers to the extent in which the researcher has considered the wider context in which the research sits; for example, reading previous studies in the area and considering those that have used similar methodologies. Background knowledge has been reviewed in the introduction chapter of this report and the extent to which the findings of this research may be placed within the context of previous research is explored within the discussion chapter.

'Commitment and rigour' is considered to be the second criterion against which to evaluate qualitative research. Yardley (2000) refers to commitment as a 'prolonged engagement with the topic' (p. 221), perhaps not only as a researcher, but as a carer or someone with lived experience of the subject being investigated. I have no lived experience of DID and I do not know anyone who defines themselves as experiencing DID, however, before planning this research I did become a member of *First Person Plural* and remained a member for two years. This allowed me to receive the organisation's magazine and access individuals' written experiences of DID. I also made contact with participants a number of times before our interviews and repeatedly read the transcripts of the interviews to try and become as immersed as I possibly could in the participants' words. I believe the time taken to complete this research has also illustrated a commitment to the topic. Yardley (2000) refers to rigour as the thoroughness of the data collection, analysis and reporting of findings. I had never used IPA previously so a lot of time was taken researching the methodology before carrying out the interviews. Through the analysis, I continued to review literature to guide me in the process of IPA, ensuring that I developed

appropriate skills and expertise to allow me to analyse the data competently. At every stage of analysis, I spoke with my supervisor to ensure that the data I was analysing were of significant depth and richness.

The third criterion suggested by Yardley (2000) is 'coherence and transparency'. Coherence refers to the fit between the research question, the philosophical position taken and the approach used. The research question sought to explore the experiences of relationships in individuals who defined themselves as having DID. The philosophical position taken is that experience can be captured through individuals' words, but this can only be accessed indirectly via the researcher's own way of viewing the world. IPA offers a way of exploring this subjective experience while also acknowledging the researcher's role in the process. Transparency is the researcher's openness in detailing every step of the research process. Keeping a research diary from recruitment to writing up has been very helpful in remaining open and transparent. It has also allowed me to revisit my own perceptions and observations, especially those made during contact with participants, to acknowledge the impact that these may have had on my interpretations of data.

The final criterion is 'impact and importance' of the research findings. My own objectives for this research were to allow seven individuals who experience themselves as having DID to be heard and to learn more about their experiences of relationships, which I believed would provide useful knowledge for counselling psychologists working with this client group. The impact and importance of these findings will be more closely considered in the discussion chapter of this report.

Methodological Reflexivity

Within the introduction chapter of this thesis I explored my own understanding of reflexivity in terms of the choice of research topic and how this may impact on the findings of this thesis. While writing about the methodology, I believe it is worth reflecting on the role I held in collecting and analysing the data, and on elements of these processes that may also impact on the findings gathered.

Le Gallais (2008) considers her position as an 'insider/outsider' in terms of her own research sample, and how this could have impacted on her interactions with her participants and her own perception of the data collected. When I consider my own position as a researcher, I wonder how I was perceived by the participants. As

someone who had no perceived experience of DID, I was quite certainly an 'outsider' and perhaps someone who couldn't fully understand their experiences. However, my status as a trainee psychologist on a doctoral programme may have suggested a certain expertise, and a number of participants expected that I would have a high level of psychological knowledge. My appearance and age may have also impacted on how I was perceived: I was conscious of not appearing intimidating but also looking smart to signify the importance I placed on the interviews. This could have made participants feel that they were talking to a professional, or they may have felt that I was someone far removed from their own experiences.

On reflection, I wonder if my first contact with participants through my recruitment material may have suggested an investment or belief in the diagnosis of DID and implied an 'insider' status. I refer to the diagnosis of DID as a 'neglected area' and express my concern over how 'misunderstood and misdiagnosed' DID appeared to be (please see Appendix 5 for recruitment material). These comments may have implied that the research would be campaigning for the recognition of the diagnosis of DID. Should I carry out similar research in the future I would be more mindful of the way in which I present myself and the research. Looking back, I believe the information given to participants was reflective of my own position concerning DID at the time, which has evolved through the process of this research.

My role as collector and analyser of data could mean that my perceptions of a participant during their interview may have impacted on my later interpretation of their interview data. On a couple of occasions, I was conscious of liking certain participants and feeling frustration towards others. Finlay (2008) states how novice researchers often assume that placing their interpretations to one side is a simple process, however, in reality, she describes this position as very difficult for the researcher as they make 'moves between... bracketing pre-understandings and exploiting them as a source of insight' (p. 3). Although I have been writing down thoughts and feelings throughout the process of the research, perhaps the only way to explore how much they are shaping my final interpretations is continuing to discuss the findings with others such as colleagues and my supervisor.

Two other methodological considerations were the sample of participants who volunteered for the research, and the places in which the interviews were carried

out. All participants were women between 30 and 50 years of age. On reflection, I wonder if the data would have been vastly different had I interviewed men experiencing DID, women of different ages or individuals who were more psychologically vulnerable. The settings used for the interviews were also not always ideal. For example, one room had large windows along one wall, which left the room quite exposed and noisy due to traffic beneath. Similarly, on a couple of occasions, the time available in rooms was limited, which placed an additional pressure on both myself and the participant.

Following exploration of the methodology, I will now move on to explore the findings of the analysis.

Analysis

Analysis of the interview transcripts produced a great deal of information about participants' experiences of relationships in the past and present, and how this may impact on their future. Due to the amount of data gathered, I have prioritised information that I deem to be more relevant in answering the research question, and also information that appears to be the most novel and unexpected. In this chapter, I will outline the themes that emerged through my analysis and explore them in more detail illustrating their relevance through quotes from participants' interviews. At this stage, I will be providing a description of what has been found through the analysis; further exploration and interpretation will be included in the discussion chapter.

The master themes are not totally distinct: there is some overlap within and between these themes. Guided by Eatough and Smith (2008) analytic themes are described and interconnections between them are acknowledged but these are explored in the discussion chapter. The master themes have been organised in this way to offer a clear structure of the results and therefore to provide clarity for myself and the reader.

Due to the sample size, themes will be illustrated by quotes from the participant/s who illustrate the theme most powerfully. Please refer to the theme table (Appendix 15), which illustrates the extent to which each master theme and emergent theme was present in each interview. The table demonstrates that all themes were present across all participants, though to varying degrees. I have labelled the presence of the themes as either 'strong', 'present' or 'barely mentioned'. Categorisation of the 'strength' of a theme was made based on my own judgement of how much time had been spent talking about the issues related to the theme, and the depth of the data provided by the participant. Some themes were present and rated as 'strong' due to my own direct questions, for example, asking about the experiences of beginning and ending relationships. Although subjective, I believe this table is useful in highlighting the presence and strength of each theme across interviews with participants.

Overview of the analysis

After analysing the interviews using IPA, three master themes emerged under which I organised the data: 'the self and the diagnosis'; 'the process of relationships'; and 'early experiences'.

Organised under these three master themes are emergent themes and these are illustrated in the figure below. For a more comprehensive table showing the breakdown of emergent themes please see Appendix 16.

1) The self and the diagnosis - <i>The perception of strength v deficit</i> - <i>Understanding internal relationships</i> - <i>Sharing of the diagnosis</i> - <i>The jigsaw pieces are falling into place</i>
2) The process of relationships - <i>Being in a relationship</i> - <i>Formation and dissolution</i> - <i>Managing change</i>
3) Early experiences - <i>Relationships with main caregivers</i> - <i>Missing out</i>

Figure 2: Representation of master themes and emergent themes.

Master theme 1: The self and the diagnosis

This master theme captures the difficulties participants discussed around their perceived experiences of DID: having difficult internal experiences; sharing the diagnosis with others; and making sense of it themselves. Across the interviews, I also noticed the different ways participants presented themselves alongside the diagnosis of DID. Some participants seemed to describe their experiences of DID as making them special or strong; others stressed their capabilities despite the experience; and for some having these experiences ruined their lives.

Emergent theme: The perception of strength v deficit.

DID as a strength⁶.

'I call normal people muggles' (Sally⁷: 1332⁸)

The perceived impact on relationships of experiencing DID was considered to be negative across all of the interviews. However, as I transcribed the interviews and analysed the data, I noticed that the way in which people perceived themselves alongside their diagnosis of DID varied greatly and therefore impacted on their relationships in different ways. Sally's use of the word 'muggles' (see quotation above) is an interesting example of this. The term 'muggles' is taken from the Harry Potter series (Rowling, 1997) and refers to people who do not possess magical skills. Perhaps Sally implies that people without DID are lacking in some way or that people who experience DID are special. On a number of occasions Sally describes herself as 'special':

'I think she calls me special, special cos I am, I am quite unique' (Sally: 1202)

Sally's words suggest that there is a value or a positive element to experiencing DID, that in some way she feels special, unique and different from other people because of the experience. Using the researcher-participant relationship as an example, Sally also directly draws the distinction between levels of understanding in those experiencing DID compared to those who do not define themselves in this way:

'Something that you certainly wouldn't get but certainly someone with DID would get' (Sally: 386)

⁶ Consideration was given whether to use the word 'strength' or 'special' as a theme heading as both seemed appropriate and accurate in describing what participants had shared with me. 'Strength' was chosen as it was seemed to encompass most of the participant's experiences rather than 'special' which was only used specifically by one participant.

⁷ All participants' names and any identifying information have been changed to ensure anonymity.

⁸ Quotes are referenced as: Participant pseudonym and line number.

The idea that I would not understand certain experiences, perhaps because they are so different or so complex is something that emerged in other interviews. Lauren uses me to illustrate how different her experiences are:

‘Because it’s not like for you, if you’re having a, a bad day you’ve still got all, like if you’re having a bad day and I don’t know twenty percent of you is feeling really irate with something, you’ve still got the eighty percent of you all in one person sort of balancing that out. If I go into one of my bad days I go into P (refers to one of her alters) and he’s a hundred percent (R: Uhuh)⁹ pissed off with the world and aggressive and angry’ (Lauren: 477)

The idea that there was something of value or positive about the perceived experience of DID was also suggested by Laura who referred to individuals who did not experience DID as singletons. Laura referred to me as an example when explaining her own experiences:

‘I think nowadays how do people that are singletons survive really (laughs)¹⁰. Umm but I suppose the proper way of looking at it would be that, you know, you’re not singletons and that you’re all there complete, whereas I’m not complete without each of my (R: Uhuh) crowd because they carry different parts of me’ (Laura: 1552)

Despite acknowledging the complexity of experiencing DID, some participants appeared to take time to emphasise their abilities. Polly mentioned a number of times throughout her interview how she considered herself as very independent and how she valued this quality in herself:

‘I’m a quite independent person so I don’t need, I don’t need to have somebody around me’ (Polly: 217)

Polly discussed how she felt that this trait had been developed as a result of her early experience of neglect and her need to cope alone. Despite being insistent that

⁹ R refers to researchers comments

¹⁰ Comments in brackets refer to researchers comments or observations

she was independent, that she didn't let being on her own stop her and that she didn't need anybody else, she also described her desire for an intimate relationship and how much she wanted to be cared for.

Laura also emphasised her capabilities throughout her interview, and shared that despite experiencing the diagnosis, she was still able to function well. She spoke about how others perceived her as a coping person and listed how many activities she was engaged with, suggesting that it was important for her to be considered as coping or functioning even to me:

'So In the end I rang this friend, R who's known me, as I say for three years and I've helped her with the cottage, we play in the team together, we were doing swimming together so, and she saw what I was going through caring for this woman with depression and kept saying 'I don't know how you cope' you know, (R: Uhuh) because it was quite hard. So I thought, she knows me as a coping person so I'm going to ring her'
(Laura: 557)

In this quote, Laura is describing a time when she was admitted to a mental health facility and needed someone who could support her in returning home. Her choice to select a friend who knew her 'as a coping person' perhaps helped her feel more comfortable in sharing what had happened and asking for support.

Janet's quote below summarises for me what many of the participants expressed during their interviews: that participants recognise the significance and complexity of their experiences of DID and desire understanding from others, but they also want to be seen as more than just experiencing DID:

'It is a big part of my life but it's not all my life' (Janet: 861)

DID as a deficit¹¹.

Among some participants, the experience of DID was described as much more difficult. They described feeling abnormal and different from others in a way that prevented them from engaging in and maintaining relationships. Janet describes trying to arrange a house share at university:

‘There was another girl in the mix who didn’t want to live with me, she said I was too screwed up’ (Janet: 203)

The perception that Janet was ‘too screwed up’ may have added to her feeling of being different and something being wrong with her. The word ‘wrong’ was used in a number of interviews to describe the experience of DID. Polly in particular described experiencing DID as something ‘wrong’ or abnormal:

‘I was sort of finding out a bit more about what actually was wrong with me’ (Polly: 196)

Polly’s perception of DID as wrong could have been impacted by her only receiving the diagnosis quite recently. Like Polly, Pam shares a very negative attitude towards her experience of DID, describing it as something that is a problem, is restrictive and that stops her feeling normal:

‘I’ve had a, you might call a good run lately, where I feel I’ve been quite consistent, you know and I can and if I feel it changing slightly, you know, I can feel this sort of, just disappointment and upset that you know, the DID is always going to kind of fuck everything up really, that’s how it feels as if you just, I just want to be normal. Umm, and I don’t feel sometimes like I even know what that is’ (Pam: 483)

In comparison to Polly and Pam, Laura had received the diagnosis of DID approximately four years ago and seemed to have found a meaning in her experience that prevented her from describing it negatively. Although drawn to using

¹¹ Consideration was given whether to use the word ‘deficit’ or ‘different’ as a theme heading. ‘Deficit’ was selected as it seemed to accurately describe the feeling of inadequacy, as if the experience of DID had removed something, described by participants.

the word 'wrong' in this passage, Laura reframes this to 'different' which offers a more positive and accepting description of her experience:

'There was no inkling to her that there was anything, I don't even want to say wrong cos to me it isn't wrong but different' (Laura: 171)

However, Laura later acknowledges that feeling different can be very lonely and in this way her experience of DID can be quite difficult:

'It makes you really lonely because you just feel so different' (Laura: 1501)

Feeling lucky.

Interestingly six out of seven participants made comments concerning how lucky they felt in comparison to others. Some participants compared themselves favourably to others experiencing DID:

'I think, myself I'm really fortunate because I think, I know lots of other people with DID that, umm, can't even get out of the house because they, they're so, their parts and stuff like that, it's, their PTSD's so bad they can't even do that. Whereas at least I've learnt, umm, lots of techniques, lots of ways of calming myself down' (Elizabeth: 968)

Other participants tended to value their personal qualities, such as independence or important others in their lives. Sally described a strong relationship with her husband, her daughter and a number of close friends, which made her feel lucky:

'I do feel really blessed because I do have some of the most beautiful people as friends' (Sally: 1387)

The analysis suggests that experiencing DID can impact on the way individuals perceive themselves. Self-perception varied between participants: for some, DID was viewed as an experience which strengthened them, made them feel special or left them feeling lucky compared to others. However, for others it was an experience that felt like it removed something from their lives, resulting in a deficit, leaving them feeling abnormal or wrong. In connection to this was the way in which participants

wished others to perceive them despite experiencing DID, such as Laura's need to be seen as a coping person or Polly's need to be seen as being independent of others.

Emergent theme: Understanding internal relationships.

Most of the participants described difficulties understanding and managing their internal relationships/alters¹² and that these difficulties impacted on their external relationships. Janet described the balance between internal and external relationships being constantly present whereas for Laura this balance was only present if there were problems among internal relationships.

A balancing act.

Janet described her alters as if they were different people with different needs, and meeting their needs caused problems with relationships in the external world. She described managing this situation as feeling like a 'balancing act' (Janet: 3: 1186) where she tried to balance the needs of her alters and the needs of her friends:

'It's always this balancing act of do my alters come first or do my relationships come first and, there isn't a simple answer to that (R: Uhuh) sometimes they have to because it's just how it is and other times they have to, even though they're having flashbacks to being raped or whatever it is, there is still a present world and I think the problem with living, having DID is that a lot of alters are stuck in the past so, therefore in any given moment their distress is going to be higher than whatever's going on in the real world but the thing is it's not actually happening now and that's very difficult' (Janet: 1186)

The difficulty in managing the needs of internal and external relationships is highlighted by Janet's quote. She expresses how hard it can be to separate the past from the present and deciding whether she needs to act on the perceived needs of

¹² Although the concept of alters is a controversial one, within this research I aim to explore individuals' perceptions of their lived experiences of DID, therefore the concept of alters was considered an important part of these experiences. Although there are many different words used to describe these internal experiences, I will refer to them as alters throughout the analysis section as this is the word that most closely describes the experience discussed by participants in their interviews.

her alters, or whether they were responding to something that may have harmed her in the past but was not risky for her now. Earlier on in the interview, Janet had described the impact she believed this balancing act had on her friendships:

‘I think especially friends who haven’t met my alters, which is most of them, umm, I think it can be quite hard. There’s this fantasy that there’s other people that are more important than them (R: Umm) and that can be quite difficult’ (Janet: 478)

Janet described a difficult dilemma that impacts on her external relationships. She discussed how she felt she needed to look after and protect certain alters from distress, such as those who were upset by going into a church, and those younger alters that needed to be home for a certain bedtime. Her feeling of duty to protect her alters was strong and she described feeling it was unfair if she did not protect them as they had protected her in the past. However, Janet also described how important her external relationships were to her. Of all the participants I interviewed, Janet spoke the most about balancing the needs of her alters internally and negotiating with them as independent identities.

At the end of my interview with Laura, she highlighted the importance of balancing her internal and external relationships, and the impact this had on her external relationships:

‘So it’s learning about all the internal relationships as well and I think it’s really hard to have outside proper relationships if your minds completely cluttered with what’s going on in the inside’ (Laura: 1669)

Managing alters.

Instead of describing managing her alters as an internal negotiation, Lauren described her alters as taking over her actions and not taking into account her current life:

‘M, one of my really teenage alters ended up nearly sleeping with one of my friend’s partners’ (Lauren: 410)

At this time, Lauren was a mother and wife and therefore this behaviour would have had a significant impact on her current life. After this event, Lauren avoided going out, fearing that something similar may happen again, and feeling out of control of her behaviour. Lauren also described a time on holiday when she believed another alter had taken over her behaviour, and how she had felt no connection to her husband or children, which had been very difficult to manage. Lauren's descriptions of behaviour which was inappropriate to her current lifestyle created problems within her family relationships but also among her friends who were very shocked by her unusual behaviour and did not understand what had changed.

Managing different alters when faced with the loss of significant relationships was also discussed by both Laura and Pam. Laura described the loss of her mother felt by her alter H:

'After five months H, my sixteen, you know sixteen year old just hit delayed grief because we hadn't had time to grieve, when there's a lot of you there's a lot of different (R: Hmm) grieving to do' (Laura: 859)

Pam described the breakdown of her relationship with her father in a similar way:

'How I experienced that was quite strange really in that I sort of, I feel as if it, it kind of ricocheted through all these different parts of myself, it's like I, I deal with it, I'd feel like one part of me would come to terms with it, this is that he's done, this is who he is, this is why we don't need, we don't need to see him anymore, you know, you can be upset about it, kind of grieve over it, if you like, then I'd leave it and then I'd, the next day there would sort of like another part of me just distraught all over again and it would just go on and on like that and, until, each kind of my personality had accepted it' (Pam: 958)

Experiencing alters was described as impacting on processes such as grieving for lost relationships making the process more time consuming, complicated and painful.

Emergent theme: Sharing of the diagnosis.

A common topic of discussion across all of the participants was the difficulty in sharing the experience of DID with other people. The experience of DID was considered as very significant in individuals' lives and had a big impact on how they behaved in relationships. This is described by Lauren who states:

'It's enormous, it's kind of not really, I, only myself am beginning to grasp how much it impacts me' (Lauren: 1103)

How to explain DID.

Sharing the experience of DID with others, such as friends and family, was very important as it allowed the individual to feel understood and their behaviour to make sense. However, there was the concern across participants regarding when and how to share this information. Janet considers this dilemma in terms of starting a relationship with a new partner:

'Now I feel like where do I put that piece of information in, which is the sort of issue I would have if I ever thought about having an intimate relationship I think, it's like would I tell them at the beginning but then that sounds really freaky and also it isn't necessarily fair on them, or me or do I tell people much further down the line?' (Janet: 856)

Lauren describes how difficult the experience of DID is to explain to other people. Lauren points out the gap between the label given to the experience and the experience itself:

'There's saying you've DID and then being dissociative is, you know, it's all very well if I'm forgetting something up at the school or, umm, I'm forgetting a conversation and I'm just looking like a blonde or whatever, erm, that's one thing but then when you, it gets to the point where you've got another alter who's, like M, just completely inappropriate, that's just very difficult to deal with (R: Uhuh, so there's not that level of understanding there and whereas there is with your husband?) Yeah well because it's hard to, I think because as well, because Dissociative Identity Disorder is very misunderstood because of all the sensationalising that there was in America particularly. It's hard to

actually, umm, describe to people what's, what the disorder is' (Lauren: 426)

In the above quote, Lauren also highlights the impact of media portrayals of DID and how this interferes with others understanding her experience. Later in our interview, Lauren refers to the character of *Sybil* (Schreiber, 1973) who offers a very extreme portrayal of DID and considers whether people expect her to behave in this way. Perhaps also due to sensational media portrayals, Pam shared that she believed there was still a lot of stigma and shame associated with DID and that this could result in her avoiding telling others about her experiences:

'There's precious few people in the world I'd wish to tell that I have DID if I'm honest, I just, I think it's still something that still got a lot of stigma and shame around it' (Pam: 997)

Who to share the diagnosis with.

Participants described being quite selective about who they chose to share their experiences of DID with, believing that some people had no capacity to understand such a complex experience. Lauren explains how she has often felt unable to tell certain friends:

'Then there's other friends who I've been close to who I've not been able to tell about DID at all and then, umm, partly that's because even if you talk, try and talk to them about, I don't know, the most minor sort of emotive issues, they just, you can tell, you, you, you must have had that experience where you can tell whether people can relate to emotional, umm, anything at all (R: Uhuh) Some people just are just not on any emotional level are they' (Lauren: 531)

Later, Lauren identifies that she often feels that if a friend has had good early life experiences, they find it difficult to understand her own more difficult experiences. This suggests that Lauren needs to feel that the other person would be able to understand difficulty, perhaps by living through similar difficulties to herself, in order for her to feel comfortable enough to disclose her experiences of DID:

'I think people who tend to have a good upbringing and erm, a relatively sound childhood, find it difficult to deal with people like me because they have no idea at all, and no sense of what it's like to get stuck at certain places' (Lauren: 605)

Not being real.

Despite participants' concerns about how to share their experiences of DID with others, not sharing these experiences could also be problematic. Some participants felt that they were lying to friends, which left them feeling as if they were not being real. This could create problems when friends did not understand certain behaviours or needs that participants may have, as Lauren describes below:

'If someone gets, gets to know me, or thinks they're getting to know me and if I don't tell them that I've got DID then they don't actually understand that I could have actually got confused' (Lauren: 595)

Pam describes feeling as if she is not able to be her real self unless she is able to disclose her experiences of DID. If she is not able to disclose, she is left feeling as if she is functioning from only one part of herself. Pam describes conducting most of her relationships in this way in the past and struggling to maintain this way of responding, leading to the breakdown of the relationships:

'You either have a choice, you don't tell somebody in which case I'm a bit back to where I was in my twenties it feels... just trying to function from one part of me and then failing and having to ditch a relationship cos I can't cope' (Pam: 989)

The dilemma between wanting to be real and for others to understand their perceived experience of DID, but also fearing others ability to cope with the information and the perceived stigma attached to the diagnosis, was described as a big problem in all participants' relationships. This situation is summarised below by Lauren:

'I'm caught between wanting people to know who I am and not wanting people to know who I am' (Lauren: 474)

Others reactions.

A lot of discussion around the sharing of experiences of DID was also centred on the reactions participants had received when they had shared their experiences with others. They reported a number of different reactions, ranging from others being fearful of them and believing them to be incapable, to others being very encouraging and embracing of the experience. Janet states:

‘Some of my friends got quite scared when they first heard about my diagnosis and some of them got weird about leaving their kids with me’
(Janet: 326)

Laura speaks about the fear that people would be frightened of her if she shared her experiences with them or that their perceptions of her would change:

‘I just thought that if she knew that I’d got all these weird issues underneath it would change things and she might not feel so safe with me and I didn’t want that’ (Laura: 492)

There also seemed to be some people with who, once disclosed to, the subject was never mentioned again. This was either attributed to a lack of understanding and therefore avoidance of the subject, or to a complete understanding and acceptance of the experience, depending on the person who had received the information. Sally explains this in the quote below:

‘People don’t talk about it either because they, they don’t think it’s necessary, my husband just doesn’t think it’s necessary to talk about it anymore, he just gets it. (R: Uhuh) Umm, friends to some degree are a bit apprehensive because they don’t really get it, so avoiding conversation with it makes it easier and they just accept my oddities’
(Sally: 1309-1311)

While analysing the interview data, I gained a sense of there not being a right way of managing the disclosure of the perceived experience of DID. In some contexts, participants relied on their own judgements, believing that some people would be able to cope, perhaps due to their own experiences or certain personal qualities. In other situations, people felt almost forced into sharing their experiences, due to

circumstances such as dissociating in front of another or needing a friend's support in a time of crisis. There seemed a real diversity of ways in which experiences had been shared with others, and a variety of ways in which people had responded. However, across all participants, sharing their experiences, or not, seemed a difficult situation to negotiate, one which caused anxiety and had a big impact on the way they conducted their relationships.

Emergent theme: The jigsaw pieces are falling into place.

'The bits of jigsaw puzzle were falling into place for me' (Polly: 124)

Across most of the interviews was the mention of change and improvement in the way participants managed their relationships. Participants described feeling as if they managed their relationships better since they understood that they experienced DID and its impact on the way they thought and behaved. In the above quote, Polly described things starting to make sense for her after receiving her diagnosis of DID, likening this to doing a jigsaw.

Elizabeth talked at length about how she felt she had changed in herself and changed in her relationships as a result of becoming a Christian. She described the church as feeling like a family to her and providing her with the love and security that she had been deprived of as a child:

'With God coming into my life then I have a, umm, a much firmer foundation and understanding of what love is all about and what security is all about' (Elizabeth: 653)

Elizabeth had also gained a greater understanding of giving and receiving love through attending church, which had helped her to gain a greater sense of her own identity. In the quote below, she explains how important she believed this to be:

'Ok now I sort of I think I understand about identity. I think identity is key to relationships because if you don't know who you are then how do you know, if, if you don't know who you are then how do you know which part of you is you're, you're giving in a relationship' (Elizabeth: 729)

Interestingly the idea of religion being useful in recovery contrasts starkly to Janet's and Sally's avoidance of churches and religious symbols, which they attribute to experiencing ritualistic abuse when they were children.

Pam also speaks about how her relationships have improved over time, especially since beginning the relationship with her current partner, one which has been very different to relationships she had engaged in previously:

'Up to then I'd got a lot of my needs just met from very intense friendships really. Umm, and some friendships that weren't very good at all. Umm, kind of, I don't know, bordered on the abusive really and they, and during the first year that we were together, I felt that there, kind of two worlds clashing, T's the very kind of pragmatic person, very, she's sort of slow to anger and, I don't know how to describe her really, but she's, she's very solid and straightforward and what she could see about some of those friendships straight away took me a long time to see myself really' (Pam: 280)

Pam also discussed how her understanding of herself had changed over time, how this had led to an acceptance of her experiences and their impact on her relationships:

'I was always looking for an external reality check and I think now I'm much better at having an internal check, if you like, and saying 'yeah ok' it just feels, you know, I've got to accept that I feel different today to how I, how I might feel tomorrow and how I felt yesterday' (Pam: 719)

Instead of trying to gain agreement from others to confirm her experiences, Pam described now being able to understand herself and accept how changeable her feelings could be. This meant she spent less of her time in relationships trying to convince the other person of her own view-point to provide her with a reality check.

Having a greater self-awareness was reported to have a positive effect on all of the participants and their relationships, and this was often described as being gained from attending intensive therapy and working through past difficulties. Sally describes this below:

'Now a) I'm the strongest I've ever been and b) I'm the most settled in relationships that I've ever been (R: Hmm) and I guess some of that's time, some of that's therapy, some of that is traumas now been dealt with' (Sally: 897)

What feels significant when considering this emergent theme is the healing impact of relationships. Of all the improvement and change mentioned by different participants, there has been a positive relationship that has been involved, either a relationship with God and religion, a supportive partner, or a good therapist. These relationships seem to have allowed the participants to learn about themselves and understand emotions such as love and security.

Master theme 2: The process of relationships

This master theme describes the experiences of participants within specific relationships and how they have managed the process of these relationships. It has been divided into three emergent themes: being in a relationship; the formation and dissolution of relationships; and the struggle with change.

Emergent theme: Being in a relationship.

A common topic of conversation across the interviews was participants' experiences of being in specific relationships. This discussion was most certainly prompted by my initial exercise and later questions. Among the relationships selected were husbands or partners, children and friendships. With the exception of Polly, each participant was able to describe a close relationship, suggesting that whatever difficulties they may face in interacting with others, participants were able to form and maintain a close bond with at least one other person.

Being a partner.

Sally, Pam and Lauren spoke at length about their relationships with their current partners. Sally spoke very positively about her husband and how important he was to her life. Pam and Lauren, although positive about their partners, also acknowledged the difficulties they experienced in these relationships as a result of experiencing DID. Elizabeth, Laura and Polly all shared that they had been married previously but were now divorced and single. Each touched briefly on their experiences within their marriages, ranging from domestic violence to simply

growing apart. Janet described having partners in the past but currently being single.

In her interview, Sally described her relationship with her husband as a positive experience. She shared that the relationship had taken a long time to form, as she had initially felt hesitant to form a relationship with a man. Sally described her husband's perseverance and patience as showing her that he really cared about and understood her, and I sensed through her descriptions that she experienced the relationship between them as healthy and strong. Sally described their relationship as being led by her husband who supports her in everyday life:

'I like the fact that he says 'right today we are going to do A, B and C' and I'll be like 'great' because he'd never choose anything I don't like, so I'm like 'brilliant that means I haven't got to think'. He'll say 'I've packed your bag'. Umm this morning he said 'I've packed your bag we're going to the Lake District straight from your meeting this afternoon', 'alright then dear, thank you' No bother not a problem, he even has access to my, my calendar, so he knows, because I'm not very good at organising time and things.' (Sally: 916)

Sally seemed to enjoy her husband guiding her activities and was accepting that he organised and managed her life. She described trusting him to look after her, to pack her bag, and that she felt secure in the knowledge that he would never choose anything for them to do that she wouldn't enjoy. Interestingly, being organised in this way appears to result in Sally not needing to think or take responsibility for her behaviour with her husband.

Lauren also described a good relationship with her husband but acknowledged that her experience of DID had complicated the partnership and created more difficulties. Despite the relationship not being perfect, Lauren stated that she valued the fact that it is a transparent relationship, one that she understands and that is not harmful to her like that with her mother:

'This is a clear looking stone and I think the, the relationship with me and my husband is clear although it's got cracks in, and umm, you know, it's a bit chipped and marked and that, that's to represent that

although it's a clear and straightforward relationship in the sense that it's not toxic like that with my mother, it still has its problems and particularly with me having DID and stuff' (Lauren: 69)

Pam is the only participant who referred to the impact of experiencing DID on her sexual relationship with her partner. She describes how she believes her inconsistency of experience impacts on her partner:

'I think that's had a big impact on our intimate life, if you like, umm, I think earlier on in our relationship it was really hard for her that, you know, I was very inconsistent, sometimes I could, umm deal with, could deal with sexual things, other times just couldn't at all' (Pam: 671)

Pam goes on to share how she believes the inconsistency of her experiences results in her partner struggling to rely on her and describes how this situation makes her feel:

'I can see it's a bit of an effort for her to, to let go of her own resources and kind of trust me to help her because she's not sure whether I can follow it through and whether I'm gonna (R: Uhuh) still be ok the next day when she's still struggling with something, you know, will she be back to just relying on herself, so I suppose the way, on a bad day, the way I feel is that I, I must seem like quite a selfish person, quite selfish, moody person to have a relationship with' (Pam: 681)

Pam described how she felt as if she was quite inconsistent in her feelings and behaviour as a result of experiencing DID and that this had an impact on both her and her partner. However, in addition to this Pam described feeling a great deal of concern about the impact of her behaviour on her partner. Later on in the interview, Pam described how she sometimes felt as if life would be easier if she were not in a relationship. She spoke of the difficulties she had in managing the conflict between the desire to live life her own way without impacting on another person, and the enjoyment and support that she gained from being in a close relationship.

Sally and Pam's descriptions of the role that their partners have in their lives are very different. Sally appears very content and accepting that her husband makes

most of her decisions and cares for her in this way. In contrast, Pam discusses her fear of her partner becoming her carer:

'I'm very, very anti the idea that our relationship just becomes her looking after me, I, that really, really nauseates me that would ever be and I see so many relationships like that with people who have experienced the sort of things I've experienced and it really distresses me that, we, we, if we, if I feel like that's happening' (Pam: 519)

Pam's fear of her partner becoming her carer appears very strong and the description of the thought nauseating her expresses her physical repulsion by the idea. Although Pam describes her partner supporting her a great deal, especially as she started to gain a better understanding of her earlier life, it seems important for her that they still maintain an equal relationship.

Being a mother.

Sally, Elizabeth, Laura and Lauren described how their past experiences had impacted on way they had decided to raise their own children. Sally's relationship with her husband seemed to contrast with the relationship she had with her daughter. She describes being much more active in decision-making and guiding her daughter's development, in order that she receive an experience very different to Sally's own:

'Some would say, erm, overly motherly at times but pushing independence you know, she moved into a flat, on her own, at the age of eighteen, no bother, well at university. Umm, could cook, could clean, knew how to hold relationships, knew how to interact with people. Umm feistily opinionated but could always, umm, negotiate things, so she'd been given so many diverse opportunities that (R: Uhuh) that she gets the world terribly well. (R: Uhuh) Umm and, and as I said, just overly motherly at times because I needed to be clear that I broke the mould and that she had every opportunity I didn't have' (Sally: 955)

Laura described how she considered her behaviour carefully around her daughter, acknowledging how DID can impact on others. Like Sally she describes using her own experiences as a child to guide her as a parent:

'I've had to learn that I don't want to ring her often now and she knows that's not cos I don't care but I don't want to put pressure on her (R: Uhuh) Cos I've seen other parents do it and I've just had it done to me by my parents and I don't want to do that. Umm and I've found that I don't need to cos most days there's not often a day goes past when we don't text about something. Umm. (R: Uhuh) And it makes it much nicer cos I feel she's not under pressure' (Laura: 658)

Both Sally and Laura had brought their daughters up in single parent homes and their children had been removed from them for a brief period when they were too unwell to care for them. Both participants spoke of how distressing this had been, and how they had fought to get their children back. It seemed that while experiencing DID had impacted on them, both parents were able to form and maintain a strong bond with their children. The same appeared true of Lauren, who had three children and reported a good relationship with each. Elizabeth described a different situation where she was separated from her son for most of his early life and was only recently building a relationship with him. She stated she found this difficult but was working on extending her skills to enable their relationship to develop.

Lack of understanding.

While discussing difficulties within specific relationships, a theme that emerged was that participants felt as if they did not understand other people. This was described by some as if they were missing some fundamental understanding that was necessary to engage in relationships. An example of this is from Sally, who described how she felt she didn't understand emotion properly:

'R: Can you tell me a bit more about what you mean when you say you don't get her?'

'Umm, I don't particularly understand people (R: Uhuh) I don't understand people's emotions, I don't understand why people do things. Umm I had very, very little social interaction until I was about 15 so what I didn't have was the, umm, learning how to interpret other peoples behaviours and to understand social etiquette and, umm. I see everything very boxed so if someone says 'I'm sad' that's it, I don't

always ask why, because they have told me they are sad then they're sad whereas most people, I believe would say 'so why are you sad?' (Sally: 88)

Sally describes how she believes not understanding emotion means she does not engage in an exploration of the reasons behind the emotion. Later, she also refers to not understanding what the word love means. Sally discusses how in the past she would often misunderstand other people's emotions and deal with them in a way that made the situation worse. Sally seems to attribute this lack of understanding to early deprivation of social interaction. Similar to Sally, Pam also describes feeling as if she does not understand how to willingly love another person:

'I don't feel as if I have an implicit understanding of how to, umm, willingly love and care for somebody. I feel as if, you know, the life that I led was all about looking after and caring for people but it wasn't willingly imposed on me' (Pam: 494)

Pam also attributes this lack of understanding to early experiences where she felt forced to care for others who mistreated her. Earlier in our interview, Pam described how she managed this lack of understanding by modelling her behaviour on her partner, who appeared to have a better understanding of how to express love and affection.

Polly describes not understanding how to describe how she, herself, is feeling:

'So it's very difficult because it's not to say I didn't have any feeling, it's just that I don't know what the word is, because that's something you learn between the ages of two and three and I never got taken through that, so I can tell you if I'm hot or cold but I can't tell you if I'm happy or sad (R: Uhuh) or any of these other type of emotional words' (Polly: 291)

In all three cases, participants describe feeling as if their deficits in understanding were a result of earlier life experiences when they were either deprived of social situations where these skills may have been acquired, or were not taught explicitly about them from a caregiver.

Janet also describes difficulties interacting with other people. Instead of struggling to understand her own or others' emotions, she describes not understanding others' motives and different responsibilities in relationships, tending to blame herself rather than recognise the other's role in the interaction:

'The things that keep me awake at night, I think, are the things that I can't work out whether it's mine or theirs. I think if I clearly know it's theirs then at least I can, even if I'm angry about it, at least it's sort of like, it's not my fault' (Janet: 713)

Like other participants, Janet attributes her difficulties to her earlier experiences, explaining that because of these, she tends to take things personally instead of considering other options:

'Obviously everything is overlaid if you've come from an abusive background, inevitability things are overlaid, as in someone cancels, someone doesn't answer the phone, someone is short with you there's always the sort of 'oh they hate me, I've done something awful'. So that's yeah, and that's kind of a theme through all relationships' (Janet: 494)

It seems that most participants describe feeling as if they have a lack of understanding of other people and how to interact with them. Participants describe these deficits in understanding emerging as a result of early experience.

Interestingly despite struggling with understanding themselves, participants emphasised the importance of other people understanding them; stronger relationships were often described as based on greater levels of understanding from the other person:

'The more somebody understands the stronger the relationship can be, because they get it' (Sally: 430)

Understanding, a lack of or a desire for, was discussed across all of the interviews and weaves throughout the first two master themes in this analysis. This presents an interesting concept in so far as how much any one person can fully understand

another; however, it appears that this is a very important part of the perceived experience of DID for these participants.

Meeting people's needs.

All participants described experiencing different alters, of different ages and genders, and which took over their behaviour at certain times. However, Sally and Lauren described their behaviour as much more changeable; as if their personalities changed dramatically depending on who they were with and what they believed the other person expected from them. Therefore, these next paragraphs will focus on Sally and Lauren's experience as they stood out for me as being different to the other participants and I believed this would have an impact on their experiences of relationships. Sally states:

'I'm very different with her to who I am with him (referring to her daughter and her husband), and so it was quite difficult to negotiate that between the two of them. So I guess it comes down to what I perceive the person needs to what alter takes hold of that relationship and responsibility for that relationship. Umm, and erm, so I guess I am very different with different people' (Sally: 1065)

Lauren describes herself in a very similar way, as if there are different personalities or alters which manage each relationship she has:

'R: How would you describe yourself when you're in a relationship?

Erm, very, erm, different, erm, depending on, erm, which personality is the main personality that's running that relationship and umm what role that personality's meant to be playing' (Lauren: 622)

In addition to describing different alters managing different relationships, both participants' also seem to describe a different alter that is created or adjusted for each relationship:

'I have developed that relationship to meeting their needs so I know what this person needs (points to a pebble representing a friend) and therefore the personality is created to provide those needs' (Sally: 1145)

Sally and Lauren seem to describe experiencing a great number of different personalities that almost match the person they are in the relationship with. Lauren describes the implications of this:

‘For years I couldn’t invite more than one set of friends to a party or anything in fear of everyone all coming and then them, what would I do cos I’d have to be loads of different personalities to, to loads of different people’ (Lauren: 549)

Sally also describes similar difficulties, describing that she tended to keep family and friends very separate and prefers spending time with people on a one-to-one basis, where she could interact without needing to switch between different alters to meet different people’s needs. These different perceptions of the experience of DID suggest that for Sally and Lauren, relationships are concerned with meeting others needs and ensuring they are accepted.

Emergent theme: Formation and dissolution.

When sharing the experiences of being in specific relationships, participants discussed how they coped with the beginning and the ending of relationships. There is clearly an overlap between this theme and the previous (‘Being in a relationship’) but I believed there was enough information about the formation and dissolution of relationships to warrant a separate discussion on the area.

Formation of new relationships.

Most participants reported struggling to form new relationships. These difficulties seemed to emerge from either a lack of understanding of other people, a lack of understanding of how relationships developed, or due to past bad experiences that had made participants cautious about trying to form another relationship. Elizabeth describes not feeling as if she understood the process of forming relationships:

‘R: Ok and what’s your experience of forming new relationships?’

Hmm, hmm, difficult, I’d say, quite difficult for me to form new relationships. Umm there’s a lot of, moving towards, moving back, moving towards, moving back, not caring, thinking maybe I’ll call, maybe

I won't, maybe I will, very, very difficult. I never quite know how to do that, how that all works really to be quite honest' (Elizabeth: 590)

Not understanding social interaction and other people's emotions are topics discussed in the previous emergent theme and were common among participants. It seems that Elizabeth's difficulty in understanding how to interact with others and the balance of making contact versus leaving space within relationships leaves her constantly questioning her behaviour and feeling unsure how to react. Elizabeth later shares how she has to really motivate herself to persevere in building new relationships and overcome her difficulties, as she knows that being with other people is actually very beneficial to her life.

Janet suggested that her difficulties in forming new relationships were due to the settings and environments she found herself in:

'I think if you've got DID it can be quite difficult to a) make new friends, cos at university I didn't know I had DID and it's just one of those environments where everyone's around and since then I've found it quite hard to make friends just because I'm not really in a setting where one would make friends' (Janet: 265)

Later in our interview, Janet spoke about recently joining an art class run by a mental health charity. She discussed this class with her therapist and decided to attend because she believed she would be in an environment where she could be more open about her difficulties. Janet spoke about how she was able to be more open, but that this had not helped her develop any new friendships, because she had felt everyone else was more severely unwell than she was. She discussed the dilemma of struggling with DID but also being able to function most of the time, and therefore not being sure where she fitted in society, and with whom it would be suitable to develop new relationships with.

Polly attributed her difficulties in forming new relationships to her shyness and lack of confidence, perhaps due to previous difficult experiences in relationships:

'I'm quite shy so it's quite difficult. I find, I do find it quite difficult to make new friends and things, as, as, I, it's one of those things that I'm shy until, it's difficult to make a new relationship with somebody' (Polly: 692)

Pam and Sally both described experiencing the breakdown of past relationships as painful, and this impacting on their desire to form new relationships. Sally appeared very final in her decision to avoid new relationships:

'I'm very, very selective about the relationships I have (R: Ok) I've been stung twice in my life and vowed I would never, never go there again. Umm and so I'm very, very careful about friends I choose and don't now, umm, set up new relationships' (Sally: 176)

Similar to Sally, Pam acknowledges that she doesn't go out of her way to form new relationships yet shares her experiences of a new relationship that has developed slowly at her place of work:

'I've sort of given up at the moment, umm, I nearly put that, somebody else there, somebody that I've kind of very slowly got to know at work, who I think, you know, probably crossing from a work colleague to a friend. I think that's the first person in certainly two or three years that I would even consider trying to develop a friendship with' (Pam: 814)

Pam goes onto express her anxiety about this new relationship, and her realisation that really it is up to her now to move it forward. She describes finding it painful to remember previous relationships that she had ended, and emphasised the necessity of the other person in the relationship having an understanding of her experience of DID:

'It has been excruciating, it, living with the fact that I've to some degree, bought, brought about the end of friendships, I find that really hard to live with, in myself, so it's made me very, very careful and more aware that unless I can make a friendship with people who can understand it, it's like all the friendships I had they, they, there was no mechanism within them, there was no understanding within them that could cope with me having DID' (Pam: 822)

Only Lauren presents a slightly different view of forming new relationships describing finding it easy to form relationships initially, as she believes she is quite chatty and friendly:

'I am good at creating relationships but there are times if I'm paranoid it's really hard, if I'm in a paranoid alter that's really hard, if I'm in a really depressed alter then I don't really want to speak to people, or, umm, and also, umm, I used to, I don't do this as much now, I used to feel very bonded to people very fast. (R: Uhuh) So that was, er, quite hard because, erm, quite weird' (Lauren: 808)

Although Lauren does not describe the uncertainty or lack of understanding of forming new relationships reported by other participants, she does describe difficulties. She describes how different mood states can impact on the way she interacts with others, such as withdrawing if she is feeling depressed. Lauren also describes how, in the past, she used to develop attachments to people very quickly, perhaps suggesting a lack of understanding of other people's needs or boundaries or her own desire to be loved.

Ending relationships.

There was considerable variation among participants' descriptions of relationships ending. Some participants described finding endings very difficult to manage and experiencing them as almost traumatic; others reported being able to cut off and remove themselves from any distress.

Sally and Laura both described close relationships that had collapsed in a very destructive manner. Interestingly, in both cases, the relationships they described had been with others who experienced DID. Sally described the impact of the relationship break down:

'I was sent an email that, that broke everything that I'd built up into millions of pieces and scattered it around' (Sally: 557)

The description of this relationship breaking 'everything' apart gives a sense of how devastating this experience was for Sally. It suggests a personal fragility that perhaps emerged as a result of the investment she made to the relationship. Sally

goes on to describe how she believed the experience had destroyed something that she was never able to get back:

'This one destroyed a whole box of resources and skills that I'd created to develop a relationship. (R: Uhuh) She set it alight and it's gone, the skills have gone and it damaged all of my relationships at that time' (Sally: 576)

Again, Sally's descriptions are dramatic and there is a strong sense of finality about what has changed for her as a result of this relationship collapsing. The idea of something being 'set alight' is deliberate and destructive, suggesting that things cannot be fixed or recovered in any way. Sally also states that the ending of this relationship had an impact on all of her other relationships and for a while she withdrew from others.

Laura spoke at length about her experience in what she now describes as an unhealthy relationship. It seemed as if through processing the event in the interview she was again trying to re-assure herself that she had not been in the wrong to end the relationship. In her descriptions of the relationships, she described how long she had tolerated the difficult situation and how much the ending of the relationship had impacted on her view of herself. Laura needed her psychologist and her daughter to reassure her that the relationship was not healthy before she finally withdrew from the situation.

Janet discussed her experience of relationships ending as difficult and referred to changing therapists as particularly challenging for her:

'I've got to change therapists in the end of the year because my therapist is leaving which is awful, but umm, and I met someone else who I was thinking of working with and I noticed that all of my questions to him were kind of sort of 'will you be like my old therapist? (Janet: 1012)

Perhaps the way in which Janet is trying to recreate the situation with her old therapist in a new therapeutic environment is an example of how she tries to avoid

endings. Interestingly Janet chose the room of her old therapist as a location for her interview.

Janet also acknowledged that endings do have to occur and distinguished between good endings and bad endings:

‘But the ones that have been ended for us, as they were, like when the funding was withdrawn from this respite centre and, and that kind of thing, when neither of us would have chosen particularly for the relationship to end have been the hardest’ (Janet: 1141)

Janet describes the hardest endings as when there has been no opportunity to discuss what has happened or to influence events; this is very similar to abusive situations. She uses the example of a centre withdrawing their funding as an example of a sudden relationship end where she was unable to maintain the relationships there even though she had wanted to.

In her interview, Polly described how difficult she found it to maintain intimate relationships, resulting in most of them ending; she attributed these difficulties to experiencing DID. She described finding the endings of these relationships very painful, as she was left with a feeling of rejection. Polly shared that she believed she was becoming more self-aware since receiving her diagnosis and reported that she felt she had been able to be more rational through her last relationship break-up, and as a result was left feeling less rejected. While Polly described this situation I had the impression that she felt responsible for the endings of these relationships, that she was in some way difficult, and that partners got tired of the way she behaved. Her description of the most recent relationship ending, below, suggests that Polly has spent some time analysing the reasons behind why the relationship ended:

‘He finished with me last February. He did it, he was not specific as to what the reason was, it was either or both that I was having an MS problem so my hand had stopped working and I was starting to limp so there was an element of him not wanting to have disabled girlfriend and also he found the whole way that he was, he triggered my Dissociative Disorder quite a lot’ (Polly: 178)

Polly also described occasions where she had been in relationships where she felt she was being badly treated by her partner at the time. She described how it was often the other person who ended the relationship, whereas she would tend to tolerate the situation, perhaps due her desire to have a partner. In the quote below, Polly describes a situation when she allowed a boyfriend to move in with her because he was experiencing financial problems:

'It just evolved to the point where he was just going out with me because he could, he would live somewhere rent free and that just made me feel terribly used and, you know, it was horrible' (Polly: 833)

Perhaps Polly's acceptance of being treated in this way suggests a low level of self-esteem and confidence. She goes on to describe the break-down of her marriage and how this impacted on the way she felt about herself:

'Umm, despite the fact you kind of like to be a, you know, I'm not so hideous that I can't be married, kind of thing. Umm and you know, so it was kind of, it was horrible cos it was the whole thing of failing and umm, you know, not, I should have, you know, it's, thought it was my fault' (Polly: 798)

The tendency to self-blame and believe that things had gone wrong because of their own actions was also evident within the interviews with Sally, Elizabeth, Janet and Laura. Perhaps this tendency is due to previous experience of being blamed, the presence of a diagnosis or the idea that 'something is wrong' with them.

Pam spoke about having been in some very enmeshed relationships and described how she feels as if she was drawn to intense relationships to fulfil a need that was not provided for her in younger life. She described being drawn to people who were experiencing unhappiness in their lives, making her very important to them. When Pam began her relationship with her current partner, she became more aware of how enmeshed she had been with others and tried to change this. Pam described how she actively ended these relationships but also how painful this had been for her:

'It was a hard couple of years because, umm, I had some fairly enmeshed relationships really, that sort of, didn't, didn't go without a fight really, do you know what I mean, there's like a lot of backlash and a lot of pain going on at that time' (Pam: 310)

Lauren described having mixed experiences with relationships ending. She described losing a lot of relationships in the past due to misunderstandings related to her experience of DID, especially when she did not disclose her diagnosis to others:

'I have a lot of other relationships, but because I can't, I, I have friendships and I lose friends quite often as well. Not like every day but I've lost friends over the years to do with having Dissociative Identity Disorder or, umm, them not understanding that I've got it and me appearing to be lying all the time cos I'm not making any sense, d'you know what I mean, like on one day I'll say this and on another day I'll say that' (Lauren: 394)

Lauren generally describes the ending of relationships as confusing but not particularly upsetting, and seems quite accepting of what has happened. However, later in her interview she described feeling very upset when she had an argument with a close friend and when she divorced her first husband. Interestingly, Lauren described feeling, at the time, very upset by the ending of these relationships, but her feelings changed very quickly, which she attributes to changing alters:

'If it's people like that then I do get very traumatised but then I'm very quickly just shut down and nothing. (R: Uhuh) So I can just cut people out. If I want to. But like I say it doesn't happen, it's all very instinctive, do you know what I mean, it's like, it's all very, when I was traumatised by the breakup in my relationship with H for those couple of days, umm, I wasn't actively thinking to myself 'oh I'm going to cut myself off from her' it just, suddenly I noticed that I just couldn't care less that she was either in my life or not in my life' (Lauren: 1029)

Lauren goes on to describe how it was only due to her friend's understanding of DID and her friend's perseverance, that they re-built the relationship. If the decision had

been left to Lauren, she believed she would have just moved on. This detachment from others is likely to have a significant impact on Lauren's relationships: it keeps her safe from the pain of relationships ending but it could be perceived quite differently by others, who might believe that she does not place much importance on her relationships. A similar experience is discussed by Elizabeth, who describes feeling as if she has a lack of attachment to things, places and people, and therefore doesn't experience any negative emotion or difficulties at the endings of relationships:

'They just end don't they (laugh) (R: Uhuh) I mean, I don't, they end, so a lot of the time I would cut off my feelings about it. (R: Uhuh) Umm, if the person I thought was important to me, umm, a lot of the time it wouldn't, I wouldn't, I wouldn't care really it, it, it wouldn't bother me whether it did or it didn't. Umm I wouldn't have any feeling about it at all' (Elizabeth: 764)

Earlier in our interview, Elizabeth had attributed her ability to cut off from her emotions as a result of her earlier experiences, and a technique that had allowed her to survive in a world where being dependent on another was dangerous:

'I learnt to sort of slice, you know, slice those feelings off, 'shoo' cut them off, because if I didn't I probably would have committed suicide' (Elizabeth: 321)

Emergent theme: Managing change.

Participants discussed change in two ways: how others around them had changed; and the ways they themselves had changed or improved in terms of how they conducted their relationships. The idea of improvement and internal change was discussed under the emergent theme of 'the jigsaw pieces are falling into place'. This emergent theme of 'managing change' contains discussion about coping with change in others and how this can impact on relationships. This is a topic that emerged mostly through interviews with Janet and Polly; it felt significant to explore further in this chapter as it had a big impact on the way, especially for Janet, relationships were experienced.

'I think my friends have moved on in a way that I haven't and that's kind of made it harder to not be upset when I can't go on holiday this year cos there's no one to go with and that sort of thing' (Janet: 275)

Janet describes how most of her friends have now got married and started a family, which Janet has not done herself. The use of the phrase 'moved on' suggests that Janet feels she hasn't 'moved on' and is stuck at a place somewhere behind her friends. However, Janet does not seem to describe this change in terms of jealousy but sadness that she has no-one to go on holiday with and that her relationships with friends are very different as husbands and children now need to be taken into consideration:

'We're not the same, it's not the same as it was ten years ago of course. (R: Uhuh) Umm and that's quite difficult because she used to be the person that, I, don't know, I went to see, I went to the cinema with and I went to, on holiday with and all this kind of stuff and now I'm not.' (Janet: 291)

Changes in friends' lives often left Janet with no-one to do activities with and a feeling that she wasn't important to her friends anymore as they now had different priorities:

'When I go and see her all I hear about is like her mummy friends and I'm kind of like, 'do, do I not mean anything?' (Janet: 233)

There also seems to be a need in Janet to be cared for, and for people to take into account her difficulties. Because she does not have a partner, this need is fulfilled by her friends. However, now her friends have husbands and children, they do not offer Janet as much support as they have in the past, leaving her to question whether she means anything to her friends.

Janet also speaks about how she has learnt to cope with these changes in relationships. She acknowledges that in the past she had always anticipated that change would have negative results, for example, if a friend moved house, but now she is learning that sometimes there can be unexpected benefits that she cannot predict:

'I think the worst relationships are when I can't let go of something, when I'm sort of clinging on, going, it's got to be like this, like, we always go on holiday together, or I always have my own bedroom when I come home or, and I think once I can loosen my grip on those and realise that actually I'm not going to die if I don't go home for a while or whatever it is. Umm but that mostly requires a huge amount of input from my therapist, those kind of entrenched things that I'm actually relying on' (Janet: 1079)

Janet describes learning to manage change but this still requires support from her therapist and is quite difficult. Polly discussed how she managed change in her relationship with her husband. She described how they seemed to complement each other at the beginning of the relationship, but by the end their different personalities were clashing:

'We'd moved from complimenting each other to basically, I was nagging and he was pissing me off' (Polly: 803)

Polly goes on to describe how it took a long time for her to accept that the marriage was over and how upset she had been at the collapse of the relationship.

It seems that being in relationships is impacted greatly by the perceived experience of DID. All participants reported being able to form close relationships and all except Polly had maintained these relationships, but this had not been easy, and managing change in relationships had proved to be challenging.

Master theme 3: Early Experiences

The master theme of early experiences captures the impact that participants believed their earlier life experiences had on how they functioned in their current relationships. All participants described difficult early experiences: these have been organised into two emergent themes: difficult relationships with their main caregivers per se; and the feeling that participants reported of missing out on fundamental aspects of development as a result of their early experiences, which then impacted on their later relationships.

Emergent theme: Relationships with main caregivers.

Although I did not ask directly about individuals' early relationships, this subject was mentioned by all seven participants, all saying that they had experienced some form of abuse in their early childhood. For Sally and Janet, this abuse had been from their parents; for Elizabeth, Pam and Lauren this abuse was from adopted parents, foster parents or step-parents. Laura mentioned that she had been a victim of sexual abuse and was not explicit about the perpetrators of the abuse, but she disclosed a difficult relationship with her parents. Polly described experiences of emotional neglect by her father from an early age. Some participants were less open in discussing their early experiences than others who selected difficult early relationships to discuss and refer to in the beginning exercise of the interview, but all reported some form of difficult early relationship.

Pam discussed her mother in our initial exercise and later was quite open in discussing the damage that she believed this relationship had caused her:

'I just think it's devastating, I can't believe how much time and therapy and hurt there is really, well not how much hurt there is but how much time in therapy it takes to express all that hurt and be able to leave it behind and I'm not sure that I'll ever leave it behind but it's not, it doesn't feel like an open sore anymore, whereas, you know, it was just all the time, I would experience the sort of, just desolation I think, anything bad happened in my life, day to day, you know, it, it always seemed to come back to the fact that I wasn't even good enough to be loved by a mother, by my own mother, you know, and it's I think the effect on your identity and your sense of worth and it, it's just appalling really, I don't think there's anything, there's anything like it for, you know, those relationships, for that relationship to be broken, umm, it's just horrible.'

(Pam: 941)

Pam explained that she found her mother a dominating and an oppressive force and that she started to argue against her during her early twenties. When Pam disclosed her abuse at the hands of her step-father, her mother did not believe her. Pam no longer has any contact with her family. Earlier on in our interview, Pam reflected on her previous experiences, discussing how she believed she fell into very entrenched

relationships due to a fear of being abandoned or alone; perhaps this originated from the problems in the relationship with her mother:

'When I look back I see that's what I keep doing, I kept doing, is kind of going back to unhealthy relationships in a desperate attempt to ward off the feeling of being utterly alone' (Pam: 592)

Even in her present relationship, Pam acknowledges that her early experience of family relationships has an impact, and that it takes a lot of effort to manage this:

'So a lot of my kind of family dynamics just play out in our household really, so I spend a lot of time trying to prevent that from happening or trying to understand what's happening and not pile it all onto T when it's not T's fault' (Pam: 498)

Lauren also spoke about difficulties in her relationship with her mother. Like Pam, Lauren described breaking contact with her mother in recent years, having found the relationship too difficult, and described self-harming after meeting with her. She speaks of her mother as confining and restrictive:

'She takes over your life and there's no room to breathe and there's no room to be yourself. Umm everything's all about her all the time' (Lauren: 345)

From this description, Lauren seems to feel very trapped by her mother, the relationship is one which stifles and suffocates. The relationships Pam and Lauren describe with their mothers are more than harmful: Pam uses the word 'devastating' to describe the breakdown of this relationship and Lauren describes her mother as 'toxic'; both are destructive and potentially lethal. Lauren goes on to explore the dilemma she feels between wanting a relationship with her mother yet finding it harmful. She describes being confused by her mother's behaviour and it not being what it appears:

'And she has this way of, umm... sort of, if you can imagine someone hugging you and stabbing you at the same time' (Lauren: 382)

Lauren describes how she believes her early experiences impact on the way she conducts her current relationships:

'I think part of the reason why I started having DID, although I've not quite got to the bottom of this. Umm there was trauma in my early childhood but I think the most traumatic thing that happened to me in my very earliest childhood was being shamed somehow so badly and rejected so badly within that that I was made to feel so, umm, urgh, so gross that I couldn't live with myself. So I had to be somebody else and I've been doing that since I was an infant. So the way I think people tend to see me is how, how I think, how I perceived that they want to see me, i.e. because I've become very good, from that early experience of being what people expect me to be' (Lauren: 689)

Lauren goes on to explain how she believes that this feeling of being shamed was caused by her mother.

Polly believes that neglect at an early age from her parents had a big impact on how she manages her relationships now. She describes the neglect occurring during a period when her mother was in hospital and she was being cared for by her father. Polly described feeling as if her father's behaviour at this time was partly responsible for her current difficulties with DID, describing him as emotionally unavailable, critical and attributing value only to academic achievement. Polly describes how she has deliberately sought to meet men who were very different to him, who were more loving and caring. However, as discussed earlier in the chapter, Polly has often found herself in unhealthy relationships where she has had difficulty dealing with feeling rejected. With a greater understanding of her DID, Polly describes how she now believes that the fear of rejection could have arisen as a result of early experiences, and how this knowledge has helped her:

'I'm more understanding that the rejection is not necessarily as personal as it sometimes, as it has felt in the past. So in the past the rejection has been very bad because it has triggered all these other historical memories' (Polly: 243)

Elizabeth discussed briefly her early experiences of being moved between foster homes, her parents and her adopted parents. She describes this impacting on her forming attachments (this is discussed further under the 'formation and dissolution' emergent theme) and learning to avoid making relationships as she felt everyone left her eventually. Although Elizabeth does not refer to any one person, she describes feeling as if everything was her fault when she was younger. People often seemed angry with her, she felt confused as to what she had done wrong and describes how that impacts on her ability to understand people and her tendency to still feel at fault:

'I suppose you can often pick up things from people that it's their stuff but actually they think it's your stuff, you know, when they're angry and it's your fault, well actually no it's not my stuff it's your stuff' (Elizabeth: 46)

Elizabeth also discussed believing her avoidance of attachment was a survival mechanism, as at the time she was thinking about meeting other more immediate needs, such as finding food:

'So relationships don't become a priority in your life, they didn't for me. It was 'I'm going to survive, I'm going to get through it and so relationships are almost like superfluous to that' (Elizabeth: 267)

Elizabeth has needed to tackle her independence and avoidance of relationships in order to maintain relationships in her current life, especially that with her son.

Emergent theme: Missing out

The final theme that emerged across participants was the feeling of having missed out, due to early experiences, on developing skills or having experiences that were needed for relationships. Sally describes feeling as if she missed out on a great deal:

'I'd had nothing socially for sorta fifteen years, I was very damaged so they put me in this secure unit and erm. As soon as I got out of there at eighteen, I, umm, became quite promiscuous for about a year and a half, umm, went out to find men to have relationships with, well no not

even relationships, to have sex with mainly, because that's the only way I knew how to function, or knew how to do anything, it was the only way I could claim any kind of umm, self-esteem almost, cos it was actually the only thing that I knew how to do, couldn't read, couldn't write, didn't know how to socialise, didn't understand people.' (Sally: 747)

Sally spoke about how she has tried to compensate for these deficits in her current relationships, for example, how she and a friend have tried to make up for missed opportunities in their early lives:

'We started doing things that I know I missed out on as a child, so I'd never been on a steam train, never in my life, so she says 'come on we'll go to a steam train', 'Ooo I'll be scared' I was like 'I don't do trains, I don't like noises', and we had a fantastic day and it was really lovely because we did things that neither of us had ever done before' (Sally: 547)

Elizabeth also described feeling as if she had missed out on early experiences and how this had impacted on the way she thought about relationships now:

'What happened to you wasn't normal, it wasn't within the normal range of being so it shaped my perceptions, it shaped my thinking in this way whereas perhaps I should be thinking in this way, and it would be more healthy for me.' Elizabeth: 286

Elizabeth describes how she now has more of an understanding of love and security, which she neither received nor understood as a child:

'I've started to understand more about what love is about and, and what security means and my identity. Umm, so I think if you, if you don't have those things then it's, it's difficult to move forward isn't it' (Elizabeth: 661)

Similarly Polly described how she is only now starting to realise what she missed out on in her earlier life:

‘The problem other than the whole of that being abandoned, umm is that a lot of the developmental things that you take a two year old through I didn’t have, nobody took me through them (R: Uhuh) and it’s only now that I, now I know, now I actually, because it’s only, it’s only the last sort of six months I’ve actually known that was what the problem was. So now I’ve got more ability to find out what it is I haven’t, what it is I didn’t do because I wasn’t properly looked after when I was two’ (Polly: 276)

The impact of early relational experiences and deficits within these, perhaps unsurprisingly, appear to have an impact on the way in which participants now experience and manage their relationships.

Summary

Considered together, participants’ discussion of their relationships fall into three broad master themes: ‘the self and the diagnosis’; ‘the process of relationships’; and ‘the impact of early experiences’.

Within the master theme of ‘the self and the diagnosis’ was discussion about different participants’ perceptions of experiencing DID either as a strength or as a deficit. Although all participants discussed the difficulties of experiencing DID, some participants seemed to take a certain pride in being different to those without the diagnosis, as if experiencing DID was special and something that those without the diagnosis would never fully understand. Other participants discussed how DID was often misunderstood by others, and how this could create a stigma around the experience, leaving them feeling abnormal and different.

This master theme also captured discussions around participants’ experience of their internal relationships, the concept of alters, and how difficult these could be to manage. Sharing the diagnosis of DID was also discussed: participants reported feeling unsure when and with whom to share their experiences, and were worried by reactions that they had had to previous disclosures. Some participants felt that things were starting to improve for them, especially following development of a greater awareness of how their individual experiences of DID impacted on them.

In the ‘process of relationships’ master theme, all participants spoke of experiences, either past or current, of being in close relationships and holding different roles

within these, such as being a wife or a mother. These experiences had positive and negative aspects, and difficulties with forming and ending relationships were common. Participants also discussed struggling with change in relationships, and feelings of others having moved on in a way participants themselves had not.

In the final master theme 'early experience', all participants revealed some kind of difficult relational experience, in their childhoods; often detrimental relationships with main caregivers. These experiences seemed to leave participants with the feeling that they had missed out on developmental stages of learning, which then impacted on how they conducted their relationships in later life.

Discussion

In this chapter I will initially explore the three master themes from the analysis, in terms of connections between them and consideration of their fit with previous literature around the concept of DID. I will also consider the implications of these findings for those who define themselves as having DID, and for those working with this client group. Each master theme will be discussed in the same order as it was presented in the analysis chapter, although in this chapter, I will take a more interpretative and reflective perspective on the data. Following this, I will consider the implications of these findings on the wider field of counselling psychology, discuss weaknesses of the study, and suggest further research that could be completed to develop these findings. Lastly, I will conclude and offer a final reflection on the research as a whole.

Discussion of findings

Master theme 1: The self and the diagnosis

A significant finding from this study was the variation in self-concept described in relation to participant's perceived diagnosis. Rosenberg defined self-concept as 'the totality of the individual's thoughts and feelings having reference to himself as an object' (p. 7). Similarly, Skaalvik and Bong (2003b) describe self-concept as a psychological construct that forms through interpersonal experiences, genetic factors and expectations of others. Skaalvik and Bong (2003a) suggest that a person's self-concept has a significant impact on the way they think and feel about themselves, their actions, and their beliefs about how they are viewed by others. Therefore, an individual's self-concept can have a significant impact on the way they behave in relationships.

In the present study, participants described the way they considered themselves in connection to their perceived diagnosis in contrasting ways: the perception of DID as a strength and/the self as capable despite the diagnosis, versus the perception of DID as a deficit and/something being wrong with the self. Some participants described conflicting views of the self, emphasising their own capabilities despite the perceived diagnosis, but also describing how they experienced DID as a deficit.

These findings suggest that individuals make sense of their experience of DID differently but that it is not considered as totally negative. Alongside some

participant's discussion of DID as a strength, the feeling of being lucky compared to other individuals who defined themselves in this way was also mentioned. There also seemed an implication of specialness at being different from others, evident in participants' use of words like 'muggles' and 'singletons' to describe those who do not define themselves as having DID. Interestingly, Hegeman (2009) also describes those who define themselves as having DID using the word 'singletons' (p. 194) and suggests that this is a way of the individual asserting a feeling of their own normality in a world that perhaps perceives them as abnormal.

The consideration that the diagnosis of DID is in some way special is very interesting and can have implications for the debate for and against the use of diagnosis. Those who argue against the use of diagnoses suggest that they can depersonalise individuals, reducing complex experience to a simple label. But what if the label isn't simple and what if it is so extreme and sensational that it provokes others to treat you in certain ways that can be quite positive. For example, others may look after you carefully because the diagnosis is associated with some difficult early experiences, they may make acceptances for certain behaviours and they may treat you as if you are special. Perhaps for some a diagnosis does not depersonalise but instead gives a social identity which guides their way of life and how they interact with others. If a diagnosis becomes functional in this way this could be problematic, some diagnoses may have a higher premium than others and may even be desirable to some individuals, therefore giving a person a diagnosis of DID could actually guide their behaviour and their sense of identity. Perhaps this is another element to reflect on when considering the positive and negatives of diagnosis.

This sense of specialness emerged through several direct comparisons that were made between participants and myself, the researcher. In considering these comments I was struck by the way in which myself and others who do not define themselves as experiencing DID, were positioned in language by some participants as the 'other'. The word 'other' is defined as 'separate in identity' (Oxford Reference Dictionary, 1987, p. 596) suggesting that those who do not define themselves as having DID are viewed as having a very different identity to those who do define themselves in this way. Dalal (2006) suggests that the need for belonging and attachment, which is desired by most humans and achieved through belonging to a group, is dependent on two conditions: there must be an alternative group to not

belong to; and only some can belong to the group while others are excluded. For some participants, this is certainly the case: there is another group, those who do not define themselves as having DID (muggles or singletons) and others are excluded by their lack of experience of DID. Davis (2011) suggests that people:

‘Appear to have a psychological imperative to empower ourselves through the negation of an ‘other’ with whom we disidentify. Without an ‘other’ to negate, we could not achieve the sense of power and invulnerability that we all consciously or unconsciously seek’ (p. 551-552).

Therefore, it is possible that in order to achieve a sense of power, control and invulnerability, we identify an ‘other’ for whom to compare ourselves to. In terms of the concept of DID, this may be achieved by disidentifying from those who do not have the diagnosis. Perhaps for those with early relational difficulties, feelings of vulnerability and powerlessness may have been frequently experienced, and therefore in adulthood, steps have been made to reduce these feelings. Davis (2011) goes on to discuss how we often project our own feelings and characteristics that are undesirable into others, and then in depreciating others, we elevate ourselves. Perhaps in those who identify themselves as having DID, fears of not understanding others are projected into others, who are then criticised for not understanding the perceived experience of DID.

It is possible that this identification of an ‘other’ by those who define themselves in this way is encouraged by the theory that DID is a ‘creative survival technique’, as suggested by authors such as Sinason (2011). Participants seemed to believe that DID formed by the self fragmenting, as a coping strategy to help them survive a difficult childhood. This seems a much more popular way of conceptualising DID than that described by Liotti (2004), who suggests that DID develops due to an inability to create a unified self at an early age. Perhaps the idea of later fragmentation is more acceptable to individuals who define themselves in this way and protects their sense of self by perceiving their experiences as demonstrations of strength and creativity, rather than as failure to create. These beliefs may even serve to combat some of the feelings associated with childhood abuse such as shame (Dorahy et al, 2012). Cannon (2010) suggested that considering DID as a

creative survival mechanism implies that it is adaptive, and therefore doesn't need to be cured or treated, maybe also reducing any feelings of abnormality.

When participants compared themselves to me, the researcher, there seemed almost a sense of superiority, as if participants were elevating themselves as suggested by Davis (2011). This behaviour could also help individuals manage the anxiety of being different. The idea of prizing difficult experience is consistent with Hegeman's (2009) comments, suggesting that individuals who define themselves as having DID may come to deeply value their different internal experiences, and that this helps a sense of identity to develop that perhaps has not been present previously. Dorahy et al (2009) suggested that feeling similar to others buffers against psychological distress and offers an individual a feeling of connectedness and acceptability. Therefore, perhaps having a shared diagnosis and a sense of identity connected to this diagnosis, reduced psychological distress.

However, some participants disliked feeling different; describing stigma around the diagnosis of DID, and feeling as if the disorder was misunderstood due to media representations. It is possible that the dislike of the diagnosis of DID is linked to past experiences that were perceived to lead to the development of this disorder. For example, participants in Dorahy et al's (2012) study into the feelings of shame and guilt in men exposed to childhood sexual abuse, described perceiving themselves as shameful due to their past experiences and believing that others would also perceive them in this way. Dorahy et al (2012) concluded that shame had an erosive effect on relationships and could prevent individuals from seeking support due to a feeling of low self-worth, and doubts over how genuine others can be. If shame and stigma are associated with the diagnosis of DID, this may impact on individuals seeking and engaging in therapy. Shame has previously been associated with other mental health issues, such as depression (Cheung, Gilbert & Irons, 2004) and anxiety (Harder, Cutler & Rockart, 1992). It is possible that if participants felt there was stigma attached to a mental health diagnosis, this could have been exacerbated by the description of DID as the most complex of the Dissociative Disorders (Livingston, 2009).

It can be concluded from these findings that among participants there were differences in the way the concept of DID was considered and this impacted on participants' self-concept; either in a positive or a negative way. The way in which

individuals perceive themselves is likely to have a significant impact on the way they interact with others. For example in Dorahy et al's (2012) sample, participants who described themselves as shameful would often withdraw from social contact. Alternatively, perceiving oneself as special could also lead to difficulties in relationships, as friends and family may find it difficult to relate to the individual, or may feel like they need to adapt or work around them, which could lead to feelings of resentment. In terms of the therapeutic relationship, it is possible that feeling abnormal or wrong may impact on how much an individual is able to disclose, and it may take time to build up trust and openness. Alternatively, a client who places themselves in an elevated position may leave the therapist feeling inferior and unable to understand their client's experiences, which could also cause difficulties in the therapeutic process. An individual's self-concept will have a significant impact on all areas of functioning; this could be an area that requires further study and exploration.

Within this master theme, participants also discussed issues in managing their internal relationships, and balancing the perceived needs of alters with those of external relationships. This finding was consistent with Cannon's (2010) study, in which participants described difficulty in knowing which to put first. Managing the behaviour of alters was challenging and certain emotions such as grief were also described as very difficult, as they needed to be processed by each alter separately, taking a long time and feeling emotionally draining. Managing internal experiences impacted on relationships, as friends and family were not always aware of what participants were experiencing, and struggled to understand what they couldn't actually see.

Davis (2011) describes how although 'otherness' exists between ourselves and other people, it can also exist in our internal states of mind. This certainly appeared true of a number of the participants in the present study. This perception of internal 'otherness' emerged when participants referred to their experience of alters. Alters were often not described as if they were different parts of the self, but as if they were separate entities or 'others' who needed managing and could interrupt external relationships. It is possible that the relationships with alters interfered with the creation of meaningful relationships with others and, suggests that the boundaries between 'self' and 'other' may be more blurred with those who define themselves as having DID.

All participants reported that the perceived experience of DID had a huge impact on their lives, particularly the difficulties in sharing such a significant part of their lives with others. Difficulties included explaining the diagnosis of DID; explaining the effect it had; knowing who to share the experience with; and choosing when to tell them. In terms of explaining the diagnosis of DID, participants described how their experience was vastly different from the media portrayals of the disorder.

Some participants described situations where they had felt forced to share their experiences due to circumstances outside of their control, but most of the time, participants had thought carefully about how the disclosure would impact on the other, and whether the other would be able to cope with the information. Friends were often selected based on whether they had their own experiences of difficulty, which was hoped to increase their ability to be understanding and empathetic. These findings are consistent with Cannon's (2010) participants, who described that the most difficult part of living with DID was managing the external environment, and deciding whether to explain or hide their experiences.

Friends and family had reacted very differently following disclosure of the experience of DID. Some had been accepting but never mentioned the subject again; some were frightened or uncomfortable; and others asked a lot of questions and seemed interested in the diagnosis and participant's experiences. The preferred response appeared to be asking questions and showing an interest, yet the different reactions to disclosure reported by participants, suggested that others' responses were quite unpredictable. These findings are consistent with those of Dorahy et al (2012), who suggested that fear was created by the unpredictable nature of how others would response to disclosure.

Yet participants found it difficult to be unable to share their experiences with others. In the current study participants were aware that their behaviour could seem odd and be misunderstood outside the context of their diagnosis; they had lost friends through not sharing their experiences and struggled to have relationships that only functioned from one part of themselves. This is similar to the descriptions in Cannon's (2010) study where participants reported feeling as if no-one knew 'the real them' and as if they were hiding a significant part of themselves by not sharing their diagnosis. However, individuals in Dorahy et al's (2012) study reported that

they sometimes lied or exaggerated aspects of their experiences or lives in order to avoid telling others the truth. In the current study, one participant described managing internal experiences, such as making up an excuse as to why they needed to leave a party early. Consistent with this are Trujillo's (2009) comments, describing how she felt she hid aspects of herself from others, and was very careful and slow to let people share her experiences.

The issue of sharing experience appears to be very conflicted: not every individual would be open to the experience participants may share; and responses are likely to be unpredictable, and in the worst case, rejecting, which could exacerbate feelings of shame and difference. However, not sharing with others may lead to misunderstanding, feels restrictive and prevents participants from being themselves. These are issues that could be addressed and worked through in therapy: for example, preparing to share experiences with others; predicting possible responses; and developing coping strategies for negative reactions. Disclosing experiences within the therapeutic relationship may also be difficult if the therapist is not perceived to be understanding of and sympathetic to the concept of DID. Gillig (2009) supports this, stating that those who have been diagnosed with DID are very sensitive to trust and rejection issues. This emphasises the importance of an understanding and non-judgemental therapeutic relationship when working with this client group. I wondered if the controversial nature of the diagnosis of DID has also impacted on the difficulty in disclosing experiences to others; specifically, if participants' diagnoses had been questioned, whether this impacted on how and who they shared their experiences with in the future.

The final emergent theme concerned change and improvement. Across all seven interviews, comments were made that participants had changed the way they interacted with others, and that their relationships had improved over time. Change had occurred in different ways, but seemingly exclusively through religious, therapeutic and intimate relationships. Through these experiences, participants described gaining a sense of self, an identity, and an understanding of why they felt and behaved in certain ways. The healing nature of a positive relationship is consistent with Schore's (2009) work, which describes how early relational trauma can impact on the right brain concerned with regulating emotions, managing stress and maintaining a unified sense of self. Perhaps when participants who experienced relational trauma in early life eventually found positive relationships, this damage

started to heal and a more unified sense of self emerged. These findings suggest that clients who define themselves in this way could benefit from therapy that takes a relational approach.

Master theme 2: The process of relationships

Participants described two different roles they had held in relationships: being a partner and being a mother. Having a relationship with a partner was considered to be impacted on by the experience of DID. Some participants described how it took them a long time to develop a relationship and a great deal of perseverance from the other person. Other participants described difficulties in managing physical touch from their partners; feeling startled or uncomfortable with spontaneous embraces. Being a good partner was also discussed and varied between participants. Some relied on partners to plan and organise them, whereas for others the possibility that a partner may need to care for them was difficult to cope with. How individuals coped in their relationships with partners seemed to be personal to the individual but difficulty was common. It appeared to be very dependent on the individual and their partner to find ways of managing the difficulties and often allowances and adaptations were made.

One issue, perhaps unique to those who define themselves as having DID, was described as inconsistency of experience. Feeling very different on a day-to-day basis meant that partners and friends struggled to rely on participants: not knowing how they would behave; feel; or be able to achieve on a day to day basis. This inconsistency was also described as impacting on the intimate side of relationships. Like the difficulties in managing internal relationships, this issue is an example of how the perceived symptoms of DID can impact on individual's relationships.

Four participants shared that they were mothers, and some described how they had used the opportunity of having children to 'make up' for deficits in their own childhood, ensuring that their own children had many more positive early experiences. I wondered if this was a way of participants separating from those they held responsible for their own difficulties, and attempting to regain an element of control by ensuring that history was not repeated. Participants were mindful that their perceived experiences of DID would impact on their relationships with their children, and had considered ways in which this could be managed, such as limiting the amount that they shared their difficulties with their children; trying not to put too

much pressure of the relationships; and attempting to explain to their children how their past experiences impacted on their behaviour. Previous literature has focused on how parenting has been negatively impacted on by mothers' own experiences of sexual abuse. For example, Jaffe, Cranston and Shadlow (2012) suggest that experiences of abuse lead to a more permissive style of parenting and Roberts, O'Connor, Dunn and Golding (2004) suggest that long term mental health problems in adulthood, as a result of childhood sexual abuse, have a negative impact on parenting ability. Little research appears to have been carried out on how parents consciously manage their relationships with their children and use their own experiences to guide their own parenting behaviour, suggesting that the results from the present study are novel and further research may be useful.

Lack of understanding of others and from others was an issue common to all participants. Deficits in understanding others' emotions, behaviours and social etiquette left participants confused and unsure how to appropriately interact with others. Participants described needing to learn how to love and care for others and how to name emotions and feelings. These results are consistent with Stickley and Nickeas' (2006) case study, which described how the client, Rachel, never felt emotions, which made it difficult for her to understand other people. Rachel had learned how to behave and interact with others by watching other people.

Participants' attributed their own lack of understanding to poor early relationships and a lack of early social interaction, which they believed had prevented the development of social skills and understanding of others' motivations. Dorahy et al (2013) suggested that higher levels of dissociation as a result of complex trauma contributed to relationship preoccupation and rumination on aspects of relationships, which is consistent with the current study. Participants in Dorahy et al's (2012) study also reported struggling to mentalise the internal perceptions of others, which made interactions difficult and caused concern. Of course, it is never possible to fully understand another's motivation, but it appears that ruminating about this issue is a trait described by those defining themselves as having DID; those who experience higher levels of dissociation; and those with feelings of shame and guilt as a result of childhood sexual abuse.

A tendency to self blame was also identified by Harvey, Dorahy, Vertue and Duthie (2012) in their sample of adults with a history of childhood mistreatment. Cohen

(2004) also suggested that individuals who define themselves as having DID struggle to separate their own internal experiences from those of others. This difficulty could have implications for a variety of different relationships, including the therapeutic relationship. Working towards a more positive perception of the self as a separate entity is something that could be addressed in therapy. Excessive rumination, difficulty in understanding internal perceptions of others and self-blame over therapeutic difficulties could be enacted in the therapeutic relationship, and therapists working with this client group may need to be mindful of these possibilities, and use their relationship with the client to explore these patterns of behaviour, and how they may impact on interactions outside the therapy room.

Despite participants struggling to understand others, it appeared to be very important that their own experiences were understood. I did wonder how this need for understanding, and a difficulty perceiving it, manifested itself in the interviews I carried out with participants. On several occasions, participants questioned the value of what they had shared with me, dismissing their discussion by saying I probably hadn't been interested or that they felt they had not told me anything significant. I don't believe that this was due to a lack of interest on my part, as a couple of participants had stated that I had been easy to talk to and I had been very interested. However, the need for understanding, alongside the tendency to dismiss or play down what had been shared, still remained. Perhaps this was due to previous experiences of being disbelieved or feeling misunderstood by others in the past, or an illustration of how participants doubted their own understanding of my internal perceptions. These behaviours could be enacted in the therapeutic relationship; the client may feel a need to be totally understood but is also fearful of this or knows it can never fully be possible. Dismissing what is discussed could be a way of avoiding emotion associated with certain situations. It may be useful for the therapist to be mindful of these possibilities when working with this client group.

Some participants described managing relationships and meeting others' needs by being very changeable. The idea of being changeable has been touched on by Trujillo (2009), who described, through her friends' feedback, becoming aware of how she felt and acted differently depending on who she was with. However, the experience of this inconsistency is varied among participants. Some participants described having internal alters who developed at an early age and remained fixed, whereas others described developing or adapting alters to fulfil the needs of each

relationship in the present day. The way in which participants make sense of their alters could be interesting to explore further, as this is likely to have a significant impact on individuals sense of self and the way in which they live their lives.

Participants offered their experiences in difficult relationships, and ending these, at several points throughout the interviews. Generally participants reported finding beginning new relationships difficult, which was attributed either to a lack of understanding of others and their emotions; or a lack of understanding of the process of forming a relationship. Cannon's (2010) participants also described difficulties in forming new relationships due to managing internal experiences. Barach (1991) considers the ability to manage new situations and relationships as developing through early interactions between a securely attached child and their caregiver. Through these interactions the child learns to tolerate anxiety and separation allowing them to manage new situations, including new relationships. Perhaps the difficulty in forming new relationships, described by those who define themselves as having DID, is due to an absence of this early attachment leaving them feeling anxious in unfamiliar situations. Relationship formation was generally described as a slow process that involved building trust and intimacy gradually, and past relationship breakdowns were described to have a big impact on the development of future relationships. This is worth considering in the context of the therapeutic relationship, clients may take a long time to develop trust in their therapists.

Endings of relationships were generally described as very difficult, with two participants talking at length about specific endings that had felt harmful to them. One participant described the ending as very final and destructive leading her to avoid new relationships. Another participant discussed how she had been engaged in a relationship which had felt unhealthy; as she spoke I had the impression that she blamed herself for the breakdown of the relationship. Perhaps this is another example of how self-blame may be a common trait in those who define themselves as having DID. The difficulty of ending with therapists was discussed by one participant, who described how an ending that was planned for and mutually agreed was much less traumatic than endings which she had no control over, and which were carried out abruptly. The findings of the present study suggest that endings should be managed as well as possible, and the impact of these on the client considered carefully. These findings could also be applied to other professional

relationships within client's lives, such as support workers, who may not realise the impact of a sudden ending on an individual who defines themselves as having DID.

Being badly treated by others and engaging in unhealthy relationships was also discussed. One participant discussed the very enmeshed relationships she had been involved in before meeting her current partner. She shared her belief that at the time she had engaged in these relationships, often with those experiencing their own difficulties, due to a personal need to be absorbed in another's life and avoid feeling and addressing her own problems. Harvey et al (2012) suggest that those who have experienced childhood psychological maltreatment are sometimes driven to please and care for others, which may act as a protection against further rejection. This comment is consistent with Trujillo's (2009) experiences. Reflecting on her past relationships, Trujillo states that she was aware she was accommodating her friends as much as possible so they would not leave, however, this often led to a sense of having lost her self in the process. In the current study, participants described feeling mistreated, yet, being very giving in their relationships and tolerating a great deal of difficulty before withdrawing.

Blizard et al (1994) suggest that dissociation can be maladaptive in adulthood as it prevents the individual from noticing the presence of abusive relationships, and sometimes traps an individual into a cycle of abuse. This could also be true of those who define themselves as having DID, as periods of dissociation, especially at times of heightened emotion, could prevent them from being aware of the damaging effect of some relationships. A different perspective is suggested by Thomas (2005), who suggests that children who have been abused do not form internal working models of protectors and therefore have difficulty in defending themselves from further abuse.

Interestingly, two participants described no difficulties ending relationships: these participants described cutting off their emotions quickly to avoid distress; becoming almost indifferent about the ending of a relationship; and dissociating into a different alter, enabling them to detach from the ending of the relationship. These comments were consistent with comments made by Cannon's (2010) participants, who described finding it easy to end relationships. It is possible that these detachment behaviours developed as a coping style: Barach (1991) describes how a child who does not have a mother to protect them detaches themselves from feelings and

needs, deactivating attachment behaviour. In the current study both participants who were able to describe this somewhat conscious, instrumental separation, described not having a caregiver to protect them or attach to in early life.

Managing change in others was discussed by participants, and could be connected to the sense of change and improvement described by participants in the previous master theme. It was discussed by one participant how she felt that others had moved on in a way that she hadn't managed, for example, getting married and having children. This participant was the youngest participant in the sample, in her early thirties, and therefore I wonder if her difficulties could have been age related rather than created as a result of her experience of DID. However, feeling different from others, because of having a mental health diagnosis, perhaps contributed to feeling as if others were moving on in a way she was not.

Master theme 3: Early experiences

None of my interview questions asked directly about early experiences of relationships but all participants spoke of this. All seven participants disclosed histories of childhood abuse and some participants spent time talking about the impact of a specific caregiver on their development. Generally there was a feeling that early experiences had resulted in the development of DID, which is consistent with literature linking the diagnosis of DID with childhood trauma (Scroppo et al., 1998). However, it is difficult to know whether individuals made the link between their experience of DID and childhood difficulties before or after receiving their diagnosis (or therapy) and starting to define themselves in this way.

Previous literature has linked the diagnosis of DID, early attachment difficulties and relational trauma (Liotti, 2004; Schore, 2009). Four of the participants interviewed in the present study discussed difficult relationships they had with early caregivers. These included the caregiver being physically or emotionally absent, being emotionally abusive, or not protecting the participant from abuse inflicted by others. Consequences of these early experiences were described as feelings of shame, individuals finding themselves repeatedly in unhealthy relationships, and lacking understanding of how to conduct and engage in relationships. It seems that difficult early relationships result in difficult adult relationships, suggesting that early attachment with caregivers does create a template which is then used as the individual grows up.

The feeling of having missed out on certain experiences emerged from analysis of the data. This theme is linked to the lack of understanding of others emotions and intentions, attributed to a lack of early social interaction which was described by several participants. One participant described physically engaging in activities she felt she had missed out on as a child such as riding on a train. This appeared to be quite therapeutic. Perhaps encouraging activities which were absent in childhood could be carried out in therapy as a way of individuals regaining a sense of control over life and engaging in positive activities. Feelings of missing out on experiences may leave an individual thinking they are less developed or less capable than others impacting on their sense of self worth.

Implications for Counselling Psychology

Woolfe stated that the priorities and focus of counselling psychology are: an increasing awareness of the significance of the helping relationship; a growing questioning of the 'medical model' of professional-client relationships and a move towards a more humanistic valuing system; and a developing interest in facilitating well-being as opposed to responding to sickness and pathology (as cited in Strawbridge & Woolfe, 2010, p. 4). Strawbridge and Woolfe (2010) suggest that these priorities may be challenged by demands placed on psychologists to reduce waiting lists, and offer economical treatment that is often perceived to consist of short-term intervention. The concept of DID does not fit well within these demands: research by Lloyd (2011) suggests that successful treatment for those who define themselves as having DID is long term therapy and until this need is met, crisis management often drains resources from both the individual and the service with which they are engaged. Perhaps counselling psychology needs to consider the effectiveness and process of engaging these individuals into therapy.

The findings from the present study are consistent with the above mentioned priorities. Knowledge about the experience of relationships in individuals who define themselves as having DID has offered insight into the therapeutic relationship; the study moves away from the medical view of DID, avoiding being drawn into the argument of whether DID exists and instead focusing on the perceived experience, meaning-making and impact of this on the individual; and the study also gives suggestions that may improve individuals' quality of life rather than 'curing' them on this experience.

Faber, Manevich, Metzger and Saypol (2005) suggest that at times, therapists are driven by their own aims, and these can be different from those of their client. Faber et al (2005) suggest that this can create a tendency to 'see the world through our own lens' (p.22), which is perhaps particularly true of the diagnosis of DID, where everyone seems to have a different perspective. This study reminds therapists and mental health professionals that their aims are secondary to the needs of the client. Strawbridge and Woolfe (2010) remind us that counselling psychology as a discipline is interested in the 'subjective worlds of self and others' (p. 4) and it is this subjective world that the present study has explored.

The findings from the present study can be used to inform clinical practice as a counselling psychologist, working with those who define themselves as having DID. Some findings support previous literature and are already employed in therapeutic practice such as considering the link between relationship difficulties and early experience, and the importance of early caregiver interaction on the regulation and understanding of emotions (Schoore, 2009). However, there are other findings that are novel, such as the impact of the perception of DID on the self-concept, and the disengagement from 'others' who do not define themselves as having DID. The perception of internal experiences as alters; and the need to balance these with external relationships seems unique to individuals defining themselves as having DID as does the impact of inconsistency in behaviour and emotion which is described by this sample. These experiences could be explored in therapy by counselling psychologists working with this client group, and their impact on the therapeutic relationship reflected upon. Additionally, the difficulty in explaining the experience to others, knowing who to share with, and when, and coping with others' reactions, are topics that could also be addressed in therapy.

These findings also reaffirm to the counselling psychologist the importance of listening to the client and being guided by their experience and what they believe may help. Despite the controversial nature of the diagnosis of DID and multiple personalities, it is important to look past this label and to the clients behind the diagnosis. It is clear that individuals who define themselves in this way experience difficulty and distress and it is important to know how it is best to support them; in order to do this, professionals need to know more about their experiences. Additionally, the focus of this thesis has been on relationships, and the many difficulties that participants described occurring in the context of a relationship or

lack of relationship. As counselling psychologists, we place a strong importance on the therapeutic relationship; this means we are well equipped to work with this client group and perhaps focus on the repair that can be achieved in a positive working relationship.

Limitations and ideas for future research

One limitation of this study was the recruitment of the sample from only one organisation. Members of *First Person Plural* are likely to perceive themselves in a way that is consistent with the values of the organisation. For example, the charity describes itself as being 'survivor led' (First Person Plural, 2011) and appears to take the perspective that DID is developed to survive severe childhood trauma. Those who do not consider DID to develop in this way, or have no traumatic background but still define themselves as having DID, may not be members of this organisation and therefore would not have been invited to take part in the research. A way of gaining a broader sample may have been to recruit from NHS trusts around the country, as well as from different organisations. Due to the small number of those who define themselves as experiencing DID this was perceived to be too time consuming for the current study.

The participants who volunteered to take part in the study were all women, aged between 30 and 50. There has been a gender bias found in the diagnosis of DID, with more women diagnosed than men (Sinason, 2011). Gleaves (1996) suggests that individuals spend on average six to seven years in the treatment system before receiving the diagnosis, and therefore may be older than those diagnosed with other disorders. Considering this, the present sample may be quite representative of those who are diagnosed with DID. However, given the gender bias, it may be important for future research to interview men who define themselves as having DID, which would offer a broader view of how relationships are experienced. The current sample was also self-selected: participants who volunteered had something that they wanted to share about their experiences of relationships. Those defining themselves as having DID and who had severe difficulties interacting with others, who were perhaps embarrassed by their experiences, or alternatively had no difficulties in relationships, may not have volunteered for this research. Although qualitative research does not seek to generalise findings in the same way as larger scale quantitative research I believe it is important to consider the findings and

suggestions made from this study in light of the sample of participants who took part.

I decided to exclude individuals who presented as very psychologically vulnerable, such as those having thoughts of suicide or actively self-harming, from this research. This decision resulted in the exclusion of one individual who, through email, described that she was currently dissociating a great deal. Even arranging an initial phone call was very difficult and after several attempts to set a time and being unsuccessful, I deemed her to be too vulnerable and her behaviour too chaotic. This exclusion criterion may have restricted the analysis to insights into the experience of those whom were deemed to be psychologically stable. However, it may have also been the case that participants who did come forward experienced a level of fragmentation of identity that actually facilitated their functioning and their ability to take part in this research. For example, they may have still been psychologically vulnerable but managed this through experiencing a distinct separation between vulnerable parts of their personality and functioning parts. Perhaps therefore my participants were not more psychologically stable but just employed different strategies to manage their vulnerabilities and protect themselves. In future research this may have been an area worth exploring during the recruitment procedure.

Ultimately the participants who volunteered for this study reported a high level of functioning; four held full time employment, one remained at home to raise her family and two held volunteering posts. Most of the participants had received the diagnosis of DID a number of years ago, suggesting that they had received more therapeutic support, had a chance to understand the diagnosis and be more reflective about their experiences. Although I believe it was appropriate to include this exclusion criteria, more obviously psychologically vulnerable individuals may have offered a very different perspective of DID, and reported different experiences in relationships. Future research building on this study could include these participants but perhaps could be carried out in a community or inpatient service where risk and vulnerability could be contained.

A limitation often directed at qualitative research is its use of small sample sizes and its lack of emphasis on producing generalisable findings, preferring to focus on a deeper understanding of a single phenomenon (Coolican, 2009). This is true of the present research, where I only interviewed seven participants, and therefore the

generalisability of findings is indeed limited. Perhaps future research could explore findings, such as the impact of the perceived symptoms of managing internal relationships and inconsistency of experience. Data could be collected in a more structured way from a larger sample, exploring to what extent the results from the present study are true of others who define themselves as having DID.

An additional option for future research may be to explore the experiences of people who are in relationships with those defining themselves as having DID. During the recruitment process of this study, I was contacted by a member of *First Person Plural* whose partner had been diagnosed with DID and who offered to speak about her experiences. This would be an interesting and worthwhile area to explore further, offering an alternative perspective to the concept of DID.

Conclusion

Overwhelmingly, the experience of DID was perceived as impacting negatively on the relationships of these seven participants. DID was considered to have developed as a result of childhood abuse and relational difficulties. The consequences of these experiences were considered to have a significant impact on later adult relationships. Participants felt that negative early attachments and an absence of social interaction had impacted on understanding their own and others' emotions, and of how to form and conduct a relationship. Excessive rumination about relationships and increased levels of self-blame were common experiences. Participants described having been in unhealthy or enmeshed relationships with others, and some used detachment to avoid emotional pain, both within difficult relationships and when they ended.

Inconsistency of behaviour and feelings was described to be one of the most problematic perceived symptoms of DID, and this had a big impact on friends and partners of participants. Additionally managing internal experiences and balancing these with the needs of external relationships was described as difficult. Sharing the diagnosis of DID and personal experiences with others was considered very challenging, and a great deal of care was taken with disclosure. This linked with individuals' perceptions of their experiences, which ranged from positive, positioning DID as a strength, to negative, considering DID as an experience to be ashamed of, and one which ruined lives.

These findings may be helpful to professionals working with individuals who define themselves as having DID, especially in a therapeutic context. Some considerations include: investigating the client's perception of DID, what DID means to them; allowing the therapeutic relationship to grow gently as genuine trust can be difficult; ensuring the individual is feeling understood and checking this with the client; the impact of perceived internal relationships on the client's interactions; addressing sharing experiences with others, considering who is appropriate to disclose to and managing their responses; remembering these clients' tendency towards self-blame, rumination and their difficulty in understanding others' motivations; as well as ensuring that careful preparations are made for the ending of professional relationships.

A theme that has woven throughout this research has been the controversies of the diagnosis of DID and how this has impacted on myself, a researcher studying the subject. The diagnosis of DID provokes passionate debate and finding a place between the two quite extreme standpoints has been difficult and something that has evolved throughout the research process. I conclude that I simply do not know whether DID, as described by DSM-5 (APA, 2013), exists. At the beginning of the research I wanted to believe it did exist and that I would find something to prove it so. This was simply not the case. I do not believe the experiences described by those defining themselves as having DID are fabricated, but I do believe that society and culture can impact on the use of certain diagnoses. I do believe that early trauma and attachment difficulties result in significant problems in adulthood, however, I am unsure whether actually having a number of alternative personalities that are separated by amnesic barriers can be possible. Maybe not knowing is an acceptable place to remain for the time being, however, I still strive to be curious about experiences described by those who identify with the diagnosis of DID and I am interested whether any conclusions about the diagnosis will be made in the future.

Reflective statement

At the beginning of this research project, I wanted to believe that DID existed, that people could have multiple personalities, and I wanted to promote the experiences of those who defined themselves in this way. I was not sure what would emerge from this research, but I did consider, through previous reading, that the experience of DID would impact negatively on relationships, although I was unsure how. It has

been enlightening and worthwhile to meet individuals who define themselves as having DID but I now take a different stance. I do not know if DID exists and whether people can have alternative identities. This has offered me a sense of freedom and I have moved from fighting a corner to being curious; from a position of 'how terrible for these individuals' to 'what does this mean for this individual?'.

In the methodology chapter of this report, I reflected on Le-Gallais' (2008) discussion of her position as an insider/outsider in her own research. Through the process of the present study, I have become increasingly aware of my own position, often as an 'other', and on many occasions as an outsider to the experience described as DID. Reading some of the literature around the concept and experience of DID, I felt at times that I was entering a mysterious world that was difficult to understand. I believe participants also positioned me as an outsider. Participants referring to those who do not define themselves as having DID as 'muggles' and emphasising how different their experiences were compared to my own, certainly contributed to my feelings. However, I also sensed that participants wanted an investment from me. In taking part in the research, participants wanted to be heard. We shared commonalities such as disbelief of how little literature there was about the diagnosis, and how difficult it was to access long-term treatment in the NHS, and during these times I became more of an insider. On reflection, I wonder if my brief insider status impacted on my ability to be objective during the analysis of the data, for example, perhaps I emphasised the 'specialness' of these individuals; seeking behaviour and experience that was different and unique to this population; ignoring the idea that human behaviour exists on a spectrum and those who define themselves as having DID may just have more extreme experiences.

This study was designed and completed over a period of three years; naturally I became very entrenched in the endeavour, and watched my own strengths and weaknesses enacted in the process. My desire to defend those who are underrepresented was almost as great as my reluctance to let go of and condense my data, which is something that came as a great challenge to me. The need to hang onto everything was perhaps linked to a personal need to get things right, and a fear that I may omit something that was important. This made analysis a long and painful process, but it also meant that I felt fully immersed in the data and had many examples to support the themes that had emerged. Initially, I was concerned about the impact of reading about, hearing and analysing individuals' difficulties on such a

regular basis, in my own home. I was also aware of the isolation that can be felt in conducting research, especially in the writing up period. Talking to peers and my supervisor were lifelines, as was having a life outside of the world of DID.

Considering the journey of writing this thesis, at times I have loved this study and at times I have never wanted to hear the words 'Dissociative Identity Disorder' ever again. Perhaps my experience is reflective of the extreme opinions evoked about the diagnosis by others. However, working through the difficulties and watching this research come together has been extremely rewarding; it has been an immense privilege to be able to hear and explore the subjective experience of the participants.

References

- Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. New Jersey: Lawrence Erlbaum Associates.
- Allport, G. (1940). The psychologist's frame of reference. *Psychological Bulletin*, 37, 1-28.
- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Rev.). Washington DC: American Psychiatric Publishing.
- American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington: American Psychiatric Publishing.
- Andrews, M., Sclater, S.D., Squires, S., & Treacher, A. (2000). *Lines of narrative: Psychosocial perspectives*. London: Routledge.
- Baker, K. (2010). From 'it's not me' to 'it was me after all': A case presentation of a patient diagnosed with Dissociative Identity Disorder. *Psychoanalytic Social Work*, 17, 79-98.
- Barach, P. M. M. (1991). Multiple Personality Disorder as an attachment disorder. *Dissociation*, 4, 3, 117-123.
- Barker, G. A. (2010). *The effects of trauma on attachment*. Retrieved from <http://traumaresources.wikispaces.com/file/detail/The+Effects+of+Trauma+on+Attachment+-+Dr+Graham+A+Barker.pdf>.

- Barlow, M. R., Cromer, L.M., Prairie Caron, H., & Freyd, J.J. (2012). Comparison of normative and diagnosed dissociation on attachment to companion animals and stuffed animals. *Psychological Trauma: Theory, Research, Practice and Policy*, 4, 5, 501-506.
- Barlow, R. (2007). Researching Dissociative Identity Disorder: Practical suggestions and ethical implications. *Journal of Trauma and Dissociation*, 8, 1, 81-96.
- Blizard, R. A., & Bluhm, A. M. (1994). Attachment to the abuser: Integrating object-relations and trauma theories in treatment of abuse survivors. *Psychotherapy*, 31, 3, 383-390.
- Blizard, R. A. (1997). The origins of Dissociative Identity Disorder from an object relations and attachment theory perspective. *Dissociation*, 10, 4, 223-229.
- British Psychological Society. (2010). *Code of human research ethics*. Leicester: Author.
- British Psychological Society, (2005). *Good practice guidelines for the conduct of psychological research within the NHS*. Leicester: Author.
- Bottoms, B. L., Shaver, P. R., & Goodman, G.S. (1996). An analysis of ritualistic and religion related child abuse allegations. *Law and Human Behavior*, 20, 1-34.
- Bowlby, J. (1988). *A secure base*. New York: Routledge.

- Brand, B., Classen, C., Lanius, R., Loewenstein, R., McNary, S., Pain, C., & Putnam, F. (2009). A naturalistic study of Dissociative Identity Disorder and Dissociative Disorder not otherwise specified patients treated by community clinicians. *Psychological Trauma: Theory, Research, Practice and Policy*, 1, 2, 153-171.
- Brand, B. L., Myrick, A. C., Loewenstein, R.J., Classen, C.C., Lanius, R., McNary, S.W., Pain, C., & Putnam, F. W. (2012). A survey of practices and recommended treatment interventions among expert therapists treating patients with Dissociative Identity Disorder and Dissociative Disorder not otherwise specified. *Psychological Trauma: Theory, Research, Practice and Policy*, 4, 5, 490-500.
- Brewin, C.R., Lanius, R.A., Novac, A., Schyder, U., & Galea, S. Reformulating PTSD for DSM-V. *Journal of Traumatic Stress*, 22, 366-373.
- Briere, J., Weathers, F. W., & Runtz, M. (2005). Is dissociation a multidimensional construct? Data from the multiscale dissociation inventory. *Journal of Traumatic Stress*, 18, 221-231.
- Briere, J. (2006). Symptoms and trauma exposure: Specificity, affect dysregulation and posttraumatic stress. *The Journal of Nervous and Mental Disease*, 194, 2, 78-82.
- Cannon, S. (2010). What is it like living with DID? (Unpublished MA dissertation). Middlesex University, London.
- Carlson, E. A. (1998). A prospective longitudinal study of attachment disorganization/disorientation. *Child Development*, 69, 4, 1107-1128.

- Casey, J. M., & Wilson, L. (1991). *The flock: The autobiography of a multiple personality*. New York: The Random House Publishing Group.
- Cassidy, E., Reynolds, F., Naylor, S., & De Souza, L. (2011). Using interpretative phenomenological analysis to inform physiotherapy practice: An introduction with reference to the lived experience of cerebellar ataxia. *Physiotherapy Theory & Practice*, 4, 263-77.
- Chase, T. (1987). *When rabbit howls*. New York: Penguin Group.
- Cheung, M. S. P., Gilbert, P., & Irons, C. (2001). An exploration of shame, social rank and rumination in relation to depression. *Personality and Individual Differences*, 36, 1143-1153.
- Chu, D.A., Williams, L.M., Harris, A.W.F., Byrant, R.A., & Gatt, J.M. (2013). Early life trauma predicts self-reported levels of depressive and anxiety symptoms in nonclinical community adults: Relative contributions of early life stressor types and adult trauma exposure. *Journal of Psychiatric Research*, 47, 1, 23-32.
- Cohen, A. (2004). Dissociative Identity Disorder: Perspectives and alternatives. *Ethical Human Psychology and Psychiatry*, 6, 3, 217-230.
- Cohen, B. M., Giller, E., & W, L. (1991). *Multiple personality from the inside out*. US: The Sidran Press.
- Cole, M., & Cole, S. R. (2001). *The Development of Children* (4th ed.). New York: Worth Publishers.

- Coons, P. M. (1994). Confirmation of childhood abuse in child and adolescent cases of Multiple Personality Disorder and Dissociative Disorder not otherwise specified. *The Journal of Nervous and Mental Disease*, 182, 8, 461-464.
- Coolican, H. (2009). *Research methods and statistics in psychology*. London: Hodder Education.
- Cormier, J. F., & Thelen, M. H. (1998). Professional scepticism of Multiple Personality Disorder. *Professional Psychology: Research and Practice*, 29, 2, 163-167.
- Coyle, R., & Thobaben, M. (1995). Understanding Dissociative Identity Disorder. *Home Healthcare Nurse*, 13, 1, 77-78.
- Costner Sizemore, C., & Sain Pittillo, E. (1977). *I'm Eve*. New York: Doubleday.
- Crossley, M. L. (2000). *Introducing narrative psychology: Self, trauma and the construction of meaning*. Buckingham: Open University Press.
- Dalal, F. (2006). Racism: Processes of detachment, dehumanization and hatred. *Psychoanalytic Quarterly*, 75, 131-161.
- Davis, J. D. (2011). Cultural dimensions of intersubjectivity: Negotiating 'sameness' and 'otherness' in the analytic relationship. *Psychoanalytic Psychology*, 28, 4, 549-559.
- Dell, P. F. (1988). Professional scepticism about multiple personality. *Journal of Nervous and Mental Disease*, 176, 9, 528-531.
- Dell, P. F., & O'Neil, J. A. (Eds.). (2009). *Dissociation and the Dissociative Disorders: DSM-V and beyond*. New York: Routledge.

- Dorahy, M. J., Corry, M., Shannon, M., MacSherry, A., Hamilton, G., McRobert, G., Elder, R., & Hanna, D. (2009). Complex PTSD, interpersonal trauma and relational consequences: Findings from a treatment-receiving northern Irish sample. *Journal of Affective Disorders*, 112, 71-80.
- Dorahy, M.J. (2010). The impact of dissociation, shame and guilt on interpersonal relationships in chronically traumatized individuals: A pilot study. *Journal of Traumatic Stress*, 23, 5, 653-656.
- Dorahy, M.J., & Clearwater, K. (2012). Shame and guilt in men exposed to childhood sexual abuse: A qualitative investigation. *Journal of Child Sexual Abuse*, 21, 155-175.
- Dorahy, M. J., Corry, M., Shannon, M., Webb, K., McDermott, B., Ryan, M., & Dyer, K.F.W. (2013). Complex trauma and intimate relationships: The impact of shame, guilt and dissociation. *Journal of Affective Disorders*, 147, 72-79.
- Dunn, G.E., Paolo, A.M., Ryan, J.J., & Van Fleet, J.N. (1994). Belief in the existence of Multiple Personality Disorder among psychologists and psychiatrists. *Journal of Clinical Psychology*, 50, 3, 454-457.
- Dutra, L., Bureau, J. F., Holmes, B., Lyubchik, A., & Lyons-Ruth, K. (2009). Quality of early care and childhood trauma: A prospective study of developmental pathways to dissociation. *Journal of Nervous and Mental Disease*, 197, 6, 383-390.
- Eatough, V., & Smith, J. A. (2008). Interpretative phenomenological analysis. In C Willig & W. Stainton – Rogers (Eds), *The sage handbook of qualitative research in psychology* (pp. 179-194). London: Sage.

- Faber, B. A., Manevich, I., Metzger, J., & Saypol, E. (2002). Choosing psychotherapy as a career: Why did we cross that road? *Journal of Clinical Psychology*, 61, 8, 1009-1031.
- Fade, S. (2004). Using interpretative phenomenological analysis for public health nutrition and dietetic research: a practical guide. *Proceedings of the Nutrition Society*, 63, 647-653.
- Finlay, L. (2008). A dance between the reduction and reflexivity: exploiting the 'phenomenological psychological attitude'. *Journal of Phenomenological Psychology*, 39, 1-32.
- First Person Plural, (2011). Retrieved from <http://www.firstpersonplural.org.uk>
- Fonagy, P. (2011). Multiple voices versus meta-cognition: An attachment theory perspective. In V. Sinason (Ed.). *Attachment trauma and multiplicity. Working with Dissociative Identity Disorder* (2nd ed.). (pp. 21-36). London: Routledge.
- Foucault, M. (1965). *Madness and civilization: A history of insanity in the age of reason*. New York: Random House Inc.
- Frankland, A., & Walsh, Y. (2000). *The values of counselling psychology*. Retrieved from http://dcop.bps.org.uk/dcop/home/values/values_home.cfm
- Fuller, P. R. (2010). Treatment of trauma: Applications of trauma treatment for schizophrenia. *Journal of Aggression, Maltreatment and Trauma*, 19, 450-463.

- Gergen, K. J., & Gergen, M. M. (1988). Narrative and the self as relationship. In L. Berkowitz (Ed.), *Advances in experimental social psychology*, Vol 21 (pp. 17-56). New York: Academic Press.
- Gillig, P. M. (2009). Dissociative Identity Disorder: A controversial diagnosis. *Psychiatry*, 6, 3, 24-28.
- Gleaves, D. H. (1996). The sociocognitive model of Dissociative Identity Disorder: A reexamination of the evidence. *Psychological Bulletin*, 120, 1, 42-59.
- Gleaves, D. H., Hernandez, E., & Warner, M. S. (1999). Corroborating premorbid dissociative symptomology in Dissociative Identity Disorder. *Professional Psychology: Research and Practice*, 30, 4, 341-345.
- Hawkins, J. M. (Ed.). (1987). *The oxford reference dictionary*. London: Guild Publishing.
- Harder, D. W., Cutler, L., & Rockart, L. (1992). Assessment of shame and guilt and their relationships to psychopathology. *Journal of Personality Assessment*, 59, 584–604.
- Harper, D. (2012). Choosing a qualitative research method. In D Harper & A. R. Thompson (Eds.). *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners psychology* (pp. 83-93). Sussex: Wiley Blackwell.
- Harvey, S. M., Dorahy, M. J., Vertue, F. M., & Duthie, S. (2013). Childhood psychological maltreatment and perception of self, others and relationships: A phenomenological exploration. *Journal of Aggression, Maltreatment and Trauma*, 21, 3, 237-255.

- Hayes, J. A., & Mitchell, J.C. (1994). Mental health professionals' scepticism about Multiple Personality Disorder. *Professional Psychology: Research and Practice*, 25, 4, 410-415.
- Hegeman, E. (2009). One or many? Commentary on paper by Debra Rothschild. *Psychoanalytic Dialogues*, 19, 188-196.
- Holmes, E.A., Brown, R.J., Mansell, W, Fearon, R.P., Hunter, E.C., Frasquilho, F., & Oakley, D.A. (2005) Are there two qualitatively distinct forms of dissociation? A review and some clinical implications. *Clinical Psychology Review*, 25, 1-23.
- Hoyt, S. L. (2002). The perception of danger cues in traumatized and nontraumatized populations. *Dissertation Abstracts International. B. The Sciences and Engineering*, 62, 12B, 5965.
- International Society for the Study of Trauma and Dissociation. (2011). Guidelines for treating Dissociative Identity Disorder in adults: Third revision: Summary version. *Journal of Trauma and Dissociation*, 12, 188-212.
- Jaeger, M. E., & Rosnow, R. L. (1988), Contextualism and its implications for psychological inquiry. *British Journal of Psychology*, 79, 63-75
- Jaffe, A. E., Cranston, C. C., & Shadlow, J. O. (2012). Parenting in females exposed to intimate partner violence and childhood sexual abuse. *Journal of Child Sexual Abuse: Research, Treatment and Program Innovations for Victims, Survivors and Offenders*, 21, 6, 684-700.
- Jamieson, A. (2009). *Today I'm Alice; Nine personalities, one tortured mind*. London: Sidgwick & Jackson.

- Kahr, B. (2007). The infanticidal attachment in schizophrenia and Dissociative Identity Disorder. *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis*, 1, 305-309.
- Kluft, R. P. (1993). The treatment of Dissociative Disorder patients: An overview of discoveries, successes, and failures. *Dissociation*, 4, 2, 87-100.
- Kluft, R. P. (1995). The confirmation and disconfirmation of memories of abuse in DID patients: A naturalistic clinical study. *Dissociation*, 8, 4, 253-258.
- Koral, S. (2008). Familial and social support as protective factors against the development of Dissociative Identity Disorder. *Journal of Trauma and Dissociation*, 9, 2, 249-267.
- Korzekwa, M. I., Dell, P. F., & Pain, C. (2009). Dissociation and Borderline Personality Disorder: An update for clinicians. *Current Psychiatry Reports*, 11, 82-88.
- Kvale, S. (2007). *Doing interviews*. London: Sage.
- La Fontaine, J. S. (1998). *Speak of the devil: Tales of satanic abuse in contemporary England*. Cambridge: Cambridge University Press.
- Le Gallais, T. (2008). Wherever I go there I am: reflections of reflexivity and the research stance. *Reflective Practice*, 9, 2, 145-155.
- Lev-Wiesel, R. (2008). Child sexual abuse: A critical review of intervention and treatment modalities. *Children and Youth Services Review*, 30, 665-673.
- Liotti, G. (1992). Disorganized/disorientated attachment in the etiology of the Dissociative Disorders. *Dissociation*, 5, 4, 196-204.

- Liotti, G. (2004). Trauma, dissociation, and disorganised attachment: Three strands of a single braid. *Psychotherapy: Theory, Research, Practice, Training*, 41, 472-786.
- Liotti, G. (2006). A model of dissociation based on attachment theory and research. *Journal of Trauma and Dissociation*, 7, 4, 55-73.
- Livingston, K. (2009). *Understanding Dissociative Disorders*. London: Mind.
- Loftus, E., Garry, M., & Hayne, H. (2008). Repressed and recovered memory. In E. Borgida & S. Fiske (Eds.), *Beyond common sense: Psychological science in the court room* (pp. 177-194). Oxford: Blackwell Publishing.
- Lloyd, M. (2011). How investing in therapeutic services provides a clinical cost saving in the long term. *Health Service Journal*. Retrieved from <http://0-www.lexisnexis.com.wam.city.ac.uk/uk/nexis/search/homesubmitForm.do>
- Lyons-Ruth, K., Dutra, L., Schuder, M. R., & Bianchi, I. (2006). From infant attachment disorganization to adult dissociation: Relational adaptations or traumatic experiences? *Psychiatric Clinics of North America*, 29, 1, 1-18.
- Lyons-Ruth, K., & Jacobvitz, D. (1999). Attachment disorganization: Unresolved loss, relational violence and lapses in behavioural and attentional strategies. In J. Cassidy & P. R. Shaver (Eds.). *Handbook of attachment* (pp. 520-554). New York: Guilford Press.
- Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, 91, 1-20.

- Main, M., & Hesse, E. (1990). Parent's unresolved traumatic experiences are related to infant disorganised attachment status: Is frightened and/or frightening parental behaviour the linking mechanism? In D. C. M. Greenberg & E. M. Cummings (Eds.), *Attachment during the preschool years: Theory, research and intervention*. (pp. 161-182). Chicago: University of Chicago press.
- Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganised/disorientated during the ainsworth strange situation. In D. C. M. Greenberg & E. M. Cummings (Eds.), *Attachment during the preschool years: Theory, research and intervention*. (pp. 121-160). Chicago: University of Chicago press.
- Martinez-Taboas, A., Dorahy, M., Sar, V., Middleton, W., & Kruger, C. (2013). Growing not -dwindling: International research on the worldwide phenomenon of Dissociative Disorders. *Journal of Nervous and Mental Disease*, 201, 4, 353-354.
- McIntee, J. (2006). *Dissociative Identity Disorder in the UK: Competing ideologies in a historical and international context*. (Unpublished doctoral dissertation). City University, London.
- Mayes, A., Horwitz, A.V. (2005). DSM-III and the revolution in the classification of mental illness. *Journal of the History of the Behavioural Sciences*, 41, 249-267.

- Ogawa, J. R., Sroufe, L. A., Weinfield, N.S., Carlson, E.A., & Egeland, B. (1997). Development and the fragmented self: Longitudinal study of dissociative symptomatology in a nonclinical sample. *Development and Psychopathology*, 9, 855-879.
- Olio, K. A., Cornell, W. F. (1993). The therapeutic relationship as the foundation for treatment with adult survivors of sexual abuse. *Psychotherapy: Theory, Research, Practice, Training*, 30, 512-523.
- Oxnam, R. B. (2005). *A fractured mind; My life with Multiple Personality Disorder*. London: Fusion Press.
- Paris, J. (2012). The rise and fall of Dissociative Identity Disorder. *Journal of Nervous and Mental Disease*, 200, 12, 1076-1079.
- Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology*. London: Routledge.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed). London: Sage.
- Piper, A., & Mersky, H. (2004). The persistence of folly: Critical examination of Dissociative Identity Disorder. Part II. The defence and decline of multiple personality or Dissociative Identity Disorder. *Canadian Journal of Psychiatry*, 49, 10, 678-683.
- Poland, J., Von Eckardt, B. & Spaulding, W. (1994). Problems with the DSM approach to classifying psychopathology. In G. Graham & G. L. Stephens (Eds.), *Philosophical psychopathology* (p. 235-261). Cambridge MA: MIT Press.

Positive Outcomes for Dissociative Survivors (PODS). Retrieved from <http://www.pods-online.org.uk/>

Putnam, F.W. (1989). Pierre Janet and modern views of dissociation. *Journal of Traumatic Stress*, 2, 4, 413-429.

Putnam, F. W. (1997). *Dissociation in children and adolescents*. New York: Guilford Press.

Regier, D.A., Narrow, W.E., Kuhl, E.A., & Kupfer, D.J. (2009). The conceptual development of DSM-5. *American Journal of Psychiatry*, 166, 645-650.

Reuter, K., & Maryann, H. (2011). Effects of early attachment on adult attachment and adult self-soothing. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 71, 9-B, 5802.

Ringrose, J.L. (2011). Meeting the needs of clients with Dissociative Identity Disorder: Considerations for psychotherapy. *British Journal of Guidance and Counselling*, 39, 4, 293-305.

Roberts, R., O'Connor, T., Dunn, J., & Golding, J. (2004). The effects of child sexual abuse in later family life; mental health, parenting and adjustment of offspring. *Child Abuse and Neglect*, 28, 5, 525-545.

Rosenberg, M. (1979). *Conceiving the self*. New York: Basic Books.

Rothschild, D. (2009). On becoming one-self: Reflections on the concept of integration as seen through a case of Dissociative Identity Disorder. *Psychoanalytic Dialogues*, 19, 175-187.

- Rowling, J. K. (1997). *Harry potter and the philosopher's stone*. New York: Bloomsbury Publishing PLC.
- Saakvitne, K. W. (2008). Some thoughts about Dissociative Identity Disorder as a disorder of attachment. *Psychoanalytic Inquiry*, 20, 2, 549-258.
- Sachs, A. (2007). Infanticidal attachment: symbolic and concrete. *Attachment: New directions in Psychotherapy and Relational Psychoanalysis*, 1, 297-304.
- Sar, V. (2011). Epidemiology of dissociation disorders: An overview. *Epidemiology Research International*, 1-8.
- Schore, A. N. (2009). Relational trauma and the developing right brain: The neurobiology of broken attachment bonds. In T. Baradon (Ed.). *Relational trauma in infancy*. (p. 19-47). London: Routledge.
- Schore, J. R., & Schore, A. N. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical Social Work Journal*, 36, 9-20.
- Schreiber, F.R. (1973). *Sybil*. New York: Grand Central Publishing.
- Scroppo, J. C., Drob, S. L., Weinberger, J.L., & Eagle, P. (1998). Identifying Dissociative Identity Disorder: A self report and projective study. *Journal of Abnormal Psychology*, 107, 2, 272-284.
- Silberg, J. (1998). Dissociative symptomatology in children and adolescents as displayed on psychological testing. *Journal of Personality Assessment*, 71, 3, 421-439.

- Sinason, V. (2011). *Attachment, trauma and multiplicity. Working with Dissociative Identity Disorder* (2nd ed.). New York and London: Routledge.
- Skaalvik, E. M., & Bong, M. (2003a). Academic self-concept and self-efficacy: How different are they really? *Educational Psychology Review*, 15, 1, 1-40.
- Skaalvik, E. M., & Bong, M. (2003b). Self-concept and self-efficacy revisited. In H. W. Marsh, R. G. Craven & D. M. McInerney (Eds.). *International advances in self-research, Vol 1*, (pp. 67–89). USA: Information Age Publishing Inc.
- Smith, J., & Osborn, M. (2008). Interpretative Phenomenological Analysis. In J. Smith (Ed.), *Qualitative psychology, a practical guide to research methods* (pp. 53-80). London: Sage.
- Smith, J. (2008). *Qualitative psychology, a practical guide to research methods*. London: Sage.
- Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.
- Smith, J.A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, 5, 9-27.
- Spanos, N. P. (1994). Multiple identity enactments and Multiple Personality Disorder: A sociocognitive perspective. *Psychological Bulletin*, 116, 143-165.
- Spitzer, C., Barnow, S., Freyberger, H. J., & Grabe, H. J. (2006). Recent developments in the theory of dissociation. *World Psychiatry*, 5, 2, 82-86.
- Spring, C. (2011). Report of DID inclusion campaign conference on 12 March 2011, London. *PODS Newsletter*. Retrieved from www.pods-online.org.uk/pods-news-may2011.pdf

- Steward, L. F. M., & Rae, A. M. (2013) Critical care nurses' understanding of the NHS knowledge and skills framework. An interpretative phenomenological analysis. *Nursing in Critical Care*, 18, 1, 23-31.
- Stickley, T., & Nickeas, R. (2006). Becoming one person: living with Dissociative Identity Disorder. *Journal of Psychiatric and Mental Health Nursing*, 13, 180-187.
- Strawbridge, S., Woolfe, R. (2010). Counselling psychology: Origins, developments and challenges. In R. Woolfe, S. Stawbridge, B. Douglas & W. Dryden (Eds.), *Handbook of Counselling Psychology* (3rd ed.) (pp. 3-22). London: Sage.
- Thomas, P. M. (2005). Dissociation and internal models of protection: Psychotherapy with child abuse survivors. *Psychotherapy: Theory, Research, Practice, Training*. 42, 1, 20-36.
- Trauma and Abuse Group (TAG). (2002). *What the heck is dissociation anyway?* Retrieved from <http://www.tag-uk.net/dissociation-article3.html>.
- Trujillo, O. R. (2009). Living with Dissociative Identity Disorder: One woman's experience. Retrieved from <http://www.health.state.mn.us/injury/topic/svp/implement/network/meetdocs/Olga--livingwithDissociativeDisorder.pdf>
- Van Dijke, A., Ford, J. D., Van Son, M., Frank, L., Van der Hart, O. (2012). Association of childhood-trauma-by-primary caregiver and affect deregulation with Borderline Personality Disorder symptoms. *Psychological Trauma: Theory, Practice and Policy*, 5, 3, 217-224.

- Van Den Bosch, L. M. C., Verheul, R., Langeland, W., & Van Den Brink, W. (2003). Trauma dissociation, and posttraumatic stress Disorder in female borderline patients with and without substance abuse problems. *Australian and New Zealand Journal of Psychiatry*, 37, 549-555.
- Vermetten, E., Schmahl, C., Lindner, S., Loewenstein, R. J., Bremner, J. D. (2006). Hippocampal and amygdalar volumes in Dissociative Identity Disorder. *American Journal of Psychiatry*, 163, 630-636.
- Waller, N. G., Putnam, F.W., & Carlson, E.B. (1996). Types of dissociation and dissociative types. A taxometric analysis of dissociative experiences. *Psychological Methods*, 1, 300-321.
- Warner, S. J., & Wilkins, T. (2003). Diagnosing distress and reproducing disorder: Women, child sexual abuse and borderline personality disorder. In: P. Reavey (Ed) *New feminist stories of child sexual abuse* (p. 21-36). London: Routledge.
- Waterhouse, R. (2013). The woman who had 48 personalities. *New Scientist*, 46-49.
- Wessely, S. (2013). Do we need to change the way we are thinking about mental illness? *The Observer*. Retrieved from <http://www.theguardian.com/science/2013/may/12/dsm-5-conspiracy-laughable>
- West, M., Adam, K., Spreng, S., & Rose, S. (2001). Attachment disorganization and dissociative symptoms in clinical treated adolescent. *Canadian Journal of Psychiatry*, 46, 627-631.
- Willig, C. (2008) *Introducing qualitative research in psychology* (2nd ed). Maidenhead: McGraw Hill Open University Press.

- Willig, C. (2012). Perspectives on epistemological bases for qualitative research. In H. Cooper (Ed.), *APA handbook of research methods in psychology: Vol 1. Foundations, planning, measures and psychometrics* (pp. 5-21). American Psychological Association.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15, 215-228.
- Yin, R.K. (2009). *Case study research design and methods* (4th ed.). London: Sage.

Appendices

Appendix 1: Interview Schedule

I want to know – How people with DID experience relationships. Tapping into experience not beliefs or assumptions.

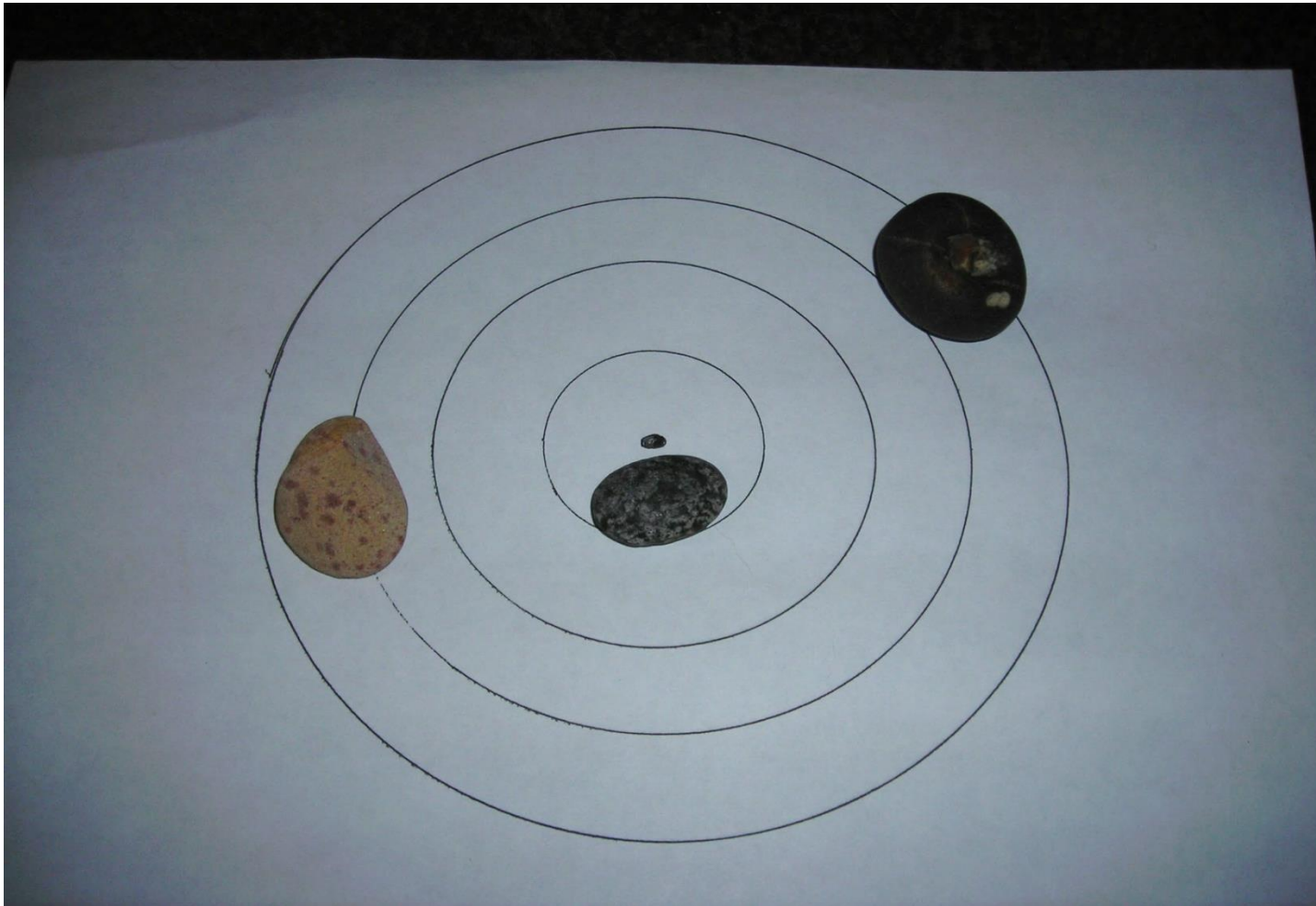
- 'This research is all about relationships, can you tell me about your understanding of a relationship?

Creative activity –

- **Could you think of three different relationships you currently have and choose three pebbles that could represent these relationships. If you imagine you are the centre of this circle could you position these pebbles around you to illustrate their relationships to you.**
- **Can you explain to me who these pebbles represent?**
- **What made you choose these pebbles to represent certain relationships?**
- **Can you explain to me why you have positioned them in this way?**
- **What made you choose these relationships to talk about?**
- I wonder if you could choose one of these relationships to talk about and then tell me a bit about how the relationships formed, continued, and if it has ended.
- What are your experiences of being in this relationship?
(Possible prompts – positive and negative experiences, difficulties)
- How does this relationship compare to other relationships you have had?
(Possible prompts – key relationships, earlier relationships, different types of relationships)
- How would you describe yourself when you are in a relationship?
- What is your experience of how others view you in a relationship?
(Possible prompts – has anyone commented or said anything about how you behave in a relationship?)
- What is your experience of forming new relationships?
- Sometimes relationships change over time, how have you experienced these changes?
(Possible prompts – experience of relationships ending)
- How do you think experiencing DID impacts on your relationships?
(Possible prompts – feelings around this)

- How do you think your experience of relationships varies with those who do not experience DID?
(Possible prompts – how is it telling significant others about what you are experiencing)
- I wondered if you could give me any feedback on this interview? How did you find the interview? How were the questions to answer? What was it like to talk about this? How was the relationship in this room today?
- Is there anything I have missed do you think?/If you were me would there be anything else you would include?

Appendix 2: Example of the Interview Activity



Appendix 3: Initial Correspondence to *First Person Plural*

Sent by email on 08/10/2011

Dear First Person Plural,

I am a second year trainee counselling psychologist and am writing to you because I hope to complete a piece of research into Dissociative Identity Disorder. I was wondering if you could offer me any guidance about whether you thought members of First Person Plural would be willing to engage in research? At this stage I am unsure of my exact research question but I am very interested in individual's experiences of living with the disorder. If anyone could spare the time to speak to me further about this possibility that would be great, if not any help or advice would be gratefully received.

Many thanks Stephanie

Appendix 4: Confirmation of Recruitment through *First Person Plural*

Received by email on 22/01/2012

Dear Stephanie,

Melanie Goodwin, First Person Plural's chairperson, has forwarded your correspondence to me to reply to your request for confirmation that FPP is happy for you to recruit participants through us.

We don't have any set procedures to give our 'ethical approval', nor as a survivor-led charity would it be appropriate for us to adopt any. Our ethos is that each of our members is responsible for their own actions and behaviour.

We can however confirm that FPP is happy to act as a conduit for you to reach possible participants for your research project. This would primarily be by publishing in our members' newsletter – Rainbow's End – an article from you about your research proposal which will include a request for potential recruits to contact you directly.

FPP will not monitor any replies you receive nor comment on a respondent's suitability for the research. Any FPP member who responds to your article will be doing so as an individual. It would be up to you, as researcher, to ensure you have their informed consent to participate. FPP will play no role in that.

I hope this clarifies the role First Person Plural is able to play in helping you to recruit participants and serves as confirmation that we are happy to help you do this.

Kind regards, Kathryn

Kathryn Livingston, Voluntary Co-ordinator

First Person Plural

National survivor-led association for Dissociative Identity Disorder and similar complex dissociative conditions

PO Box 2537, Wolverhampton, WV4 4ZL

fpp@firstpersonplural.org.uk

www.firstpersonplural.org.uk

Registered Charity No: 1109464

A member of The Survivors Trust

Appendix 5: Recruitment Material



Would you like to help increase awareness and understanding of a neglected area?



My name is Stephanie Fletcher and I am a counselling psychology student. I have been learning about Dissociative Identity Disorder (DID) for over a year and have been surprised and concerned about how misunderstood and misdiagnosed the area appears to be. I have also been surprised at the lack of research and time that has been dedicated to understanding the experience of DID. I have recently been given the opportunity to complete research into an area of my choice and jumped at the chance to study DID and improve the knowledge available concerning this important area.

My research is concerned with exploring the experiences of relationships in individuals experiencing DID. This is a unique opportunity to increase knowledge of the condition and therefore improve health care opportunities for individuals experiencing DID in the future.

- **Are you a member of First Person Plural?**
- **Do you experience Dissociative Identity Disorder?**

If so I would invite you to take this opportunity to improve knowledge and awareness of DID and to tell me your story. This would involve an informal meeting to discuss your experiences of relationships. Please email me at: Stephanie.Fletcher.1@city.ac.uk or call me on 07842692943.

This study is supervised by Dr Jacqui Farrants (J.Farrants@city.ac.uk) at City University.

This research has obtained ethical clearance from City University London.

Appendix 6: Telephone Interview Prompts

Thank you for agreeing to speak to me today.

I wondered if it would be ok to run through a few things on the phone with you?

(Check they meet selection criteria) – member of First Person Plural and experiences DID?

How long ago did you realise you experienced DID?

What is your current experience of living with DID? Experience of identity alterations/switching? (Assessing level of stability and how to manage this in the interview).

How stable do you feel to take part in the research? (Clarify length – an hour to an hour and a half, structure – an informal interview and topic – about experiences of relationships).

Are you 18 or older? (Checking they can offer informed consent).

Are you currently, or have you previously engaged in therapy? (Ensure they have spoken to others before or have current support).

Are you currently experiencing any suicidal feelings or engaging in self harm? (Measurement of vulnerability and risk).

Where are you based? Where would you be happy to meet? What days or times would be better for you? Clarify contact details.

Confirm I will send them an information sheet and contact them again in a weeks' time. (Allowing time to identify potential meeting places and allowing the individual to read the information sheet and ensure they are happy to take part)

Appendix 7: Information Sheet

Researcher: Stephanie Fletcher, DPsych Counselling Psychology, City University.
Stephanie.Fletcher.1@city.ac.uk
07842692943

Supervisor: Dr Jacqui Farrants, City University.
J.Farrants@city.ac.uk
020 7040 0172

Thank you for considering taking part in this study. The following information will tell you more about the research and why it is being completed. This will help you to understand what is involved in the study and to decide whether to take part. Please take your time and read the following information carefully.

Background to the study

Dissociative Identity Disorder (DID) is often misdiagnosed and misunderstood. Research has been completed into the condition but this has often focused on the causes of DID and possible treatments. Limited research has been completed into individuals' experiences of living with the disorder and therefore this research is interested in exploring experiences of relationships in individuals diagnosed with DID.

What does the study involve?

The study will involve an audio-taped interview in which I will ask you questions about your experiences of relationships. The interview will last between an hour and an hour and a half and will be held at a time and location convenient to you. The interview will take the form of a discussion about your experiences. There are no right or wrong answers as I am interested in your perception of your experiences. During the interview I may also take notes, these are to help my recall of our interview at a later date.

At the beginning I will ask for the contact details of your GP or community worker in case I feel further support is needed after our interview. These details will only be used if I am concerned about your wellbeing and will be destroyed after our interview.

What you need to know

What if I start and don't want to continue?

If you start the interview and feel for any reason you no longer want to take part you are free to withdraw. Your participation is totally voluntary and you will not be penalised or disadvantaged in any way.

What will happen to the audio recordings?

All interviews will be audio recorded and later transcribed. These transcripts will be coded to ensure anonymity and stored in a locked filing cabinet. The audio recordings will be stored securely on a password protected computer.

Your responses will not be disclosed in any way that will identify you in any presentation or publication of the findings. However anonymous quotations may be used in the final report.

Are there any risks or disadvantages to taking part?

It is possible that discussing experiences of attachment may trigger traumatic memories which could be difficult to manage. If you would like to bring someone who could support you a waiting area for them can be accommodated. At the beginning of the interview I will ask for the contact details of your GP or community worker who can offer you support if need be after the interview. These details will be destroyed after the interview. Your distress levels and feelings will be monitored throughout the interview

If what has been discussed causes you any significant distress, details of help-lines and support groups will be provided at the end of the interview.

What are the benefits of taking part?

The benefits of this research include furthering the understanding of a condition which is greatly misunderstood. This understanding could help professionals recognise DID earlier, avoiding misdiagnosis and inappropriate treatment. It could also help to improve the effectiveness of treatment for DID.

What will happen to the results of the study?

On completion of the study it will be handed in to City University London to be assessed. It is possible that, if deemed appropriate, the results will be submitted for publication in a peer-reviewed journal. You will be given the opportunity to request a brief summary of the findings if you wish.

This research has been approved by the University Research Ethics Committee, City University London.

What next?

If you would like any further information about this study, please do not hesitate to contact either Stephanie Fletcher (Stephanie.Fletcher.1@city.ac.uk/07842692943) or Dr Jacqui Farrants (J.Farrants@city.ac.uk/020 7040 0172).

Thank you for taking the time to read this information sheet.

Stephanie Fletcher

Appendix 8: Consent Form

Research Study: Experiences of relationships in individuals with Dissociative Identity Disorder.

Researcher: Stephanie Fletcher, DPsych Counselling Psychology, City University.
Stephanie.Fletcher.1@city.ac.uk
07842692943

Supervisor: Dr Jacqui Farrants, City University.
J.Farrants@city.ac.uk
020 7040 0172

Please place your initials next to each statement and sign the bottom of the page to confirm that you have read and agree to what has been written:

- I confirm that I have read and understood the information sheet provided. I have had the opportunity to ask questions about anything I am unsure of and I have had any questions answered satisfactorily.
- I understand that my participation in this study is voluntary and I have the right to withdraw at any time for any reason without implication.
- I understand that any information provided by me will be held anonymously and confidentially.
- I agree to my interview being audio recorded.
- I agree to the use of anonymous quotations in publications.
- I have given the researcher the name of my GP or support worker.
- I agree to take part in this study.
- I would like to be contacted with the results from this study: Yes.....
No.....

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

Appendix 9: Debrief sheet

Research Study: Experiences of relationships in individuals with Dissociative Identity Disorder.

Researcher: Stephanie Fletcher, DPsych Counselling Psychology, City University.
Stephanie.Fletcher.1@city.ac.uk
07842692943

Supervisor: Dr Jacqui Farrants, City University.
J.Farrants@city.ac.uk
020 7040 0172

Thank you for taking part in this study concerning your experiences of relationships. The present study seeks to explore experiences of relationships in individuals diagnosed with Dissociative Identity Disorder.

In the event that you feel distressed by participation in this study there are a number of resources that you may like to contact for further support:

- The Samaritans – A confidential 24/7 helpline who can offer non-judgemental support. Contact them on – 0845 790 9090
- NAPAC (National Association for People Abused in Childhood) – A charity providing support for people abused in childhood. Their calling times are 10am to 9pm on Monday, Tuesday and Thursday, 10am to 8pm on Wednesday and 10am to 6pm on Fridays. Contact them on – 0800 085 3330

Further information about the relationship between attachment and Dissociative Identity Disorder can be found in the resource sections of the following websites:

- www.tag-uk – Trauma and Abuse group.
- www.estd.org – European Society for the Study of Trauma and Dissociation.

If you have any further questions about this study please do not hesitate to contact me, Stephanie Fletcher, or my supervisor, Dr Jacqui Farrants. Our contact details are at the top of this form.

If you decided in your consent form that you would like to receive a brief summary of the results of this study then I will be in contact with you following writing up this research.

Thank you again for agreeing to take part in this research I greatly appreciate your participation.

Appendix 10: Sample of Transcription Identifying Initial Notation and Emergent Themes

Initial Notation		Interview seven	... – Significant pause. () – Explanatory information added by researcher. R refers to researcher and L refers to Lauren the participant.	Emergent themes
Wedding dictated by mother	373	L61... that I didn't like, I had to have a veil, I didn't want a veil, I had		wedding dictated by other
Not how she wanted it	374	people to my wedding who I didn't even want to invite to my		
Other took over	375	wedding, I had a service I didn't want to have, I didn't have a disco		Self as unimportant
Loss of control	376	when I wanted to have a disco, my husband C wanted to have his		
Opposite to what she wanted	377	best friend as his best man, 'oh no' he couldn't have his best		
Sense of anger & frustration	378	friend as his best man, he had to have my mother's best friend as		other as taking over - feeling squashed
Takes over (people's lives) - not just her.	379 380	his best man. That is how much she takes over people's lives and that is why I feel squashed.		
'Squashed' - made small	381	R62 Uhuh		
unimportant Extreme	382	L62 In relation to her. And she has this way of, umm... sort of, if you		other as affectionate but harmful
Affection as damaging	383	can imagine someone hugging you and stabbing you at the same		
Harmful	384	time, it's like that with her. It's very confusing and she can say		Relationship as confusing
Confusing	385	something and on the one hand you're thinking 'ah, oh that's quite		
Things are not what they seem	386	alright' but there's a kind of like a backlash to it, a kind of really,		Things not as they appear.
'Backlash' ' nastiness'] negative experience	387	negative, nastiness underneath.		
Different levels - underneath				

Interview seven

... – Significant pause.

() – Explanatory information added by researcher.

R refers to researcher and L refers to Lauren the participant.

388 R63 Hmm

On guard
unable to trust
unsafe

389 L63 So you have to be on guard with her all the time as well and
390 umm... you can't trust her. Yeah.

On guard with
other
unable to trust
mother

391 R64 Uhuh, ok and how to these relationships compare to other
392 relationships that you have or had?

Differences between
relationships -
some more intense
than others

393 L64 Umm, (sniff) well they're more intense relationships. Umm, all of
394 them in their different ways. Umm... I, I have a lot of other
395 relationships, but because I can't, umm, like friendships and that
396 but because I can't, I, I have friendships and I lose friends quite
397 often as well. Not like everyday but I've lost friends over the years

Relationships as
intense

Lot of friendships
Loss of friendships

Impact of DID on
loss of relationships

DID as impacting
on relationships

DID impacting on
loss of relationships

Lack of self understanding

Others not understanding

Appearance of lying

Lack of sense to
others

Others misunderstood

Changeable / inconsistent

400 appearing to be
401 lying all the time cos I'm not making any sense, do you know what
402 I mean, like on one day I'll say this and then another day I'll say

Lack of understanding

Self as inconsistent

Interview seven

... – Significant pause.

() – Explanatory information added by researcher.

R refers to researcher and L refers to Lauren the participant.

Changeable Self

Saying different things on different days

403

404

Loss

405

Explanation of own

DID

406

Other parts appearing for long periods of time

407

408

Dual processes

409

Other parts as others v 'me'

410

411

Taken over 'someone else'

412

Not in control of own behaviour

413

Self as complicated behaving inappropriately

414

415

416

Husband exposed to alters

417

that, or, or then I've lost friends from, umm, like, umm, like I've got

a teenage alter who ever now and again appears for months on

end, because that's how alters tend to be, they tend to run dual

processes with me, so it's like I can most of the time be just a sort

of, a, a current, I would say, an everyday alter, someone from

now, someone from my forties but every now and again I have

someone else who's really almost taking over but not quite. I think

that's come from therapy, but, umm, like PG one of my really

teenage alters ended up nearly sleeping with one of my friends

partners, you know, you have stuff like that going on and, you

know, it's just very complicated so.

R65 Uhuh

L65

I think... (sighs) how, say with P and my friends how that would

compare is that P, cos P meets these alters, like he meets

particularly some of the more aggressive male alters sometimes.

Dual processes

Alter taking over

Alter as acting ~~on~~ inappropriate

DID as complicated

Husband having a different level of understanding

Interview seven

... – Significant pause.

() – Explanatory information added by researcher.

R refers to researcher and L refers to Lauren the participant.

Husband as understanding Accepting	418		Whereas <u>he would understand and</u> , umm, and see that, that was	Husband as understanding
Not everyday 'me'	419		not necessarily the everyday me that he knew or that he would	
puts as having a purpose	420		see that that alter was doing a job, or, you know, <u>he would have</u>	
Other as understanding DID - 'some level'	421 422		<u>some level of understanding</u> . Friends just think <u>you're crazy</u> and <u>you just loose them</u> .	Others as not understanding
Friends lack understanding	423	R66	Uhuh	
Friends withdraw	424	L66	So <u>it's hard</u> cos you have to feel like you're <u>hiding yourself</u> all the	Hiding real self
Loss self as considered 'crazy'	425		time, like even while you're like, in your relationships. Unless I	
'Hard'	426		can be honest with people and say 'look I've got DID' but even	
Not being real or honest	427		then there's saying you've DID and then being dissociative is, you	Difficult for others to fully understand.
Need to be honest	428		know, it's all very well if I'm forgetting something up at the school	
Sharing of the diagnosis	429		or, umm, I'm forgetting a conversation and I'm just looking like I'm	
Others not understanding	430		blonde or whatever, you know, that's one thing but then when you,	
Extremes of behaviour	431		it gets to the point where you've got another alter who's, like PG,	
Forgetting conversations	432		just completely inappropriate, that's just very difficult to deal with.	
Dissimulate				
Difficult to deal with				
Alters as inappropriate				

Appendix 11: Theme List for Lauren

Different types of relationships

7, 13-16 'a relationship can be anything from.. the relationship that a child has with its parents or a sibling has with its brothers and sisters or husband has with its wife or a work colleague has with their boss'

What is a relationship?

7, 17-18 'some level of umm interaction between people'

Relationship with mother

7, 940-941 'like with my mother, umm, who's done... an incredible amount of damage to me over the years'

Being squashed

7, 345-347 'she takes over your life and there's no room to breathe and there's no room to be yourself... everything's all about her all the time'

Other as affectionate but harmful

7, 382-384 'if you can imagine someone hugging you and stabbing you at the same time'

Younger life

7, 65 'can remind me of a small egg kind of shape so it was making think of younger life'

Relationship with husband

7, 69-70 'this is a clear looking stone and I think the, the relationship with me and my husband is clear although it's got cracks in'

Limits to how close others are to self

7, 80-81 'my husband and son are as close to me as anybody would be'

Self as having many friends

7, 87 'I could have chosen loads of friends'

Self as struggling with mental health

7, 161-163 'I, erm, was in the process of... having a psychotic break... it was quite turbulent times for me'

Relationship with son

7, 331-333 'my experience of my son is like hope, kind of watching someone grow'

Relationships with siblings

7, 199-200 'and partly because I felt a great deal of responsibility to my two younger, er, siblings'

Feeling responsible for siblings

7, 209-212 'my mother, when I was sixteen, sort of said in this one statement, umm, I would never have had J, had it have not been for you telling me you would look after her'

Acknowledgement of abuse

7, 223-224 'those two siblings that are still with her don't acknowledge it'

Shared commitments

7, 232-236 'we've got strong commitments to each other and a life to each other and it's hard to imagine breaking all of that up'

Feeling love for another

7, 245-246 'I don't often feel a sense of love for P'

Impact fading

7, 271-272 'I'm starting to forget now what it is actually that my mother's done to me'

Abusive step-father

7, 277-278 'who is my stepfather who was, who's a very aggressive, umm, violent, abusive man'

Other unable to accept responsibility

7, 286-287 'she just can't accept responsibility for anything at all'

Negative impact of relationship with mother

7, 305-306 'she does have a kind of toxic effect on me and it's very unsettling'

Physicality as difficult

7, 254-255 'P tried to hug me today, but because he came from behind me he frightened me and it makes, all my startle reflexes come up and that's after I've known him for, er, well getting on for twenty years'

Other as teaching about trust

7, 318-319 'my relationship has taught me a lot about, er, trust... and being able to rely on somebody... being able to know that you can depend on someone'

Self as unable to reach her potential

7, 334-335 'it's really nice for me to know that he can meet his potential which is not what I've been able to do with my life'

Loss of friendships

7, 397-399 'I've lost friends over the years to do with having Dissociative Identity Disorder... either not understanding that I've got Dissociative Identity Disorder or umm, them not understanding that I've got it and me appearing to be lying all the time cos I'm not making any sense'

Self as inconsistent

7, 402-403 'on one day I'll say this and on another day I'll say that'

Managing alters

7, 405-406 'that's how alters tend to be, they tend to run dual processes with me'

Others understanding DID

7, 418-421 'whereas he would understand and, umm, and see that, that was not necessarily the everyday me that he knew or that he would see that, that alter was doing a job... he would have some level of understanding'

Self as not remembering information

7, 450-453 'unless I've remembered that we've had the conversation it's like you're telling me something that I don't know'

Difficult to share diagnosis

7, 474-475 'I'm caught between wanting people to know who I am and not wanting people to know who I am'

DID as different

7, 477-482 'it's not like for you, if you're having a bad day you've still got... Twenty percent of you is feeling really irate... you've still got the eighty percent of you all in one person sort of balancing that ok. If I go into one of my bad days I got into P and he's a hundred percent pissed off with the world'

Not understanding her without the diagnosis

7, 595-600 'if someone gets, gets to know me, or thinks they're getting to know me and if I don't tell them that I've got DID then they don't actually understand that I could have actually got confused'

Different people reacting differently to the diagnosis

7, 614-617 'I've got another friend I mentioned it to, I doubt... she'll ever mention it to me again, it's like... telling them that I wore blue today'

Self as different in each relationship/meeting others expectations

7, 623-625 'different, erm, depending on, erm, which personality is the main personality that's running that relationship and umm what role that personality's meant to be playing'

Learning about self

7, 1103-1105 'it's enormous... I only even myself am beginning to grasp how much it impacts me'

Change in response to stress

7, 652-653 'although I will sometimes shift in times of acute stress'

Lack of understanding from other

7, 660 'he just looked at me as if to say 'what is wrong with you?!

Impact of early experience

7, 690-691 'I think part of the reason why I started having DID... there was trauma in my early childhood but I think the most traumatic thing that happened to me in my very earliest childhood was being shamed somehow so badly and rejected so badly within that that I was made to feel so, umm, urgh, so gross that I couldn't live with myself. So I had to be somebody else and I've been doing that since I was an infant'

Not being herself

7, 703-704 'I've lost all sense of who the real me is a long, long time ago'

Creation of new self

7, 705-707 'I don't think of changing self, do you know what I mean, or, I just create a new alter without thinking of it either'

Relationships as hard work

7, 778-779 'all this about relationships it's hard bleeding work'... it's just not straightforward'

Self as good at forming relationships

7, 791-792 'I'm quite good at forming relationships I think because I'm quite a chatty person'

Internal processes impacting on relationships

7, 798-799 'everywhere I was going I was constantly getting, erm, interrupted with suicide ideas and I just didn't want to see anyone or talk to anyone'

DID as a lonely disorder

7, 837-839 'it's quite a lonely Disorder to have because... you've got so many different, umm, sort of masks so to speak'

Relationship with husband highlighting attachment issues

7, 845-848 'I particularly notice that in my relationship with P actually, who is the person I should be the closest to but that's when I really notice that I've got major problems in terms of attachment issues'

Self-hatred

7, 857-858 'I feel very, umm, a lot of hatred towards myself in the most, erm, in the real me places'

Parts of self that are locked away

7, 854-855 'they're parts of me that I've locked away a long time ago and I'm working on it in therapy in terms of thinking of letting them be exposed'

Unsure of cause of DID

7, 876-878 'it was either be someone else or die. I don't know quite how my mother achieved that... fascinates me what she actually did to me to make me so like that'

Self as not moving

7, 883-888 'a couple of years ago, just out, randomly out of the blue I decided to, er, contact somebody who I hadn't seen since I was eighteen to discuss a conversation I had with them, when I was eighteen'

Lack of connection

7, 923-924 'she wakes up after eighteen years, she's got no connection to P or whatever's going on in my life'

Feeling disjointed

7, 961 'so it's sort of disjointed, I think the world is... It's very disjointed but there again everything in my mind is very disjointed... unconnected and separate and boxed off'

Wish for greater control

7, 967 'If only I could control it though a bit better that would be useful'

Head as full

7, 766-769 'it gets very full... there's no space in your head... you've got this mass of thinking going on but there's no space to actually be clear'

Ending of relationships as traumatic

7, 993-995 'I cried for about two days solid... I was very traumatised by what had happened'

Ability to cut off quickly

7, 987-988 'then I have a, a very fast step into a dissociated place where that relationship didn't matter'

Other as putting energy into re-building relationship

7, 1011-1014 'but if she had not kept saying to me that she'd missed me and can we, could we meet up and could we talk... probably would still not be speaking to her today'

Moving in a straight line

7, 1121-1122 'it's like you're moving forward in a straight line whereas mine is like I might be moving forward one day and then I'm back when I was sixteen the next day and or I'm depressed another day'

Self needing energy to maintain relationships

7, 1133-1135 'even if I might be making it appear like it's going in a straight line it's not and that takes a lot of energy to do'

Self as lucky

7, 1181-1182 'at least I don't, I'm not like some people who are going into their child alters'

Self as improved

7, 1185 'I used to be but I'm not now, so that's good'

DID impacting on some relationships differently

7, 1198-1201 'some relationships like turning up at the school and being the mother is quite easy... some relationships are easier to deal with than other

Appendix 12: Table illustrating initial clustering of themes from Lauren's interview

<u>Cluster heading</u>	<u>Emergent theme</u>	<u>Interview and page number</u>	<u>Supporting quote</u>
<u>Defining a relationship</u>	<i>Different types of relationship</i>	7, 13-16	'a relationship can be anything from.. the relationship that a child has with its parents or a sibling has with its brothers and sisters or husband has with its wife or a work colleague has with their boss'
	<i>What is a relationship?</i>	7, 17-18	'some level of umm interaction between people'
<u>Early family relationships</u>	<i>Relationship with mother</i>	7, 940-941	'like with my mother, umm, who's done... an incredible amount of damage to me over the years'
	<i>Maintaining a relationship due to feeling responsible</i>	7, 209-213	'my mother, when I was sixteen, sort of said in this one statement, umm, I would never have had J, had it have not been for you telling me you would look after her... so I felt very responsible for J and always did'
	<i>Acknowledgement of abuse</i>	7, 222-223	'they're two of the sisters who acknowledge the abuse'
	<i>Impact of early relationships</i>	7, 690-691	'I think part of the reason why I started having DID... there was trauma in my early childhood but I think the most traumatic thing that happened to me in my very earliest childhood was being shamed somehow so badly and rejected so badly within that that I was made to feel so, umm, urgh, so gross that I couldn't live with myself. So I had to be somebody else and I've been doing that since I was an infant'
<u>Current family relationships</u>	<i>Relationship with son</i>	7, 331-333	'my experience of my son is like hope, kind of watching someone grow'
	<i>Relationship with husband</i>	7, 69-70	'this is a clear looking stone and I think the, the relationship with me and my husband is clear although it's got cracks in'
	<i>Feeling love</i>	7, 245-246	'I don't often feel a sense of love for P'
	<i>Physical contact</i>	7, 316-318	'my physicality is different with my son, in the sense that I can actually have a cuddle off him and not feel like... well like a problem'

<u>Sharing the diagnosis</u>	<i>Difficult to tell people about the diagnosis</i>	7, 474-475	'I'm caught between wanting people to know who I am and not wanting people to know who I am'
	<i>Not being the real me</i>	7, 830-834	'I'm just being a small aspect of myself and just being what I think they want me to be. I'm not really showing them the whole spectrum of myself'
	<i>Self not making sense without the diagnosis</i>	7, 595-600	'if someone gets, gets to know me, or things they're getting to know me and if I don't tell them that I've got DID then they don't actually understand that I could have actually got confused'
	<i>Others reactions to the diagnosis</i>	7, 619	'it's different with different people'
<u>Forming and ending relationships</u>	<i>Ending relationships</i>	7, 987-988	'then I have a, a very fast step into a dissociated place where that relationship didn't matter'
	<i>Forming relationships</i>	7, 791-792	'I'm quite good at forming relationships I think because I'm quite a chatty person'
<u>Self as different</u>	<i>DID as different/special</i>	7, 477-482	'It's not like for you, if you're having a bad day you've still got.... Twenty percent of you is feeling really irate... you've still got the eighty percent of you all in one person sort of balancing that ok. If I go into one of my bad days I got into P and he's a hundred percent pissed off with the world'
	<i>Meeting others expectations</i>	7, 697-698	'the way I think people tend to see me is how, how I think, how I perceive that they want to see me, i.e. because I've become very good... what people expect me to be'
	<i>Not remembering/being inconsistent</i>	7, 450-453	'unless I've remembered that we've had the conversation it's like you're telling me something that I don't know'
	<i>Managing internal processes</i>	7, 431-432	'it gets to the point where you've got another alter who's, like PG, just completely inappropriate, that's just very difficult to deal with'
	<i>Relationships as taking energy</i>	7, 1133-1135	'even if I might be making it appear like it's going in a straight line it's not and that takes a lot of energy to do'

<u>Self as improving</u>	<i>Learning about self</i>	7, 1103-1105	'It's enormous... I only even myself am beginning to grasp how much it impacts me'
	<i>Self as lucky</i>	7, 442-445	'have quite a relative amount of control over my alters, umm, compared to some people with DID that I know'

Appendix 13: Initial Clustering Between Cases

<u>Master theme</u>	<u>Emergent themes</u>	<u>Categories within emergent themes</u>	<u>Interview and page number</u>	<u>Supporting quotes</u>
The Self and the Diagnosis	Wanting to be perceived a certain way	Despite the diagnosis	4, 557-562	'I rang this friend, R who's known me, as I say for three years and I've helped her with the holiday cottage, we play in the orchestra together... she saw what I was going through caring for this woman with depression and kept saying 'I don't know how you cope'... she knows me as a coping person'
		Being lucky	1, 1387-1388	'I do feel really blessed because I do have some of the most beautiful people as friends'
			2, 968-973	'I'm really fortunate...I know lots of other people with DID that.. can't even get out of the house'
			4, 1558-1561	'I'm probably more lucky than some because... we have worked through a lot of the trauma'
			7, 442-445	'have quite a relative amount of control over my alters, umm, compared to some people with DID that I know'
		Being independent but wanting a relationship	6, 161-162	'I'm a very independent person as a consequence of... my coping strategy for the things that occurred to me is to be very independent'
			6, 1071-1072	'I'm very much looking for a close relationship because I want to make up that lost bit'
		Being different/special	1, 386-387	'something that you certainly wouldn't get but certainly someone with DID would get'
			1, 1332	'I call normal people muggles'
			3, 203-204	'there was another girl in the mix who didn't want to live with me, she said I was too screwed up'

			4, 1552-1553	'I think nowadays how do people that are singletons survive really'
			5, 488-489	'I just want to be normal... I don't feel sometimes like I even know what that is'
			7, 477-482	'It's not like for you, if you're having a bad day you've still got.... Twenty percent of you is feeling really irate... you've still got the eighty percent of you all in one person sort of balancing that ok. If I go into one of my bad days I got into P and he's a hundred percent pissed off with the world'
	DID as a problem	A balancing act	3, 1186-1188	'It's always this balancing act of do my alters come first or do my relationships come first, there isn't a simple answer to that'
			4, 1654-1656	'because they are relationships with the people you have on the inside and, and if they're difficult it makes the whole of life difficult'
			7, 410-412	'PG one of my really teenage alters ended up nearly sleeping with one of my friends partners'
		Deficits	1, 90	'I don't particularly understand people'
			2, 240-241	'I didn't have an understanding of emotion at all'
			6,196-197	'at the same time I was sort of finding out a bit more about what actually was wrong with me'
			7, 245-246	'I don't often feel a sense of love for P'
		Lack of understanding	3, 714-715	'the things that keep me awake at night... are the things that I can't work out whether it's mine or theirs'
			4, 1392-1400	'just questioning myself all the time, did I do something wrong, am I bad at relationships?... I'm still friends with the people I left in M, I've got a friend who moved to W...'
			5, 494-495	'I don't feel as if I have an implicit understanding of how to... willingly love and care for somebody'

	Sharing of the diagnosis	When and who to tell	1, 309-310	'I'll trust people to say 'actually I'm a little bit mad'
			3, 857-858	'the sort of issue I would have if I even thought about having an intimate relationship... would I tell them at the beginning but then that sounds really freaky... or do I tell people much further down the line'
			4, 492-493	'I just thought that if she knew that I'd got all these weird issues underneath it would change things and she might not feel so safe with me and I didn't want that'
			5, 989-991	'you either have a choice you don't tell somebody in which case I'm a bit back to where I was in my twenties it feels... just trying to function form one part of me and then failing and having to ditch a relationship cos I can't cope'
			6, 1002-1003	'you have somebody you can talk about who understands that you can be quite different'
			7, 474-475	'I'm caught between wanting people to know who I am and not wanting people to know who I am'
		People's reactions	1, 1305-1307	'people don't talk about it either because they don't think it's necessary, my husband just doesn't think it's necessary to talk about it anymore' (1305-1307)
			2, 358-359	'she just wouldn't have the capacity...to understand'
			3, 326-327	'some of them got weird about leaving their kids with me'
			4, 460-461	'I kept hoping I'd be wrong and that she'd be fine with it but I wasn't wrong'
		Not being real	2, 341-343	'she tells me about what's going on in her life. I mean I don't tell her about what's going on in mine'
			3, 741-742	'I'll slightly twist things... because I can't say 'my four year needs to leave now'
			4, 446-447	'I can be ourselves rather than just me'
			7, 424-425	'it's hard cos you have to feel like you're hiding yourself all the time'

	The jigsaw pieces are falling into place		2, 729-732	'if you don't know who you are then how do you know...which part of you ...you're giving in relationship'
			5, 838-843	'I feel as if I've needed to get much more comfortable with who I am, the reality of who I am rather than... sort of kidding myself and ... just acting from one part of myself... and then unable to sustain it having to just retreat'
			6, 601-602	'they think it's unpredictability but in fact now I know what it is it's not, it's actually incredibly predictable'
			7, 1104-1105	'I'm actually starting to unravel it in my therapy'
Process of relationships	Being in relationships	Different roles	1, 929-931	'I love looking after him, so I love the washing and the ironing and cooking and cleaning, I love making him happy'
			4, 222-224	'It just became really important to me to save all the energy I had to interact with her and then when she was at home'
			7, 845-848	'I particularly notice that in my relationship with P actually, who is the person I should be the closest to but that's when I really notice that I've got major problems in terms of attachment issues'
		Experiences in relationships	1, 529	'It felt like abuse' (529)
			7, 1133-1135	'even if I might be making it appear like it's going in a straight line it's not and that takes a lot of energy to do'
			4, 1172-1173	'I've never had a relationship that's so difficult and so hard'
			5, 125-127	'she's the only relationship I've ever had that... works and feels healthy and like there's air in it'
			6, 320-326	'if you're having a grotty day to phone up... if I'd had a bad day at work to have somebody just so that you could just phone up and chat to'

		Meeting others needs and expectations	1, 1069-1071	'I am very different with different people... my husband will say 'I can't be doing with you and your friends... because you're so different'
			7, 697-698	'the way I think people tend to see me is how, how I think, how I perceive that they want to see me, i.e. because I've become very good... what people expect me to be'
	Formation and dissolution		1, 573-574	'I'm fairly clear that I don't think I will ever make another relationship'
			2, 314-315	'it was very easy for me...because I don't have any emotional attachment to things'
			3, 1170-1171	'I think good endings are quite hard cos I think obviously I get so angry that people who are leaving'
			5, 311-312	'I had some fairly enmeshed relationships really... didn't go without a fight... there's like a lot of backlash and a lot of pain going on at that time'
			6, 396-397	'it was sad, I was... dreadfully upset when it broke up'
			7, 987-988	'then I have a, a very fast step into a dissociated place where that relationship didn't matter'
	Struggle with change		3, 985-987	'I then have to get used to a whole other picture when there's a child involved or a husband involved'
			5, 38-40	'it's probably changed over time... there are, a lot less people that I have any sort of relationship with'
			6, 803-804	'we'd moved from complimenting each other to basically, I was nagging and he was pissing me off'

	Different types	Therapy	2, 666-674	'you could have a million external help, helps like counselling'
			3, 75-77	'on one level she's quite a small part of my life, because obviously I only see her in session time and on another level she's sort of very important'
			4, 1673-1676	'that's why when I'm feeling ok I don't think 'ah I don't need therapy anymore'
		Others with DID	1, 646-648	'the relationship with somebody with a DID lots of people think shouldn't work and doesn't work' (646-647)
			4, 775-778	'It was nice to meet somebody else with DID and share what it was like'
			5, 1014-1016	'I don't think any of us could look after ourselves well enough to then cope with all the complexities of being friends'
Early experiences	Relationships with main care givers		1, 1034-1035	'I'd been brought up in an environment where... the only attraction I had was negative, I had no idea'
			2, 498	'I ...constantly felt that it was my fault'
			5, 949-950	'anything bad happened in my life... it always seemed to come back to the fact that I wasn't even good enough to be loved by a mother, by my own mother'
			6, 152-156	'he's a significant factor in his, his behaviour towards me, in terms of how I ended up as, as an adult'
			7, 940-941	'like with my mother, umm, who's done... an incredible amount of damage to me over the years'
	Missing out		1, 93-94	'I had very, very little social interaction until I was about 15'
			2, 492-493	'there wasn't really anybody in my life that...I could have that relationship with'
			6, 277-278	'a lot of the developmental things that you take a two year old through I didn't have, nobody took me through them'

Appendix 14: Ethical Approval Form

Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

D.Psych†

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

Exploring the experiences of relationships in individuals with a diagnosis of Dissociative Identity Disorder.

2
number)

Stephanie Fletcher
53 Shoebury Road
Southend on Sea
Essex, SS1 3RP

3. Name of research supervisor

Dr Jacqui Farrants

4. Is a research proposal appended to this ethics release form?

Yes

5. Does the research involve the use of human subjects/participants?

Yes

If yes,

a. Approximately how many are planned to be involved?

6-8
participants.

b. How will you recruit them?

I plan to recruit participants through the organisation *First Person Plural*. This organisation is a charity led by individuals with lived experience of dissociative identity Disorder(DID). I have spoken to one of the chairs of the organisation who has helped people complete research into DID in the past and she seems confident that there would be enough people who would participate in my research. The charity has about 80 members who have a diagnosis of DID. They publish quarterly a magazine called 'Rainbows End' and I plan to place an article in the magazine advertising my research. If I am unable to recruit enough volunteers this way then the leaders of the organisation would be willing to approach members directly and ask if they would take part in the study.

Please see appendix three in my research proposal to view my recruitment advertisement. My recruitment criteria include individuals who are members of First Person Plural and who are diagnosed with dissociative identity disorder. This will include those who have been self diagnosed as well as those who hold a professional diagnosis. I will exclude any individual diagnosed with a different Dissociative Disorder.

I have concerns about recruiting individuals who have recently been diagnosed with DID or are at the beginning of their treatment journey as I believe these individuals may be too vulnerable or chaotic to take part in the study. I will assess this through discussion with the individual before we arrange to meet for the interview.

vulnerable adults or those unable to give informed consent?

Yes – Vulnerable adults

d1. If yes, will signed parental/carers consent be obtained?

No

d2. If yes, has a CRB check been obtained?

Yes

(Please append a copy of your CRB check)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? (If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).

Each participant will be asked to give up approximately an hour of their time to complete a semi-structured interview with myself. This will involve discussing their experiences of relationships. I will travel to meet the participant so their travelling time and cost will be kept to a minimum. No psychometric instruments will be used.

7. Is there any risk of physical or psychological harm to the subjects/participants?

Yes – Psychological harm

If yes,

a. Please detail the possible harm?

Participants will be asked to discuss their experiences of relationships which could be distressing. A great deal of research has suggested that there is a link between dissociative identity Disorder and severe childhood trauma, therefore talking about previous relationships could mean remembering distressing events from the past and may be upsetting.

b. How can this be justified?

There is currently a lack of knowledge and awareness concerning dissociative identity Disorder(DID). Due to this individuals with the condition spend a long time in the mental health system, are often misdiagnosed and therefore do not gain access to appropriate treatment. This can be frustrating and distressing both for the individual and their families. There is barely any research completed about the experiences of DID and how it impacts on life for individuals. Research into this area could improve psychologist's awareness of the condition, their knowledge of what it is actually like to live with DID and therefore this could improve their work with these individuals. Therefore a greater understanding of DID would be gained through this research which could provide benefits for many individuals experiencing DID in the future.

I will consider excluding individuals who have only recently been diagnosed with DID or have just started treatment therefore trying to avoid recruiting participants who could be more vulnerable. I will assess this on an individual basis through a thorough discussion before arranging a first meeting. I will also offer the opportunity for individuals to bring a support worker, friend or family member to the interview to ensure that participants are supported if they become distressed and that they have someone to take them home, if necessary, at the end of the interview. If an individual does not wish to bring anyone I will ask them to give me a contact detail of their GP or community worker in case I am concerned about their wellbeing at the end of the interview.

Throughout the interview I will ask participants how they are feeling and if at any point I believe they are becoming too distressed I will terminate the interview.

At the end of the interview I will give out debrief sheets which offer participants help line numbers in case they become distressed after the interview. I will also spend some time at the end of the interview checking how they are feeling and bringing conversation back to more regular topics.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes – Please see appendix four of my research proposal.

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes – Please see appendix five of my research proposal.

If no, please justify

NA

~~If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)~~

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

All interviews will be audio recorded. The interviews will then be transcribed at a later date. I will also be taking very brief notes during the interviews to record any nonverbal communication from the participants and any feelings I may have about what the participants are telling me.

The audio recordings will be recorded on a hand-held recorder. As soon as it is possible these will be transferred to a password protected computer and stored. The notes I make during the sessions will be written up as soon as possible. These notes will be stored in a locked filing cabinet in my home.

13. What will happen to the records at the end of the project?

My audio files and notes will be stored for 5 years in line with BPS guidance. At the end of this period I will delete the audio files and transcripts from the computer and shred any written notes I have.

14. How will you protect the anonymity of the subjects/participants?

The anonymity of my participants will be protected by using codes to label their audio recordings, transcripts and any written notes made about them. I will ensure that where I use quotes in my results these will not identify anyone who takes part in the study.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

Please see appendix six of my research proposal to see my de-brief sheet. At the end of each interview participants will be de-briefed. I will ask how they are feeling and about their experience of taking part in the research. At this stage conversations will be returned to more regular subjects. In addition to this each participant will be given a de-brief sheet which gives them two help lines in case they feel they need psychological support after completing the interview. On the de-brief sheet will be the names and numbers of myself and my research supervisor should individuals have any questions after the interview.

support options)

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

I have circled three items that were underlined in bold print.

The first item stated that the participants planned to be recruited for this study are vulnerable adults. The link between the DID and childhood trauma suggests that at least some individuals diagnosed with the condition have had difficult past experiences. Many have been in the mental health system for a long time without the correct diagnosis and for some individuals this could have been re-traumatising. However, carrying out research with individuals diagnosed with DID will always involve working with some vulnerable adults and I believe that research in this area is important to raise awareness and understanding of the condition.

I will not be gaining parental or carer consent because although my participants are vulnerable they are able to decide whether or not to take part in a research study and to read and sign a consent form.

I believe that there is a slight risk of psychological harm to my participants as it is possible discussing relationships will mean remembering past relationships which could have been abusive. However, I believe the risk is manageable and balanced by the need for research into this area. Individuals will be made fully aware of the questions they will be asked, they will be de-briefed at the end and be given further information to take away with them. Levels of distress will be monitored throughout the research and if I deem the participant to be too distressed I will terminate the interview. In the same way that if the participant wishes to stop the interview then they have the right to withdraw at any time. In addition to this I have experience as a Counselling Psychologist in training of working with distressed and traumatised individuals and therefore believe I will be able to work with empathy and manage any distress participants may experience. Although I believe there is a risk I believe this is something that can be managed.

Signature of student researcher -----Date 13/2/12

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal
Recruitment Material
Information Sheet
Consent Form
De-brief Information

Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself?

Yes – Psychological risk

If yes,

a. Please detail possible harm?

I am at risk of secondary trauma if individuals start to disclose their experiences of childhood trauma. Additionally if a participant gets distressed in an interview I could also find it distressing to witness. I don't believe I would be at risk of any physical harm as individual's diagnosed with DID are not recorded to be violent or volatile.

b. How can this be justified?

I believe the psychological risk to myself is small. I believe that the research is very valuable in improving awareness and understanding of this disorder and that the results could be very beneficial in helping individuals with DID to gain an accurate diagnosis and access treatment more quickly in the future.

c. What precautions are to be taken to address the risks posed?

I will be accessing personal therapy throughout the data collection process to discuss any difficulties I am facing listening to someone's experiences of trauma. I will also be supported by my supervisor with the university who I can contact as necessary. I will carefully self monitor throughout the process of data collection, interpretation and write up of the piece of work to be aware of the impact that exposure to this material is having. I will also ensure that I psychologically take care of myself, scheduling breaks and spending time away from the material.

Section C: To be completed by the research supervisor

(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

Please mark the appropriate box below:

Ethical approval granted

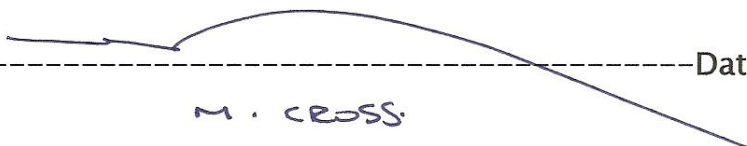
Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature  Date 13/2/12

Section D: To be completed by the 2nd Departmental staff member *(Please read this ethics release form fully and pay particular attention to any answers on the form where underlined bold items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above

Signature  Date 24/02/12
M. CROSS

Appendix 15: Presence of Themes Across Participants

Key: (X) – Barely mentioned, X – Present, X – Strong theme

	1: Sally	2: Elizabeth	3: Janet	4: Laura	5: Pam	6: Polly	7: Lauren
A) The self and the diagnosis							
- <i>Perception of strength v deficit</i>	<u>X</u>	X	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>	X
- <i>Understanding internal relationships</i>	X	(X)	<u>X</u>	<u>X</u>	(X)	(X)	<u>X</u>
- <i>Sharing of the diagnosis</i>	<u>X</u>	X	<u>X</u>	<u>X</u>	<u>X</u>	(X)	<u>X</u>
- <i>The jigsaw pieces are falling into place</i>	<u>X</u>	<u>X</u>	X	(X)	X	<u>X</u>	X
B) The process of relationships							
- <i>Being in a relationship</i>	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
- <i>Formation and dissolution</i>	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
- <i>Struggle with change</i>	(X)	(X)	<u>X</u>	(X)	X	<u>X</u>	X
C) Early experiences							
- <i>Relationships with main caregivers</i>	X	<u>X</u>	X	X	<u>X</u>	<u>X</u>	<u>X</u>
- <i>Missing out</i>	<u>X</u>	X	(X)	(X)	X	<u>X</u>	X

Appendix 16: Table Demonstrating the Breakdown of the Emergent Themes

A) The self and the diagnosis - <i>The perception of strength v deficit</i> -DID as special -DID as different/abnormal - <i>Understanding internal relationships</i> -A balancing act between alters -Managing different alters - <i>Sharing of the diagnosis</i> -Knowing when and who to tell -Others reactions - <i>The jigsaw pieces are falling into place</i> -It has taken time/been a journey to learn more about the self and the diagnosis -Improvement has taken place
B) The process of relationships - <i>Being in a relationship</i> -Being able to hold different roles – specific examples – mother, wife, friend, patient, friend to other with DID -Good and bad experiences in different relationships and the impact of this -Not understanding others behaviour and emotions -Meeting people's needs - <i>Formation and dissolution</i> -Experiences forming relationships – easy and hard -Experiences ending relationships – easy and hard - <i>Managing change</i> -People moving on in a different way -Not moving on
C) Early experiences - <i>Relationships with main caregivers</i> -Damaging/abusive, neglectful or absent others - <i>Missing out</i> - Not having the things other children had and the impact of this

Section C: Publishable Paper for the Journal of Trauma and Dissociation¹³

¹³ Please see Appendix 1 for the submission instructions for authors to the Journal of Trauma and Dissociation.

Research Article:

Talking to the Muggles:

**A Qualitative Investigation into the Concept of Self and the
Experience of Relationships in Those who Define Themselves as
Having Dissociative Identity Disorder**

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Word count: 5496

KEYWORDS: Dissociative Identity Disorder, DID, relationships, self-concept,
qualitative methodology

This research formed part of the final portfolio for a Professional Doctorate in
Counselling Psychology (DPsych) submitted to City University London.

ACKNOWLEDGEMENTS

I would like to thank Dr Jacqui Farrants for her support and assistance with this work.

ABSTRACT

The findings described in the following report form part of a qualitative study into the experiences of relationships in those who define themselves as having Dissociative Identity Disorder (DID)¹⁴. Using semi-structured questionnaires, data was collected from seven participants who defined themselves as experiencing DID and analysed using Interpretative Phenomenological Analysis (IPA). Significant findings from this research suggest that participants perceived themselves and their experiences of DID in different ways which impacted on the way they interacted with others. While some participants reported the experience of DID as a strength; others perceived it to be a deficit. These findings seek to provide insight into the perceived experiences of DID and to offer suggestions which may be helpful for professionals working with this client group.

LITERATURE REVIEW

Dissociative Identity Disorder (DID) has been a controversial diagnosis for a number of years with some professionals arguing against its existence (Piper & Mersky, 2004). Paris (2012) describes DID as a socially created phenomenon developed by clients seeking attention or trying to avoid responsibility for their behaviour. Alternatively, it has been suggested that the experience is created by therapists who encourage the emergence of alters and past memories through the therapeutic

¹⁴ Taking into account the controversy around the diagnosis of DID this research sought to avoid relying on diagnostic labels which make assumptions concerning experiences and to remain focused on the reported experience of the individual. Thought has been given to the language used to define the concept of DID and the phrases ‘individual who defines themselves as having DID’ or ‘individual experiencing DID’ will be used throughout this report to describe those who identify with the diagnosis.

process (Waterhouse, 2013). However, other professionals such as Kluft (1995) take a posttraumatic view of the diagnosis, describing DID as developing when a child has repeatedly used dissociation to mentally avoid experiences of abuse and trauma.

The posttraumatic approach to DID has been developed through research linking dysfunctional early attachment to dissociative behaviour (Liotti, 2006). Main and Solomon's (1990) identification of a disorganised/disorientated pattern of attachment has led other researchers to explore the patterns relationship to the development of later pathological behaviour such as dissociation (Ogawa, Sroufe, Weomfield, Carlson & Egeland, 1997). Results offered by Carlson (1998) suggest that early disorganised/disorientated attachment is related to higher levels of dissociative behaviour in adolescence; high levels of dissociative behaviour is a described symptom of DID.

Other researchers have also considered DID to be a developmental psychopathology; suggesting that specific elements of the child-caregiver relationship predict its development (Putnam, 1997). Findings from Dutra, Bureau, Holmes, Lyubchik and Lyons-Ruth (2009) report that dissociation in young adulthood was predicted by the level of parental responsiveness the child experienced in their childhood. It has been suggested that the relationship between the child and caregiver provides a way of regulating internal states and therefore responding inappropriately to a child's emotions can impact on the development of their sense of self and the way in which they interact with others (Schoore & Schoore, 2008). Schoore (2009) refers to relational trauma which he states can have a lasting impression on the right brain impacting on

the individual's ability to regulate and manage life stress, perhaps encouraging coping strategies such as dissociation to develop.

Research into attachment and trauma offers an interesting perspective into the concept of DID but does not offer much information about what it is like for an individual who defines themselves as experiencing DID. Qualitative research into the experience of DID is limited and only one example has been found. In an unpublished Masters dissertation, Cannon (2010) explored 'what is it like living with Dissociative Identity Disorder – and what has helped or hindered on the journey.' Her results suggested that conducting relationships were problematic for her participants and that this area of experience required further investigation.

DID, Early Attachment and Adult Relationships

Published literature suggests that early dysfunctional attachment leads to the development of DID (Liotti, 2006) and that individuals who define themselves in this way report difficulties in their adult relationships (Cannon, 2010). Both early attachment difficulties and the experience of dissociative behaviour are likely to impact on the way an individual conducts their adult relationships. This is supported by Blizard and Bluhm (1994) who suggest that the child's internal model of the environment and those in it will create a template for later relationships.

Limited research has been carried out specifically to look at the relational experiences of those who define themselves as having DID. Despite the controversial nature of the diagnosis it is clear that individuals who define themselves in this way experience difficulties and distress and this needs to be explored in order to understand how and what support should be provided. The present study sought to

keep in mind previous literature linking DID with early attachment (Liotti, 2006) and explore experiences of relationships in those who defined themselves as having DID.

METHOD¹⁵

Participants

Participants were recruited through an advertisement in *Rainbows End*, a publication created by *First Person Plural*, a charity run by individuals who define themselves as having a Dissociative Disorder. The organisation is nationwide and has approximately 80 members. Inclusion criteria for the study included participants a) defining themselves as experiencing DID, and b) being members of *First Person Plural*. Participants were excluded if they: were deemed to be too psychologically vulnerable, assessed through an initial telephone conversation; lived outside of England; were under 18; or were unable to speak English. Seven participants were recruited, aged between 30 and 50 years. All participants were women and all reported experiencing childhood abuse.

Interview Schedule

Semi-structured interviews were used to gather data as they offered flexibility to explore any unexpected topics while still providing a schedule and allowing preparation for the content of the interview (Smith, Flowers & Larkin, 2009). The development of an interview structure was guided by Smith and Osborn (2008). The interview began with a question asking the participant to define what they believed

¹⁵ Ethical clearance was granted for this study from City University London and permission given for recruitment from the organisation *First Person Plural*.

was meant by the word 'relationship' to ensure a shared understanding of the term. Participants were then asked to select one of their relationships to speak about specifically. Questions moved to a more general level where participants were asked how this relationship compared to others they had experienced, and three questions were then asked about the process of relationships. Questions asking specifically about the perceived impact of DID were left until the end of the interview.

Procedure

All participants responded to the recruitment material by email and telephone conversations were arranged before meeting, allowing a brief assessment of vulnerability, information about the interview to be offered and meeting arrangements to be confirmed. Participants were informed that interviews would take up to an hour and a half and would be recorded. Interviews were carried out in public buildings such as libraries and universities. On meeting with participants the purpose of the interview was reviewed and participants were invited to ask any questions. Participants signed a consent form confirming they were willing to take part and were aware that findings may be used for publication. Each interview was concluded with a verbal debrief to assess distress and each participant given a debrief sheet thanking them for taking part and providing them with helpline numbers should they want any further support or information.

Analytic Strategy

Each interview was transcribed allowing space for coding and comments. Analysis was guided by Smith et al. (2009) who emphasise the importance of becoming immersed in the data. This was achieved through re-listening to the interviews and

reviewing the transcriptions repeatedly. Smith et al. (2009) describe four stages of analysis using IPA; a) initial noting of descriptive, linguistic and conceptual concepts, b) identifying emergent themes within the data, c) clustering emergent themes within each interview and d) clustering emergent themes between each interview (Smith et al., 2009). From the findings three master themes emerged each containing a small number of emergent themes. This article will focus on the emergent theme labelled ‘the perception of strength versus deficit’. This was the most original and exciting theme collected from the research because it offers an insight into how a perceived diagnosis and experience can impact on the way the self and others are viewed. This has implications when considering other mental health diagnoses and should be held in mind when debating the value and impact of using diagnostic categories for mental health difficulties. The theme also raises questions about whether there is something perceived to be unique and special about the diagnosis of DID.

ANALYSIS

The Perception of Strength versus Deficit

Across all interviews the perceived impact of experiencing DID on relationships was described to be negative. However, an interesting finding was the different way in which participants described their experiences and how this impacted on the way they viewed themselves and others. Some participants presented themselves as strong and capable in spite of the perceived diagnosis and others believed that having DID was a deficit and that they felt abnormal as a result.

The self as strong and capable.

Sally¹⁶ explained how she described those who do not define themselves as experiencing DID as ‘muggles’:

‘I call normal people muggles’

The term ‘muggles’ is taken from the Harry Potter series of books (Rowling, 1997) and refers to people who do not possess magical skills. This comment from Sally implies a belief that those who do not define themselves as having DID, described here as ‘normal’, are lacking in some way or that people who define themselves as experiencing DID are superior. Sally describes herself as ‘special’ on a number of occasions:

‘I think she calls me special, special cos I am, I am quite unique’

The use of the words ‘muggle’ and ‘special’ may suggest that there is a value or a positive element to describing the self as experiencing DID, that Sally feels special, unique and different compared to those who do not define themselves in this way.

Several individuals referred to the researcher-participant relationship to illustrate the differences between those who define themselves as experiencing DID and those who do not. For example, Sally states:

‘Something that you certainly wouldn’t get but certainly someone with
DID would get’.

¹⁶ All participants’ names and any identifying information have been changed to ensure anonymity.

Lauren also refers to the researcher, to illustrate how different she considers her experiences to be:

‘Because it’s not like for you, if you’re having a, a bad day you’ve still got all, like if you’re having a bad day and I don’t know twenty percent of you is feeling really irate with something, you’ve still got the eighty percent of you all in one person sort of balancing that out. If I go into one of my bad days I got into P and he’s a hundred percent (R: Uhuh)¹⁷ pissed off with the world and aggressive and angry’.

The idea that there was something of value or positive about the perceived experience of DID was also suggested by Laura who referred to individuals who do not define themselves in this way as ‘singletons’; questioning how they survived without internal alters:

‘I think nowadays how do people that are singletons survive really (laughs)¹⁸. Umm but I suppose the proper way of looking at it would be that, you know, you’re not singletons and that you’re all there complete whereas I’m not complete without each of my (R: Uhuh) crowd because they carry different parts of me’

Consistent with the idea that part of the perceived experience of DID was positive and differentiated participants from those who did not define themselves as having

¹⁷ R refers to researchers comments

¹⁸ Comments in brackets refer to researchers comments or observations

DID was the way in which some participants took time to emphasise their abilities despite the diagnosis. Polly mentioned a number of times throughout her interview how she considered herself as very ‘independent’ and that she did not feel as if she needed to have others around her; she described valuing this quality in herself. Polly discussed how she felt that this trait had developed as a result of her early experience of neglect and a need to cope alone.

Laura also emphasised her capabilities throughout her interview and shared that despite perceiving herself to experience DID she was still able to function well. She spoke about how others viewed her as a coping person and listed how many activities she was engaged with suggesting that it was important for her to be considered as coping or functioning:

‘So in the end I rang this friend, R who’s known me, as I say for three years and I’ve helped her with the cottage, we play in the team together, we were doing swimming together so, and she saw what I was going through caring for this woman with depression and kept saying ‘I don’t know how you cope’ you know, (R: Uhuh) because it was quite hard. So I thought, she knows me as a coping person so I’m going to ring her’.

In the quote above Laura describes a time when she needed support and selected a friend to ask who she believed perceived her as capable and strong, suggested by her referral to her friend’s words ‘I don’t know how you cope’.

Six out of the seven participants made comments concerning how lucky they felt in comparison to others; both those who defined themselves as having DID and those who did not. Elizabeth compared herself favourably to others defining themselves as experiencing DID:

‘I think, myself I’m really fortunate because I think, I know lots of other people with DID that, umm, can’t even get out of the house’.

Other participants valued their personal qualities, such as independence or important others in their lives. Sally described a strong relationship with her husband and her daughter as well as with a number of close friends which made her feel lucky, she stated:

‘I do feel really blessed because I do have some of the most beautiful people as friends’.

DID as a deficit/the self as different or abnormal.

Among other participants the experience of DID was described as much more difficult. Individuals described themselves as feeling abnormal and different which impacted on their ability to engage in and maintain relationships. Janet provided an example of when she was trying to arrange a house share at university and how this feeling of difference was sometimes exacerbated by comments from others:

‘There was another girl in the mix who didn’t want to live with me, she said I was too screwed up’.

The word ‘wrong’ was used in a number of interviews to describe the perceived experience of DID. Polly in particular described experiencing DID as something ‘wrong’ or abnormal. Like Polly, Pam shared a very negative attitude towards her experience of the diagnosis, describing it as something that was a problem, was restrictive and that stopped her from feeling normal:

‘The DID is always going to kind of fuck everything up really, that’s how it feels as if you just, I just want to be normal. Umm, and I don’t feel sometimes like I even know what that is’.

Pam’s comment emphasises her feeling of being abnormal, describing how she felt she has lost touch with what it would be like to perceive herself as ‘normal’. In comparison Laura appeared to have found a meaning in her experience which prevented her from describing it as negatively:

‘There was no inkling to her that there was anything, I don’t even want to say wrong cos to me it isn’t wrong but different’

Although drawn to using the word ‘wrong’ Laura reframes this to ‘different’ which offers a more positive and accepting description of her experience. However, she later acknowledges that feeling different can be very lonely and in this way her perceived experience of DID can be quite difficult:

‘It makes you really lonely because you just feel so different’.

These findings suggest that the perceived experience of DID can impact on the way individuals view themselves and the way they conduct their relationships.

DISCUSSION

Findings from this research suggest that among participants there were different ways of considering the self in relation to the diagnosis of DID; either in a positive way that elevated the self; or a negative way which left the individual feeling abnormal. Although feelings of difference are commonly associated with mental health difficulties, what is interesting in this sample, is that at times the perceived experience of DID is considered positively. Perhaps identifying with the diagnosis of DID may serve a function for the individual; it may be attractive to consider the self as special or lucky.

Skaalvik and Bong (2003) define self-concept as a psychological construct which forms through interpersonal experiences, genetic factors and expectations of others and which has a significant impact on the way individuals think and feel about themselves, how they behave and how they believe they are viewed by others. Sedikides and Gregg (2008) describe how people are generally motivated to create and maintain a positive self-concept but Luke and Stopa (2009) suggest this process is often disrupted in those who experience mental health difficulties, especially in those who have experienced childhood abuse. Interestingly, the findings from the present study suggest that some participants discussed the concept of DID in a way that reflected positively on the self, implying a different level of understanding from others and a way in which they could be considered as 'special' or 'unique'.

It appears that in positioning the self in this way a sense of ‘otherness’ is created, in which individuals who do not define themselves as experiencing DID are considered as ‘others’; ‘muggles’ or ‘singletons’. Dalal (2006) suggests that human beings desire a sense of belongingness and attachment and this can be achieved through belonging to a group. He suggests that these feelings are dependent on two conditions; there must be an alternative group to not belong to; and only some can belong to the group while others are excluded. This could be the case with the concept of DID, there is another group, those who do not define themselves in this way and only those with the diagnosis can belong to the group. Davis (2011) suggests that without the development of an ‘other’ to separate from ‘we could not achieve the sense of power and invulnerability that we all consciously or unconsciously seek’ (p. 551). In considering this in terms of the concept of DID feelings of power and invulnerability may be achieved by disidentifying from those who do not define themselves as experiencing the diagnosis. Leary, Haupt, Strausse and Chokel (1998) suggest that feeling accepted or belonging to a group can lead to higher self-esteem and therefore a more positive self-concept. Perhaps those participants who consider their diagnosis as an identity and themselves as members of an ‘in-group’ consider the experience in a more positive light than those who do not.

Having an ‘other’ that could not understand created a sense of superiority or elevation among some participants. Davis (2011) discusses how people often project their own undesirable feelings and characteristics onto others and then depreciate others elevating themselves. Elevating the self could help individuals to manage difficult feelings associated with the sensation of being different. This is consistent

with Hegeman's (2009) comments suggesting that individuals who define themselves as having DID may come to value their different internal experiences and that this helps a sense of identity to develop that perhaps has not been present previously. The protective factor of feeling similar to others has been discussed by Dorahy et al. (2009) who suggests it buffers against psychological distress and offers feelings of connectedness and acceptability.

The act of comparing the self with others also occurred in participants' discussions about how lucky they felt. Festinger (1954) described how individuals often considered their own abilities by comparing themselves with others. Different types of comparisons can take place; downward comparisons are made when an individual compares themselves to others worse off than themselves; upwards comparisons refer to comparing the self to those in a better position (Luke & Stopia, 2009). Downwards comparisons, as demonstrated in the participants in the present study, can have a positive effect on levels of self-esteem, suggesting that in comparing themselves to those who are struggling with their own experience of DID, participants felt more able and capable resulting in a positive self-concept.

Considering the organisation of self-knowledge Showers (1992) suggests that there are two ways in which individuals organise positive and negative information about the self; in a compartmentalised way, where these categorises of information about the self are kept separate, or in an integrated way where they are merged. It is possible that individuals who define themselves as experiencing DID organise their self-knowledge in a compartmentalised way consistent with the perceived experience of different selves, therefore certain alters may be allocated positive or negative self

attributes. Showers (1992) suggests that the way in which information is organised can impact on an individual's level of self-esteem. She suggests that the grouping of information found in compartmentalisation is only beneficial when important aspects of the self are deemed as positive. If important aspects of the self are compartmentalised into different alters, depending on whether the parts are considered to be positive or negative will impact on how an individual feels about themselves in general and may impact on the way they perceive the experience of DID; as a strength or as a deficit.

In contrast to considering the experience of DID as a strength was the negativity associated with feeling as if the self was abnormal or, as described by Polly, that there was something 'wrong'. Some participants described feeling as if there was a stigma around the diagnosis of DID and as if the experience was very misunderstood due to how it had been presented by the media. It is possible that this perceived stigma related to the concept of DID is linked to past experiences of abuse reported by participants. This would be consistent with participants in Dorahy et al.'s (2012) study who described themselves as shameful due to early experiences of childhood sexual abuse and believed others would also perceive them in this way.

Feelings of shame have also been linked to mental health issues such as depression (Cheung, Gilbert & Irons, 2004) and anxiety (Harder, Cutler & Rockart, 1992). It is possible that if participants felt there was stigma attached to the concept of DID this could have been exacerbated by the way DID has been described as the most complex of the Dissociative Disorders (Livingston, 2009).

Treatment Implications

Recommended treatment for those with the diagnosis of DID is in its infancy and is in itself controversial. The International Society for the Study of Trauma and Dissociation [ISSTD] (2011) suggests that successful treatment includes identifying and working directly with alters. This guidance assumes that alters may emerge through the process of therapy and it could be argued that they are produced as a result of interactions with a therapist.

Findings from the present study have suggested that among individuals who define themselves as having DID the self is perceived in different ways; this is likely to have a significant impact on the way they interact with others. For example Dorahy et al.'s (2012) findings suggest that those participants who described themselves as shameful withdrew from social contact. However, if individuals perceive themselves as special or elevated in relation to others, this could also lead to difficulties in relationships, others may find it difficult to relate to the individual or may feel like they need to work around them. Considering the therapeutic relationship, it is possible that perceiving the self as abnormal and different from others may impact on how much an individual is able to disclose and it may take time to build up trust. Alternatively placing the self in an elevated position may leave a therapist feeling helpless or as if they cannot understand their client's experiences which could also cause difficulties in the therapeutic process.

The findings from the present study can be used to inform practice working as a therapist with those who define themselves as having DID. Remaining mindful of the differences in self-concept among these participants would be useful as would

considering how an individual positions themselves in relation to others. Working on modifying a negative self-concept could be addressed in order to increase levels of self-esteem which would be beneficial to everyday functioning. Having a greater understanding of the experience of relationships in those who define themselves as having DID would help to inform therapeutic work, especially in terms of building and maintaining the therapeutic relationship and knowing what may be enacted.

Limitations

One limitation of this research was the recruitment of the sample from only one organisation as members of *First Person Plural* (2011) are likely to perceive themselves in a way which is consistent with the values of the organisation. The organisation describes itself as being ‘survivor led’ and appears to take the perspective that DID is a coping strategy to survive severe childhood trauma. Those who do not consider the concept of DID in this way or have no traumatic background but still define themselves as having DID may not be members of this organisation and therefore would not have been invited to take part in the research.

The participants who volunteered to take part in the study were all female and were all between the ages of 30 and 50. There has been a gender bias found in the diagnosis of DID, with more women diagnosed than men (Sinason, 2011) and Gleaves (1996) reports that individuals who define themselves as having DID describe spending six to seven years in the treatment system before being diagnosed, and therefore may be older than those diagnosed with other disorders. Considering this, the present sample may be quite representative of those who define themselves in this way. However, interviewing men who define themselves as having DID may

offer a broader view of how relationships are experienced and would be a worthwhile area to study in the future. The current sample was also self-selected which suggests that participants who volunteered had something to share about their experiences of relationships. Additionally the decision to exclude those individuals who presented as more psychologically vulnerable would have led to data which only provided insight into the experience of those deemed to be psychologically stable.

Future Research

Further research needs to be completed to explore the findings offered by this study and assess their generalisability. However, additional research with a different sample size and type may also offer valuable findings and discover how useful the current study is. A way of gaining a broader sample may be to recruit from NHS trusts around the country, as well as from different organisations, and recruiting men. Psychologically vulnerable individuals may offer a different perspective on the experience defined as DID and report different experiences in relationships. Future research building on this study could include participants who are psychologically vulnerable but could be carried out in a community or inpatient service where risk and vulnerability could be contained.

CONCLUSIONS

Findings suggest that among those who define themselves as having DID there are differences in the way the self is described in relation to their diagnosis, either in a positive way that elevates the self or in a negative way, describing the self as abnormal. In both cases individuals described feeling differently to those who do not

define themselves as having DID. The way in which individuals perceive themselves is likely to have a significant impact on the way they interact with others and conduct their relationships. Findings have implications for those working with this client group and future research is needed to broaden the findings of the present study.

REFERENCES

- Blizard, R. A., & Bluhm, A. M. (1994). Attachment to the abuser: Integrating object-relations and trauma theories in treatment of abuse survivors. *Psychotherapy*, 31, 3, 383-390.
- Cannon, S. (2010). What is it like living with DID? (Unpublished MA dissertation). Middlesex University, London.
- Carlson, E. A. (1998). A prospective longitudinal study of attachment disorganization/disorientation. *Child Development*, 69, 4, 1107-1128.
- Cheung, M. S. P., Gilbert, P., & Irons, C. (2001). An exploration of shame, social rank and rumination in relation to depression. *Personality and Individual Differences*, 36, 1143-1153.
- Dalal, F. (2006). Racism: Processes of detachment, dehumanization and hatred. *Psychoanalytic Quarterly*, 75, 131-161.
- Davis, J. D. (2011). Cultural dimensions of inter-subjectivity: Negotiating 'sameness' and 'otherness' in the analytic relationship. *Psychoanalytic Psychology*, 28, 4, 549-559.
- Dorahy, M. J., Corry, M., Shannon, M., MacSherry, A., Hamilton, G., McRobert, G., Elder, R., & Hanna, D. (2009). Complex PTSD, interpersonal trauma and relational consequences: Findings from a treatment-receiving northern Irish sample. *Journal of Affective Disorders*, 112, 71-80.

- Dorahy, M. J., & Clearwater, K. (2012). Shame and guilt in men exposed to childhood sexual abuse: A qualitative investigation. *Journal of Child Sexual Abuse*, 21, 155-175.
- Dutra, L., Bureau, J. F., Holmes, B., Lyubchik, A., & Lyons-Ruth, K. (2009). Quality of early care and childhood trauma: A prospective study of developmental pathways to dissociation. *Journal of Nervous and Mental Disease*, 197, 6, 383-390.
- Festinger, L. (1954). A theory of social comparison processes. *Human Relations*, 7, 117-140.
- First Person Plural, (2011). Retrieved from <http://www.firstpersonplural.org.uk>
- Gleaves, D. H. (1996). The sociocognitive model of Dissociative Identity Disorder: A reexamination of the evidence. *Psychological Bulletin*, 120, 1, 42-59.
- Harder, D. W., Cutler, L., & Rockart, L. (1992). Assessment of shame and guilt and their relationships to psychopathology. *Journal of Personality Assessment*, 59, 584-604.
- Hegeman, E. (2009). One or many? Commentary on paper by Debra Rothschild. *Psychoanalytic Dialogues*, 19, 188-196.
- International Society for the Study of Trauma and Dissociation. (2011). Guidelines for treating Dissociative Identity Disorder in adults: Third revision: Summary version. *Journal of Trauma and Dissociation*, 12, 188-212.
- Kluft, R. P. (1995). The confirmation and disconfirmation of memories of abuse in DID patients: A naturalistic clinical study. *Dissociation*, 8, 4, 253-258.

- Leary, M. R., Haupt, A. L., Strausse, K.S., & Chokel, J. T. (1998). Calibrating the sociometer: The relationship between interpersonal appraisals and the state self-esteem. *Journal of Personality and Social Psychology*, 74, 1290-1299.
- Liotti, G. (2006). A model of dissociation based on attachment theory and research. *Journal of Trauma and Dissociation*, 7, 4, 55-73.
- Livingston, K. (2009). *Understanding Dissociative Disorders*. London: Mind.
- Luke, M. A., & Stopa, L. (2009) Psychological theories of the self and their application. In L. Stopa (Ed.) *Imagery and the threatened self: Perspectives on mental imagery and the self in cognitive therapy*. (pp. 15-64). Oxford: Routledge.
- Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganised/disorientated during the ainsworth strange situation. In D. C. M. Greenberg & E. M. Cummings (Eds.), *Attachment during the preschool years: Theory, research and intervention*. (pp. 121-160). Chicago: University of Chicago press.
- Ogawa, J. R., Sroufe, L. A., Weinfield, N.S., Carlson, E.A., & Egeland, B. (1997). Development and the fragmented self: Longitudinal study of dissociative symptomatology in a nonclinical sample. *Development and Psychopathology*, 9, 855-879.
- Paris, J. (2012). The rise and fall of Dissociative Identity Disorder. *Journal of Nervous and Mental Disease*, 200, 12, 1076-1079.

- Piper, A., & Mersky, H. (2004). The persistence of folly: Critical examination of Dissociative Identity Disorder. Part II. The defence and decline of multiple personality or Dissociative Identity Disorder. *Canadian Journal of Psychiatry*, 49, 10, 678-683.
- Putnam, F. W. (1997). *Dissociation in children and adolescents*. New York: Guilford Press.
- Rowling, J. K. (1997). *Harry potter and the philosopher's stone*. New York: Bloomsbury Publishing PLC.
- Schore, A. N. (2009). Relational trauma and the developing right brain: The neurobiology of broken attachment bonds. In T. Baradon (Ed.). *Relational trauma in infancy*. (p. 19-47). London: Routledge.
- Schore, J. R., & Schore, A. N. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical Social Work Journal*, 36, 9-20.
- Sedikides, C., & Gregg, A. (2008). Self-enhancement: Food for thought. *Persepctives on Psychological Science*, 3, 102-116.
- Sinason, V. (2011). *Attachment, trauma and multiplicity. Working with Dissociative Identity Disorder* (2nd ed.). New York and London: Routledge.
- Showers, C.J. (1992). Compartmentalization of positive and negative self-knowledge: Keeping bad apples out of the bunch. *Journal of Personality and Social Psychology*, 62, 1036-1049.

- Skaalvik, E. M., & Bong, M. (2003). Self-concept and self-efficacy revisited. In H. W. Marsh, R. G. Craven & D. M. McInerney (Eds.). *International advances in self-research, Vol 1*, (pp. 67–89). USA: Information Age Publishing Inc.
- Smith, J., & Osborn, M. (2008). Interpretative Phenomenological Analysis. In J. Smith (Ed.), *Qualitative psychology, a practical guide to research methods* (pp. 53-80). London: Sage.
- Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.
- Waterhouse, R. (2013). The woman who had 48 personalities. *New Scientist*, 46-49.

APPENDICES

Appendix 1: Submission instructions for authors to the Journal of Trauma and Dissociation

JOURNAL OF TRAUMA & DISSOCIATION

Submission Instructions for Authors

Editor Jennifer Freyd, PhD

1. MISSION. The *Journal of Trauma & Dissociation* is the official journal of the International Society for the Study of Trauma and Dissociation. The Journal is dedicated to publishing peer-reviewed scientific literature on dissociation, the Dissociative Disorders, posttraumatic stress disorder, psychological trauma and its sequelae, and on aspects of memory associated with psychological trauma and dissociation. The *Journal of Trauma & Dissociation* seeks manuscripts on theory, basic science research, clinical treatment and research related to psychological trauma, dissociation and traumatic memory in children and adults. The Journal welcomes contributions from anthropological, cross-cultural, neurobiological, pharmacologic, physiologic, psychological, psychometric, psychotherapeutic, and social viewpoints. The journal is published quarterly.

2. TYPES OF ARTICLES. The *Journal of Trauma & Dissociation* accepts review articles, theoretical articles, original research articles, clinical contributions, case reports, and letters to the editors. Regular articles are limited to 5,500 words and brief reports to 3000 words. Authors should specify the type of article they are submitting. The editors may reclassify the type of submission as appropriate. The Journal does not review or publish first person case reports (accounts of authors' personal psychological experiences). Due to our value on authenticity and veracity of crucial case information, composite case studies are not published. The Journal does not publish unsolicited book reviews but welcomes recommendations of recent books for book reviews. Book authors and publishers should send copies of books for review to either of the Book Review Associate Editors and should notify the Editors by email of the name and author of the books sent to the Book Review Editors.

3. PRIOR PUBLICATION. Submission of a manuscript to the *Journal of Trauma and Dissociation* represents a certification on the part of the author(s) that it is original material, and that neither the manuscript or a version of it has been published elsewhere, is not being considered for publication elsewhere, and has been approved by each author. Any form of publication other than an abstract of less than 400 words constitutes prior publication. This includes portions of symposia, proceedings, books/chapters, invited papers or any types of reports, and electronic databases. Authors wishing to submit manuscripts involving data or clinical observations previously used in published, in press, submitted (or to be submitted) papers should provide the Editor with this relevant information and an explanation regarding how those papers differ from the current submission.

4. AUTHORSHIP. Authorship credit should be limited to those who have made substantial contributions to the article in terms of design, data collection, data analysis and interpretation, and drafting and revising the manuscript. Acquisition of funding or provision of data alone is not sufficient to merit authorship. General supervision of the research group is not sufficient either. Individuals contributing less than a key role to the paper should be recognized in an Acknowledgement. Editors may require authors to justify the assignment of authorship. Each author must take public responsibility for the content of the article.

5. DISCLOSURE OF COMPETING INTERESTS. All forms of financial support must be stated in an Acknowledgment. Any commercial or financial involvements among the authors that might present the appearance of a conflict of interest in connection with the submitted article should be disclosed in the cover letter. Such involvements may include (but are not limited to) institutional or corporate affiliations not already specified, paid consultations, stock ownership or other equity involvement, patent ownership, travel funds, and royalties received from rating scales, inventions, or therapeutic methods. The Editor may share this information with the reviewers, but such involvements will not represent automatic grounds for rejection of the submission. A statement of such involvements will accompany the article, if published. Authors will be asked to attest in writing concerning any competing interests at the time of submission.

6. PATIENT INFORMED CONSENT AND PATIENT PRIVACY. Authors must have written informed consent from any patient/clients described in case study material. The authors must take steps to protect the identity of patients reported in case reports and elsewhere. Identifying information (e.g., names, initials, hospitals, dates) must be avoided or changed. Note that authors must both protect the integrity of the case study information such that crucial details for interpretation are retained, and protect patient privacy such that non-crucial details that could violate the privacy of the patient are changed. Authors who wish guidelines for protection of patient anonymity are referred to "Statements from the Vancouver Group, International Committee of Medical Journal Editors" in *British Medical Journal* 1991; 302: 1194. Authors submitting case study material will be required to complete a "Case Presentation Checklist" available at <http://dynamic.uoregon.edu/~jjf/jtd/>. Within the case report itself there should be a statement that the patient/client has given informed written consent for the publication and that the identity of the patient/client has been disguised by omission and alteration of non-crucial information.

7. INSTITUTIONAL REVIEW BOARD APPROVAL AND INFORMED CONSENT. Papers that report results of data collected from human participants must include a statement that written informed consent was obtained from participants after adequately explaining the study's procedures to them. Deviations from the standard written informed consent process should be fully explained. Approval by an Institutional Review Board or Ethics Committee should be documented and mentioned in the written report.

8. MANUSCRIPT LENGTH. Manuscript articles may be 1,500 to 5,500 words (approximately five to 18 double-spaced pages) including references and tables and figures, as appropriate to the type of article. Review articles, theoretical articles, research reports, and clinical discussions should contain a maximum of 5,500 words. Brief reports should be no more than 3,000 words. Letters to the editor may contain no more than 500 words and 3 references, and must be received within 10 weeks of the original article's publication. Letters to the editor are reviewed in a

manner similar to other manuscripts. Lengthier manuscripts may be considered for special reasons or circumstances.

9. MANUSCRIPT FORMAT. Manuscripts must be prepared in a standard U.S. letter or A4 page format, double-spaced, with 1 inch or 3 centimeter margins on all sides. Text font should be proportional and with serif (e.g., Times New Roman 12 point font). Manuscripts should have the following order: Title page, abstract, text, references, tables and figures. Pages should be numbered beginning with the title page.

Title Page. Title page must include, title; authors and degrees; location of the institution and place where the work was done; corresponding author's name, address, telephone number, fax number, and e-mail address; word count; key words for index purposes; and acknowledgment of previous presentation, grant support, commercial support, or other credit. For mailing of a complimentary copy of the issue in which your article is published, please supply a postal mailing address for each author. Please place addresses of authors other than the Corresponding Author on a separate page immediately after the Title Page.

Abstract. A single paragraph abstract of 100-250 words must be provided.

Text. The text should contain an introduction that describes the objectives of the article and a review of the relevant scientific literature. Subsequent sections should describe the main subject matter (theoretical, clinical or research), a discussion of the subject matter, and conclusions. Research papers must include sections on methods and results, followed by discussion. Methods must contain an adequate description of instruments, research participants and statistical analyses, and results must be fully reported including the test values, degrees of freedom, whether tests were one- or two-tailed, probability and significance, and N values as appropriate. Research articles involving research with human participants must include a statement that informed consent was obtained or if not, why not.

Citations and References. For writing style and reference formats, the Journal uses the style of the Publication Manual of the American Psychological Association (6th Edition, 2010). We urge authors to consult this manual for formats not listed in the Information for Authors. The Publication Manual of the APA may be obtained from the APA Order Department, P.O. Box 92984, Washington, DC, 20090-2984, USA, www.apa.org/books/ordering.html.

Citations in Text. Use the author-date method within parentheses inserted into the text.

1. Work by one author: (Putnam, 1989).
2. Work by two authors: (Cardeña & Spiegel, 1993). Cite both names every time the reference occurs in the text. Use no comma between authors.
3. Work by three, four or five authors: First text citation: (Van der Hart, Van Kijke, Van Son, & Steele, 2000). Use commas after all authors. Subsequent text citations: (Van der Hart et al., 2000).
4. Work by six or more authors: In all text citations, use only the surname of the first author followed by et al. and the year of publication, e.g., (Ross et al., 1992).
5. Organizations as authors: Spell out the name of the organization the first time it is cited in the text. The organization name may be abbreviated in subsequent in-text citations only if the abbreviation is listed with the spelled out name in the first

citation. First text citation: (International Society for the Study of Dissociation [ISSD], 1997). Subsequent text citations – use either of two formats: (ISSD, 1997) or (International Society for the Study of Dissociation, 1997).

6. Works by the same author(s) within the same year: Use the suffixes a, b, c, etc. following the date to distinguish works by the same author(s) within the same year. The first work cited in the text will be “a”, the second work will be “b”, etc., e.g., (Coons, 1994a, 1994b).

7. If there are two or more multiple author citations with the same first author within the same year, cite the surnames of as many subsequent authors as needed to distinguish references, e.g., (Van der Hart, Nijenhuis et al., 2001; Van der Hart, Steele et al., 2001).

8. Order of citation: When citing two or more works within the same parenthesis, list them in alphabetical order by the surname of the first author. Separate citations by semicolons. If citing the same author(s) more than once, place works in chronological order by publication dates separated by commas. Example: (Allen, 1997; Allison, 1978; Chu & Bowman, 2000; Kluft 1985a, 1985b, 1986; Kluft & Fine, 1993; Michelson & Ray, 1996; Ross et al., 1992). 9. Quotations: Citations for quotations must contain page numbers, e.g., (Van der Hart et al., pp. 35-36).

Reference List. Consult the Publication Manual of the American Psychological Association for formats of types of references other than those listed below.

1. Journal article. Putnam, F.W., Guroff, J.J., Silberman, E.K., Barban, L., & Post, R.M. (1986). The clinical phenomenology of Multiple Personality Disorder: Review of 100 recent cases. *Journal of Clinical Psychiatry*, 47, 285-293. Titles of and volume number journals should be italicized. Journal titles should have all important words capitalized.

2. Book. Putnam, F.W. (1997). *Dissociation in children and adolescents*. New York: Guilford Press. Titles of books should be italicized. Only the first word of book titles should be capitalized.

3. Edited Book: Kluft, R.P., & Fine, C.G. (Eds.). (1993). *Clinical perspectives on Multiple Personality Disorder*. Washington, D.C.: American Psychiatric Press.

4. Book Chapter Goodwin, J. (1996). Childhood DID: The male population. In J.L. Silberg, (Ed.), *The dissociative child* (pp. 69-84). Lutherville, MD: Sidran Press. Page numbers must be included for book chapters.

5. Association Author: American Psychiatric Association. (2000). *Statement on therapies focused on memories of childhood physical and sexual abuse*. Washington, DC: Author.

6. Republished works: James, W. (1902/1961). *The varieties of religious experience*. London: MacMillan.

7. Formatting. Double-space all references. Please use a hanging indent format.

8. Authors. Please include all authors for each reference. Use commas after all authors except the last (including two author references).

9. Order of references. List references in alphabetical order by surname of first author. List multiple references by the same author(s) in chronological order from earliest to most recent publication date. List the sole-author works of an author before co-authored works.

Graphics, Tables, Figures, and Illustrations. All graphics must be “camera-ready.” Tables should be prepared using standard word processing software (MS Word preferred). Illustrations should be prepared using either graphics software or artistically rendered in black ink so that they can be used either as they are or reduced in size. Whenever possible, figures should be submitted with the

manuscript in digital form. Fonts should be proportional and sans serif (e.g., Arial). Author name(s) and manuscript name should be lightly written on the reverse of graphics. Indicate in the text the approximate placement of all graphics. Graphics including photographs are considered part of accepted manuscripts and are retained by the Publisher. If submitted graphics are unacceptable for publication, the Publisher reserves the right to redo the graphics and to charge the author(s) a fee of \$35 per hour for this service.

10. MANUSCRIPT STYLE. Authors who need a guide for English journal writing may wish to refer to the Style section of “Suggestions to Authors” in *Neurology* 1996; 46: 298-300. The editors are recommending only the writing style section. Use gender inclusive language. In referring to human beings, authors should use the phrases “in humans,” “in humankind,” or “in human beings,” rather than the phrase “in man” or the word “man.” Authors should avoid “he” in referring to generic persons as well as the awkward “he/she” construction by making the subject plural, e.g., “Therapists should inquire about amnesia whenever they suspect dissociation,” rather than “A therapist should inquire about amnesia whenever he/she suspects dissociation.” Alternatively, when referring to hypothetical persons, authors may alternate between male and female subjects. Numbers in the text. Authors should use Arabic numerals for numbers above nine, and for designators such as Case 4 or Patient 2. Authors should spell out numbers one through nine and numbers at the beginning sentences. Use the active voice whenever possible: We will ask authors that rely heavily on use of the passive voice to re-write manuscripts in the active voice. While the use of the phrase “the author(s)” is acceptable, we encourage authors to use first and third person pronouns, i.e., “I” and “we,” to avoid an awkward or stilted writing style.

11. SUBMISSION AND REVIEW PROCESS. All manuscripts must be submitted on our submission website: <http://mc.manuscriptcentral.com/WJTD>. In addition authors will need to submit the Author Assurance form that can be found at: <http://dynamic.uoregon.edu/~jjf/jtd/submission.html>. All submissions are peer-reviewed by anonymous reviewers. Reviewers provide written comments that are sent to the authors by the Editor. Authors are informed about the Editor’s decision after completion of the review process. In most cases, we inform authors within eight to ten weeks following receipt of the manuscript as to the results of the initial review of their manuscripts.

12. COPYRIGHT TRANSFER. Copyright ownership of manuscripts must be transferred to the Publisher by signature of author(s) prior to publication. It is permissible for a single author to sign the copyright transfer form provided that the author is authorized by all co-authors to sign on their behalf. We will send copyright assignment forms to the corresponding author upon acceptance of a paper.

Section D: Professional Case Study

Using Trauma Focused Cognitive Behavioural Therapy:

**Working with Ehlers and Clark's Cognitive Model of
Posttraumatic Stress Disorder**

Word Count - 6600

Introduction and Start of Therapy

Introduction and rationale for choosing this case

This case study describes my work with Marie¹⁹ who was referred to me for treatment of her trauma-related symptoms after being violently raped a year previously. Although I have worked with many clients who have experienced trauma Marie was the first client I worked with specifically to resolve her trauma-related symptoms and therefore this provided a new experience, employing my existing skills to learn and implement different techniques. Working with Marie has involved learning new methods but I have found this exciting as therapy has been successful at reducing her trauma-related symptoms and therefore it has felt professionally and personally rewarding. I also have a special interest in working with clients who have experienced trauma as I find the human capacity to survive devastating events fascinating and inspiring. This case was chosen to be presented, as it has tested my abilities as a therapist and I have learnt a great deal through the experience but also because I find Marie's determination to work through her trauma inspiring and feel it deserves to be shared.

Summary of theoretical orientation

Cognitive behavioural procedures are often used for the treatment of trauma-related symptoms and have been shown to be more successful at reducing these symptoms than other interventions such as supportive counselling (Foa, Rothbaum, Riggs & Murdock, 1991). Brewin and Holmes (2003) review a number of cognitive based models for understanding and treating Posttraumatic Stress Disorder(PTSD) including Emotion Processing Theory, Dual Representation Theory and Ehlers and Clark's Cognitive Model of Posttraumatic Stress Disorder. Guided by my own theoretical knowledge of the model, and it being the preferred approach used by the service in which I am based, I followed Ehlers and Clark's (2000) cognitive model of Posttraumatic Stress Disorder while working with Marie. The decision to use cognitive behavioural therapy is supported by NICE guidelines which state that trauma focused cognitive therapy should be used for the treatment of PTSD when symptoms have been present for more than three months, which was true of Marie (NICE, 2005).

¹⁹ All names and certain biographical/personal identifying details have been changed in order to preserve confidentiality.

PTSD is defined as 'the development of characteristic symptoms following exposure to one or more traumatic events' (American Psychiatric Association (APA), 2013, p. 274). However, not all individuals who experience an extreme traumatic stressor develop PTSD. Ehlers and Clark (2000) suggest that PTSD develops as a result of the way in which an individual processes the event. Grey (2009) states that if traumatic information is processed in a way that creates a sense of current threat then this can lead to the development of PTSD. Ehlers and Clark (2000) describe how this threat can be external; the world may seem a much more dangerous place after the traumatic event, or internal; the event has changed the way in which the person views themselves. Additional negative interpretations about symptoms experienced can also serve to maintain PTSD.

Alongside the negative appraisal of the event is the way in which the trauma memory is coded. The Dual Representation Theory of Posttraumatic Stress Disorder (Brewin, Dalgleish & Joseph, 1996) suggests that memories are stored in two parallel systems as verbally accessible memory (VAM) or situationally accessible memory (SAM). The VAM system is analytical, reflective and logical and is often based on verbally accessible information. The SAM system is connected with bodily responses, it relies on fast automatic processes, is not dependant on verbal information and memories in this system can be retrieved by sensory information (Brewin et al., 1996). More recent discussions by Schore (2010) suggest a difference in the way the right and left brain hemispheres process information. Schore (2010) states that the left hemisphere leads on verbal communication and the right on emotional communication suggesting that Brewin et al's (1996) VAM system is consistent with the left hemisphere and the SAM system with the right. Ehlers, Hackmann and Michael (2004) state that individuals diagnosed with PTSD often have difficulty deliberately retrieving complete memories of the trauma but experience intrusive memories in an involuntary manner which are often very vivid and feel as if they are happening in the here and now. Perhaps trauma memories become stuck in the SAM system; Rackman (1980) suggests this could be due to heightened emotion at the time of the event and the reliance on body response systems and automatic processes. These memories are later triggered by a wide variety of sensory cues, causing the individual a great deal of distress and interference in life functioning. Brewin et al (1996) suggest re-living the trauma can move SAM to VAM as it allows the individual time to reflect and integrate information into a more logically accessible system.

Ehlers and Clark (2000) suggest that change in the negative appraisals and trauma memory is prevented by an avoidance of places, situations or reminders associated with the event and a numbing or suppression of intrusive thoughts and feelings about the event.

Support for the Ehlers and Clark cognitive model (2000) has highlighted its effectiveness at reducing trauma-related symptoms. Ehlers, Clark, Hackmann, McManus and Fennell (2005) discuss the results of a randomised controlled trial which shows that cognitive therapy using this model led to large reductions of PTSD symptoms in a group of 20 participants compared to a waiting list condition. Similar results were found by Duffy, Gillespie and Clark (2007) in a study exploring the effectiveness of cognitive therapy in the context of terrorism and civil conflict in Northern Ireland. Support for cognitive behavioural treatments specifically for female survivors of rape has been conducted recently by Resick, Williams, Suvak, Monson and Gradus (2012) who highlight the long-term effectiveness of these therapies.

The context for the work and the initial referral

Treatment was offered to Marie at a Psychological Services centre in London. The service provides therapy in both individual and group settings to clients experiencing moderate to severe mental health concerns. Therapeutic approaches used in this setting include cognitive behavioural, integrative and psychodynamic. Clients are placed on one of these waiting lists depending on their need identified at an initial assessment.

Marie was referred to our service by a local Access and Assessment team who had initially received a letter from her GP. Marie's GP had noticed that her trauma-related symptoms were not reducing and believed that she may benefit from psychological input. The Access and Assessment team had visited Marie in her home and decided that her trauma-related symptoms were moderate to severe resulting in a referral to the service in which I was based. I was provided with an assessment carried out by the Access and Assessment team and the results of the initial assessment held at my own service. This provided me with a background of what Marie had experienced.

Client's biographical details

Marie is a twenty-two year old woman. She currently lives with her mother and step father and reports a good relationship with both, her mother in particular has been

very supportive of her during her recent difficulties. She is in regular contact with her father and her sister who live separately and describes a good relationship with both. Marie works as a psychology assistant in a learning disabilities unit. She describes the work as requiring a lot of patience but she enjoys it and hopes that in time she will be able to gain a place on a clinical psychology training course. Marie is currently single but had been in a relationship at the beginning of our therapy which has since broken down. Marie reports no significant difficulties before her sexual assault and no previous mental health concerns.

Convening the first session

Marie attended our first session on time. My first impressions were of a young, pretty woman who was fashionably dressed. She was friendly but appeared reluctant to meet my smile, seeming wary. I remember wondering if she was reluctant to revisit past events again or whether she doubted that our sessions would be helpful to her.

We started by discussing whether Marie would be happy for me to record our sessions and she agreed to this. She then spoke about what had brought her to therapy and told me about her sexual assault. She recalled certain elements of her experience without emotion but I was aware of her struggling to hold back tears as she told me about the actual rape itself. Marie also told me how this event continued to impact on her life a year later.

The presenting problem

Marie stated that she had completed her undergraduate degree a year ago and decided to spend the following summer working abroad. She described how on her first night abroad she had agreed to let a man she had met that evening walk her home. She explained how this man had tried to kiss her and when she had resisted he attacked and raped her. Marie stated that she had been determined not to let the event ruin the summer that she had planned and looked forward to for so long. She stated she went to the police immediately but decided not to tell her family as she thought they would insist on her returning home. She reports not experiencing any trauma-related symptoms during this time.

Marie told me she returned to England two months later. She stated that her family noticed there was something different about her and eventually she disclosed the assault to them. She reported it was at this time the trauma-related symptoms

started to emerge; this is consistent with the DSM-5 (APA, 2013) which suggests that sometimes recalling a traumatic event serves as a reminder of the original trauma which up until this time had been suppressed. She described feeling unable to get out of bed for a two month period, experiencing frequent flashbacks and nightmares as well as intrusive thoughts about the rape. Marie reported that these symptoms had reduced by the time of our first session and she now held full time employment and engaged in a social life.

In considering Marie's case her symptoms could be clearly matched to the diagnostic criteria of PTSD described by DSM-5 (APA, 2013); of which the main three characteristics are re-experiencing, avoidance and arousal. In our first session Marie described re-experiencing the trauma in several ways, she stated she had two to three nightmares a week. She told me that the content of these dreams were of her being sexually assaulted by different men in different places, most commonly her home. She described these nightmares as being extremely distressing, lowering her mood for the rest of the day and leaving her exhausted and irritable with family and friends. Marie described flashbacks as rare, occurring approximately once a month.

Marie stated she felt low in mood most of the time and as if her personality had changed, feeling less carefree and more introverted and anxious when she was out with her friends. These symptoms met the 'negative alterations in cognitions and mood' criteria of PTSD (APA, 2013, p. 273). Marie described feeling very fearful when alone, especially around men, she had trouble sleeping and felt physically tense most of the time matching the PTSD criteria of heightened arousal (APA, 2013). To manage these fears she stated she had altered her behaviour to ensure she was never alone resulting in her feeling safer and distracted from her anxiety. This behaviour matched the PTSD criteria of avoidance (APA, 2013). She also described having trouble concentrating at work finding herself drifting off and taking a long time to complete tasks which provided further evidence of increased levels of arousal since the traumatic event.

Initial formulation

My formulation was based on the Ehlers and Clark (2000) Cognitive Model of Posttraumatic Stress Disorder. Through discussions with Marie in our early sessions I was able to identify her current difficulties (her sense of current threat) and how she was trying to manage these difficulties as well as the nature of her trauma

memory and her appraisal of what had happened all of which fitted into the Ehlers and Clark's (2000) model. I took this information and developed a formulation diagram (please see Appendix one) which I shared with Marie on our third session and asked her to take away and alter if she felt I had misunderstood or missed anything. Marie returned with two cognitions which we added to the formulation.

Current threat.

Marie's sense of current threat arose from her re-experiencing the rape through occasional flashbacks and frequent nightmares. She described several symptoms of increased arousal including feeling constantly fearful, having difficulty falling and staying asleep, struggling to concentrate at work and checking other people around her and the security of her home. Marie also described feeling generally low in mood and as if her personality had changed.

Nature of trauma memory and negative appraisals.

Marie described gaps in her memory of the night of her assault and struggled to organise the evenings events to gain a sense of the time period over which they occurred. This experience was consistent with Ehlers and Clark's (2000) model which suggested that trauma memories were often fragmented and poorly elaborated. Marie described her memories, flashbacks and nightmares as very vivid and feeling as if they were happening in the present time. Brewin et al (1996) suggested that trauma memories may be experienced in this way as they had not been integrated correctly into a verbally accessible memory system.

Marie described a number of negative cognitions about her sexual assault and her behaviour since. These appraisals included; 'I did some bad things in the past and this is my punishment'; 'the world is a risky place'; 'I should have done more to fight back, I'm physically vulnerable' and 'I should be back to normal by now' (please see Appendix two for a full list). The nature of Marie's trauma memory and her negative appraisals of the event served to maintain her sense of current threat.

Strategies to manage current threat.

Marie had been managing her trauma-related symptoms through avoidance and checking behaviours. She avoided being on her own especially during the night. When her family were away she invited friends or other family members to stay with her. On nights out she would not leave her friends even to go to the bathroom and insisted on being the first person to be dropped off on the way home to avoid being

alone on any form of transport. At times when Marie was alone, for example using public transport to get to work, she would watch men carefully, avoiding sitting next to a man and always wondering whether they had attacked anyone. Marie distracted herself from thoughts of the rape due to the fear that if she thought about it she would fall apart and return to how she felt when she initially returned home.

Marie's avoidance strategies prevented change in her negative appraisals as she never exposed herself to situations that would challenge these cognitions. Preventing herself from thinking about the event stopped her memories being integrated resulting in her continuing to re-experiencing the event through nightmares and flashbacks.

Negotiating a contract and therapeutic aims

The service in which I work offers clients 12 sessions of therapy and expects sessions to be on a weekly basis. Due to the complexity of the work with Marie my supervisor suggested that we start with 12 but leave the option open to extend the sessions if necessary. I explained this to Marie and she shared that she had attended supportive counselling on her return to England and had found it to be unstructured and unhelpful. We agreed to have regular reviews, approximately every four sessions, to ensure that our work was being of help to Marie and to plan our future sessions to ensure the therapy felt structured.

Marie's aims of therapy were to reduce the trauma-related symptoms she was experiencing, in particular to reduce her nightmares and her anxiety concerning being alone.

The Development of Therapy

The pattern of therapy

Marie attended her therapy sessions very regularly only missing one due to illness. She was often a couple of minutes late which she stated was due to having trouble with traffic or parking the car. She had shared in our early sessions that she found talking about her assault difficult and therefore I wondered if these lost minutes were due to a reluctance to go through it again. So far I have not addressed this as I did not feel it was problematic but I wonder if it would be useful to highlight this to Marie to increase her awareness of her own possibly avoidant behaviour.

We started our sessions by checking how Marie was feeling presently and how her previous week had been. Marie always kept this short apart from one session when she was distressed by the break-down of a relationship and some time was spent discussing her feelings around this. Our sessions continued by reviewing our previous work together and whether Marie had any thoughts or questions about what had been covered in our last session. We then returned to the main focus, working with Marie's trauma-related symptoms.

Our therapy sessions were all fifty minutes long and Marie made time management very easy always appearing very happy to leave. On session nine and session 12 we carried out re-living exercises and therefore extended our sessions to 90 minutes allowing enough time for the exercise to be completed and discussed and for Marie's distress to be contained as suggested by Foa and Rothbaum (1998).

The therapeutic plan and main techniques used

The therapeutic plan was guided by Ehlers and Clark's (2000) model and focused on challenging Marie's negative appraisals of her rape, reducing her re-experiencing of the traumatic event, integrating her trauma memory and reducing her avoidance and coping strategies. I followed Grey's (2009) suggestions that the key techniques used to achieve these aims were cognitive restructuring and re-living.

I had discussed with my supervisor the importance of a good therapeutic relationship working with clients who had experienced trauma due to the distressing nature of what would be disclosed and possible anxiety before and during re-living exercises. The essential nature of a safe therapeutic relationship is supported by Grey (2009) who suggests that for change in trauma-related symptoms to occur 'treatment must provide a safe environment for the client' (p. 8). In consideration of this my first priority working with Marie was to develop a relationship where she could feel safe. Westbrook, Kennerley and Kirk (2007) emphasise how displaying characteristics such as empathy and warmth can help build a therapeutic relationship working within a cognitive modality and I kept this in mind while trying to create an environment where Marie could share her experiences openly without feeling judged.

Key content issues

My work with Marie began by her explaining what had happened before, during and after the traumatic event. Through discussion I offered her some information on

trauma-related symptoms which I hoped would normalise her experience and challenge her negative appraisals of these symptoms, for example 'I should be back to normal by now'.

Due to my prioritisation of developing a safe therapeutic relationship with Marie I decided to focus on exploring her negative cognitions related to her trauma first. Through discussion we identified these cognitions and I created a separate diagram (see Appendix two). Through supervision it was highlighted to me that a number of cognitions often arose from the re-living exercise and perhaps my exploration had been premature.

Exploring Marie's negative cognitions and restructuring these took approximately six sessions. During a review Marie described finding the activity helpful and that she had been surprised by how much her thinking had changed. One of the most significant changes occurred around the belief; 'I should have done more to fight back, I'm physically vulnerable'. Marie often recalled how physically weak she had felt during the attack and how she felt as if her muscles didn't seem to work. She wondered if it was the shock of what was happening to her but this did not fit comfortably and she feared that if something similar happened in the future she would be unable to fight back. Through our discussion Marie disclosed that the perpetrator of her assault had been strangling her so hard during the attack that she had almost lost consciousness. We spoke about the physiology of human muscles, how they required oxygen to function and how therefore a deprivation of oxygen may have made her muscles weaker resulting in her being unable to physically react. We also discussed how her screaming had attracted attention, perhaps shortening her attack and probably saving her life. These discussions eradicated her previously held belief that she had not done enough to help herself.

After reviewing Marie's cognitions I introduced the idea of re-living. I gave a great deal of consideration to the use of this technique and assessed carefully the risk involved. The nature of re-living meant I was asking Marie to image herself back in a place which she had found extremely painful and distressing, there was also the risk that through the process more upsetting memories may be recalled causing more distress and Marie was already a vulnerable young woman. An assessment of these risks was carried out and the costs of the exercise weighed against the potential benefits. It was clear that Marie would find the re-living distressing but I didn't believe she was so vulnerable that this may push her to behave self-destructively,

she had reported no history of self-harm or suicidal thoughts, or to harm anyone else. I was also aware that Marie was already living with thoughts and memories of the event, we would not be searching for new information, it was present already. In addition Marie was struggling to cope, her experiences were already distressing her and allowing her the opportunity to try something that could alleviate her pain felt important.

We took a session and a half to prepare for this activity as Marie was quite anxious about completing the exercise. We explored her fears about becoming upset in the room and about the exercise actually increasing her trauma-related symptoms. I explained the rationale behind the re-living exercise, relying on Foa and Rothbaum's (1998) explanation that the activity would allow Marie to process the event and to become more habituated to the experience which would lower her anxiety. We spoke about how I could support Marie if she became upset during the exercise and how she could set time apart after our session to take care of herself.

We carried out the re-living exercise in session nine. Marie was able to talk through the rape but what also emerged was how difficult disclosing to the police and being examined at the hospital afterwards had been. She described her experiences with the emergency services as intrusive and violating, she had not been treated compassionately but as someone who was to be doubted. During the re-living I had taken notes especially focusing on the times when Marie had become most distressed as I was aware that emotional 'hotspots', as described by Grey, Young and Holmes (2002), could be points at which cognitive restructuring may be needed. I shared what I had noticed with Marie following the re-living exercise. Two main thoughts seemed to emerge; 'he is going to kill me', referring to the perpetrator of the assault and 'they don't believe me', referring to the police and hospital staff after the event. Guided by Grey et al (2002) we explored the meaning behind these thoughts in subsequent sessions and updated them in terms of what she knew today to be true. Marie decided she did not want to complete another re-living exercise in which to insert these updated thoughts and instead we decided to listen to a recording of the last re-living and stop when certain thoughts needed manually updating. Session twelve was our last meeting and we have three remaining sessions left together.

The therapeutic process

My work with Marie was the most focused and structured work I have ever completed with a client. My therapeutic approach usually adopts a more holistic view of client difficulties but Marie had a clear goal in mind, to reduce her trauma-related symptoms and was focused on achieving this goal. She rarely used her sessions to discuss anything else that was going on in her life and in this way the therapeutic process was led by meeting her goals. However, I felt that Marie relied on me for knowledge and I took the lead in guiding the content of our sessions. When asked in our reviews whether there was anything she thought we had missed or should be explored further Marie never reported anything. In time I reflected that I had never felt so close to a client without knowing very much about their general life.

An undercurrent throughout our work together was the similarities between myself and Marie. We both studied psychology and were working towards a career in the field, we were both young women who had travelled after university and we both worked in caring roles. These similarities made me aware that Marie's rape could have just as easily happened to me. This was a deeply unsettling thought, one which I became more aware of after our re-living exercise. Speaking to Marie gave me a glimpse of how fragile life was and how quickly it could change. I don't believe my thoughts hindered our therapeutic work and in some ways our similarities in ages and career interests may have strengthened our relationship. I was aware of often feeling emotionally exhausted at the end of our sessions as a result of experiencing real distress in our sessions. I believe that by recognising my own emotions I was able to be totally genuine in my empathy and on a couple of occasions I shared my own feelings to normalise Marie's emotions about what had happened to her.

I was also aware of sometimes feeling intimidated of Marie as she was an attractive, young woman who had an assistant psychologist position, a position I knew was in great demand and one I had never held. At times I wondered if Marie doubted my ability as she was aware of my position as a trainee. However, on reflection I believe these feelings arose as a consequence of my own core beliefs about myself. Marie looked to me often for guidance about what may reduce her symptoms. She trusted me to complete the re-living exercise and always completed activities that I suggested without the hint of doing so to please me, for example listening to a recording of our re-living exercise at home.

Difficulties in the work

Most of the difficulties during my work with Marie came from learning to use the Ehlers and Clark (2000) model. As mentioned previously I had decided to explore Marie's cognitions early on in our work as I believed it would allow us time to develop a good therapeutic relationship. At this time I had not referred to Grey et al (2002) and made the distinction myself or with Marie between cognitions that had emerged at the time of the traumatic event, peritraumatically, and those which had developed after the event. I believe my lack of explanation led to confusion from Marie about the role of hot spots, as described by Grey et al (2002), and how these differed from the cognitions we had challenged earlier in our work together. This confusion may have been the reason why Marie decided she did not wish to engage in the second re-living activity as she did not understand the benefit of the exercise fully. I believe if I had clearly explained the differing types of thought I would have been able to give a clearer rationale as to why the second re-living was important and Marie may have agreed to complete the exercise.

The re-living exercise created anxiety for both myself and Marie. Marie described being fearful that the experience may worsen her symptoms and I was fearful of somehow getting it wrong and causing Marie more distress. Herman (1992) states that 'avoiding the traumatic memories leads to stagnation in the recovery process' (p.176) and I kept this in mind throughout the exercise. Ultimately the activity went well and resulted in Marie experiencing a reduction in her nightmares.

Making use of supervision

Working with Marie was the first time I had undertaken trauma focused cognitive therapy and therefore I sought my supervisor's support regularly. My supervisor felt quite passionate about working with clients who had suffered trauma and was experienced in working in the area. She offered me help and encouragement before the re-living exercise and during supervision we undertook a role play ensuring I knew how to set up the exercise. My supervisor also shared some of her own experiences of completing re-living exercises with clients to help me identify hot spots and know different ways to manage client anxiety. I found this support very helpful in managing my own anxiety around completing the re-living exercise with Marie.

After the re-living exercise I debriefed with my supervisor and was aware of feeling physically and mentally drained. She encouraged me to take care of myself and

shared that these feelings were positive as they showed I was engaged and cared about my client. I also discussed with her the similarities between myself and Marie and she allowed me time and space to share this without judgement.

Changes in the formulation, therapeutic plan and therapeutic process

Marie's formulation did not change a great deal throughout our work together which was unusual as I often experience formulation and making therapeutic plans as an evolving process. I wonder if this was perhaps due to the way in which Marie engaged in our initial discussions around her trauma-related symptoms which allowed me to gain a great deal of information easily and early on about her experiences or due to the nature of our work which was very focused on one event. Marie did take the formulation diagram home after our third session and added two more negative cognitions to it; 'he will come and find me' and 'I've ruined peoples lives'.

A change in our therapeutic process occurred when Marie reported that her nightmares had started to reduce following the re-living exercise. Her relief that her trauma-related symptoms were reducing was visible from her big smile. She described feeling less irritated with others because she was getting more sleep and was able to concentrate more at work. This experience really showed me how effective re-living exercises could be in reducing re-experiencing symptoms.

As our therapy continued I started to notice changes in Marie's attitude towards her sexual assault. After the re-living exercise I became aware of how much Marie had faced on her own, not only had she survived the attack but she had tolerated the intrusive nature of the police investigation and persevered in taking the perpetrator to court. I shared these thoughts with Marie and she admitted that more recently she had allowed herself to feel proud of the way she had faced the situation and felt a more resilient person as a result. Marie had also started working with convicted sex offenders and she hoped she could help educate and support these individuals to prevent them behaving in this way in the future. Fosha (2002) states that 'we try and help our patients and ourselves become stronger at the broken places' (p. 7) and I wondered if Marie was starting to experience what Calhoun and Tedeschi (2006) refer to as post-traumatic growth; using her experiences to make herself stronger and to help others.

The Conclusion of Therapy

The therapeutic ending

At the time of writing this report I still have three more sessions of therapy remaining with Marie. Within this time we plan to explore and challenge her maladaptive coping and avoidance strategies, which despite having reduced, can still prove problematic to her. In our final session we plan to complete a review of our work together to consolidate what has been covered in our 15 sessions, to review the changes which have occurred and to ensure Marie is equipped to deal with any problems with her trauma-related symptoms that may occur in the future.

We have been considering the ending of therapy throughout our regular reviews and after the re-living exercise collaboratively decided to extend the initially allocated 12 sessions to 15 as this would allow us enough time to cover all aspects of our formulation. Through discussions with Marie we have decided she will be ready to be discharged from our service at the end of our last three sessions. She described feeling as if the reasons behind her attendance at therapy had been addressed; her trauma-related symptoms had reduced. Marie does not seem sad that therapy is ending but relieved that it has helped and that she will not need to go through what has happened to her on a weekly basis anymore.

Marie was referred to us by the local Access and Assessment team therefore a letter will be sent to her referrer briefly summarising her work in therapy to ensure they are aware of her discharge from our service. I will also copy this letter into Marie's GP as more help may be needed from them by Marie in the future.

Evaluation of the work

Being guided by an unfamiliar model has been challenging but has allowed me to learn and consider how I may work within this framework in the future. In the future I believe it would be helpful to make the distinction between thoughts occurring during the trauma and thoughts which developed after the trauma. I believe offering Marie this distinction would have helped her to understand her cognitions and which needed to be updated or reframed.

During our work Marie felt able to share her traumatic experience with me and we have both worked hard to implement change. Marie's nightmares started to reduce after our re-living exercise which was a significant step in her recovery. Following this exercise she reported gaining a greater amount and a better quality of sleep

resulting in her being less irritable with family and friends and being able to concentrate on tasks at work. Noticing these changes has improved Marie's mood and challenged her fears that her personality had permanently changed as a result of her assault. I believe these changes have created a good foundation for Marie to continue to move forward with her life.

Together we have discussed how Marie may feel when the perpetrator of her assault is released from prison and how she may cope at this time. At the moment she finds the idea very frightening and therefore it is possible that she may seek further therapeutic support at this time.

Personal learning

I have learnt a great deal about psychotherapeutic practice and theory through working with Marie. I now have practical experience of implementing Ehlers and Clark's (2000) Cognitive Model of PTSD whereas before I held only a theoretical knowledge. I have experience of offering a client a formulation from this model and explaining how maladaptive coping strategies can often exacerbate trauma-related symptoms. Providing a rationale has been very important in my work with Marie and sometimes this has been challenging due to limitations in my own knowledge base. This has encouraged me to read more and compile an information sheet as well as using analogies to make the rationale for interventions more accessible to clients.

Learning how to rationalise, explain and conduct a re-living exercise has been a new experience. I have also become aware of practical aspects of this activity such as allowing more session time and finding an appropriate place which is quiet and private. Although Marie did not become extremely distressed or dissociate throughout the re-living exercise I had prepared some grounding exercises in case of these situations occurring. Being able to manage Marie's distress while still encouraging her to engage in the re-living exercise and probing for thoughts and feelings was challenging and often meant fighting my own instincts to alleviate suffering and offer comfort. In the future I believe I would feel much more confident to promote re-living exercises as the longer-term benefits for Marie have been very beneficial.

I have found Ehlers and Clark's Cognitive Model of Posttraumatic Stress Disorder very effective. The combination of cognitive re-structuring and the re-living exercise allowed changes in both memory and cognition and these changes appear to have

been very beneficial to Marie. Although guided by the model I did not abide by all of its features. I did not use subjective unit of distress scales (SUDS) while completing the re-living exercise instead relying on my own judgement to identify periods of heightened emotion from which I could locate hotspots in Marie's thinking. The decision not to use SUDS was based on a belief that there may be too much to think about both for myself and Marie. However, in future I would consider using these scales to confirm my own judgements about levels of distress. This model offers a very detailed and prescriptive way of working with PTSD and I wonder whether some flexibility using this approach is necessary, for example Marie's trauma-related symptoms had virtually disappeared following her first re-living exercise suggesting there was little need for a second. Perhaps this is where a counselling psychologist needs to use their judgement and as with all models tailor them to the individual needs of the client and refer to them as guidance.

Through my work with Marie I have made full use of supervision. I have at times felt emotionally exhausted after listening to her describe her assault, this was especially true following the re-living exercise. This experience has shown me how important supervision and support is for working with survivors of trauma as without being able to share my distress and at times horror with another person would have left me feeling very overwhelmed and would have eventually impacted on my work with Marie.

I have found working with Marie enjoyable and rewarding and feel very pleased that our therapy has been effective and her trauma-related symptoms have reduced. I have always been attracted to working with people recovering from traumatic experiences. My work with Marie has confirmed that I do feel passionately about working with this client group in the future and has reassured me that with support from a good supervisor I have the resources to support people in this situation.

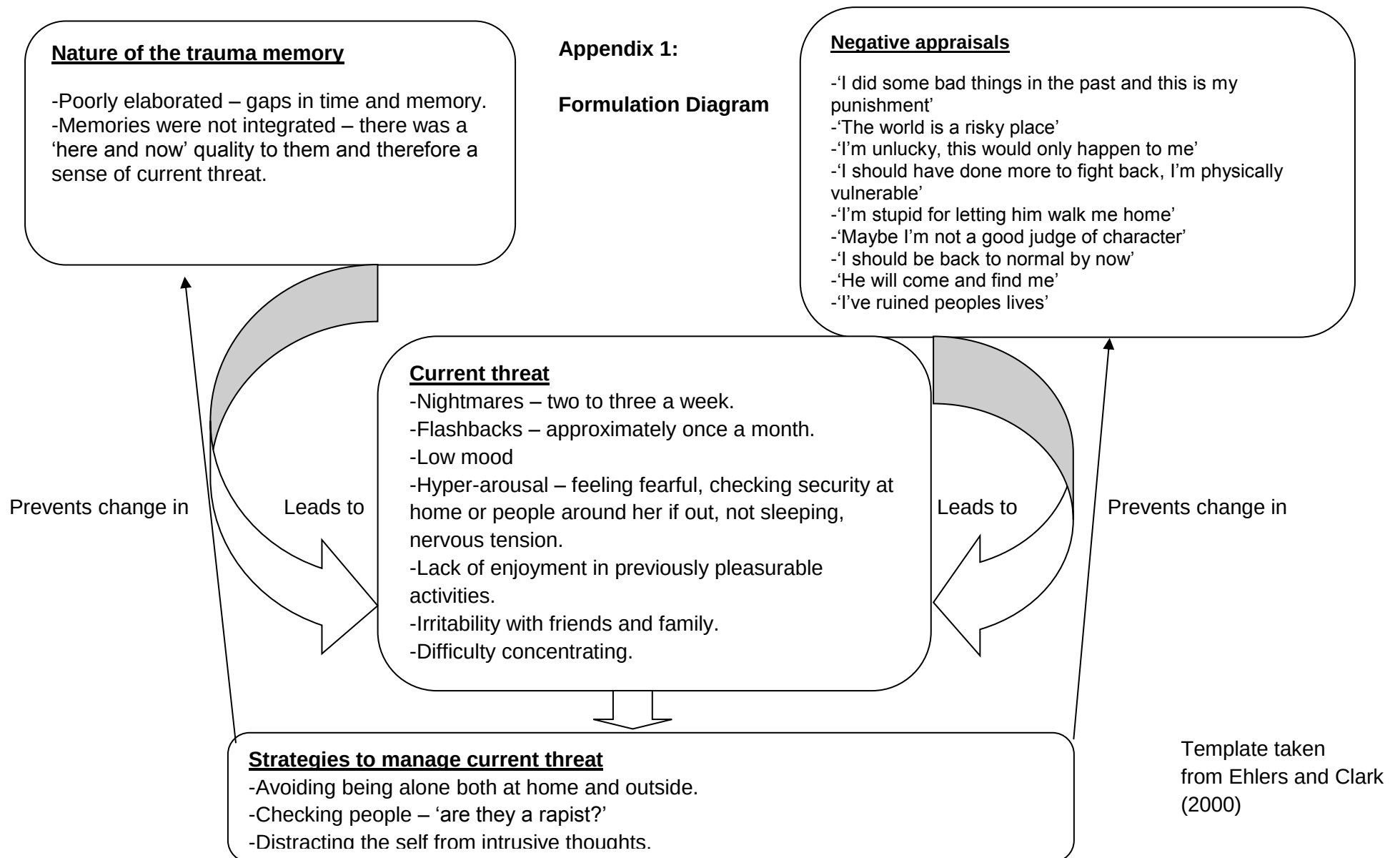
As a trainee counselling psychologist I often have doubts about my ability and I believe in the past this has often prevented me from trying new approaches or techniques with clients due to a fear that I may do something wrong. These fears have been activated by my work with Marie, I was very concerned about making a mistake during our re-living exercise, that I would miss something or that I would cause Marie harm through distressing her. I was not congruent with Marie and did not share these concerns perhaps because I already sensed her own concerns that therapy wouldn't work. Despite my fears I followed the model and tried to accept

myself as a 'good enough' therapist who was learning. This experience has been positive and I feel more confident in using this model again in the future. I also feel more confident of my own ability to try new approaches or techniques which I believe will only help to improve what I can offer my clients.

References

- American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington: American Psychiatric Publishing.
- Brewin, C.R., Dalgleish, T., & Joseph, S. (1996). A dual representation theory of posttraumatic stress disorder. *Psychological Review*, 103, 4, 670-686.
- Brewin, C.R., & Holmes, E.A. (2003). Psychological theories of posttraumatic stress disorder. *Clinical Psychology Review*, 23, 339-376.
- Calhoun, L.G., & Tedeschi, R.G. (Eds.). (2006). *Handbook of posttraumatic growth: Research and practice*. Mahwah, NJ: Lawrence Erlbaum.
- Duffy, M., Gillespie, K., & Clark, D.M. (2007). Posttraumatic stress Disorder in the context of terrorism and other civil conflict in Northern Ireland: Randomised controlled trial. *British Medical Journal*, 334 (7604), 1147.
- Ehlers, A., & Clark, D.M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, 38, 319-345.
- Ehlers, A., Hackmann, A., & Michael, T. (2004). Intrusive re-experiencing in post-traumatic stress disorder: Phenomenology, theory and therapy. *Memory*, 12, 4, 403-415.
- Ehlers, A., Clark, D.M., Hackmann, A., McManus, F., & Fennell, M. (2005). Cognitive therapy for post-traumatic stress disorder: development and evaluation. *Behaviour Research and Therapy*, 43, 413-431.
- Foa, E.B., Rothbaum, B.O., Riggs, D.S., & Murdock, T.B. (1991). Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive-behavioural procedures and counselling. *Journal of Consulting and Clinical Psychology*, 59, 5, 715-723.
- Foa, E.B., & Rothbaum, B.O. (1998). *Treating the trauma of rape, Cognitive-behavioural therapy for PTSD*. New York: The Guildford Press.
- Fosha, D. (2002). Trauma reveals the roots of resilience. *Constructivism in the Human Sciences*, 6, 1&2, 7-15

- Grey, N., Holmes, E., & Brewin, C.R. (2001). Peritraumatic emotional 'hot spots' in memory. (2001). *Behavioural and Cognitive Psychotherapy*, 29, 367-372.
- Grey, N., Young, K., & Holmes, E. (2002). Cognitive restructuring within reliving: A treatment for peri-traumatic emotional 'hotspots' in posttraumatic stress disorder. *Behavioural and Cognitive Psychotherapy*, 30, 37-56.
- Grey, N. (Ed.). (2009). *A casebook of cognitive therapy for traumatic stress reactions*. London: Routledge.
- Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.
- National Institute for Health and Clinical Excellence. (2005). *Quick reference guide. Post-traumatic stress Disorder (PTSD). The management of PTSD in adults and children in primary and secondary care (CG26)*. London: National Institute for Health and Clinical Excellence.
- Rackman, S. (1980). Emotional processing. *Behaviour Research and Therapy*, 18, 51-60.
- Resick, P.A., Williams, L.F., Suvak, M.K., Monson, C.M., & Gradus, J.L. (2012). Long-term outcomes of cognitive-behavioural treatments for posttraumatic stress Disorder among female rape survivors. *Journal of Consulting and Clinical Psychology*, 80, 2, 201-210.
- Schore, A.N. (2010). The right brain implicit self: A central mechanism of the psychotherapy change process. In J.Petrucci (Ed.), *Knowing, not knowing and sort-of knowing, psychoanalysis and the experience of uncertainty* (pp. 117-202). London: Karnac books.
- Westbrook, D., Kennerley, H., & Kirk, J. (2007). *An introduction to Cognitive Behaviour Therapy*. London: Sage.



Template taken
from Ehlers and Clark
(2000)

Appendix 2: Negative Cognitions

The first quotes in each bubble were Marie's initial thoughts.
The second quotes are Marie's reframed beliefs.

