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Walden University

College of Social and Behavioral Health

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Jacqueline Nelson

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Walden University
2024

Abstract

The Experiences of Counselors Who Treat Persons with Dissociative Identity Disorder

by

Jacqueline Nelson

MA, Liberty University 2014

BA, University of Houston 2009

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

February 2024

Abstract

At least 1 in 20 American adults will experience the misdiagnosis of dissociative identity disorder (DID), and this number equates to about 5.08% or 12 million U.S. adults who will experience diagnostic errors specifically to DID. The purpose of this study was to collect qualitative data to examine the experiences of counselors who provide mental health services to clients who have been diagnosed with DID. Eight licensed mental health professionals were interviewed and their lived experiences working with DID and complex trauma were explored. The purpose of this Interpretative Phenomenological Analysis study used a hermeneutical approach to find and highlight specific reasons for misdiagnoses and provide resolutions and answers to the problem. A Trauma Informed Care approach was used to explore the lived experiences of the clinicians and to determine the causes for misdiagnoses. Four major themes were identified after coding the narrative data. Themes included academic unpreparedness, experts' postgraduate education and training experiences, recommended trainings for postgrad counseling students, and challenges treating DID. The findings in this study revealed positive social change implications which include contributing to the knowledge base about the process of educating counselors differently and more efficiently enabling them to diagnose and treat complex trauma and DID. Findings may also add insight on academic changes. Using study findings, mental health providers may be able to develop academic enhancements to better prepare counselors to treat DID. While the sample was limited in size and scope, the study results potentially added to the current limited body of research on DID and provided some direction for future research.

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Dedication

I would like to dedicate this body of work to my children, Jillian L. Thomas and Darryl J. Thomas, Jr. All my work and sacrifices have been supported by you both. Thank you for being patient with me and encouraging me to move forward through this process. Thank you for being the best kids ever, freeing me from having to deal with anything negative or chaotic in our lives due to your good behaviors at home and at school. I would not have accomplished this task if I would have had to deal with unruly or troubling children. I also dedicate this work to my dearest friend, Angella B. Christie, who has been a constant, dedicated, strong, and loving force in my life throughout this entire process. Your words of support, wisdom, and guidance have been a constant foundation for me. Thank you for your love. I also dedicate this work to my parents who were a constant example of excellence for me to emulate and have always supported higher learning.

Additionally, the findings in this research are dedicated to the participants who generously gave their time and personal stories to this project. Your experiences along with my own strengthen me to continue to push harder in all my endeavors. Thank you for the rich information you provided, for which this study could not have been completed.

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First and foremost, to my heavenly Father who has made all things possible and who has enabled and sustained me throughout this journey, thank you.

It has been a long, challenging, and unpredictable journey. As this journey comes to a close, it is evident to me that I have not walked it alone. There were many people for whom I am truly grateful for their pleasant distractions, which made this process a little easier. Thank you to my family who has supported me throughout. To my daughter, Jillian, and my son, Darryl, I thank you explicitly for listening and encouraging me through the tough times. To my parents and my closest friend, Angella, who encouraged me and expressed their faith in me from the beginning of pursuing my doctoral degree. My father died during this process, and my mom transitioned into a mental state of Alzheimer's, so neither will be able to see my hooding ceremony, but I know they would be proud of all my accomplishments. I thank you all with all my heart.

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Chapter 1: Introduction to the Study

Introduction

Dissociative identity disorder (DID) is a complex and challenging disorder derived from prolonged traumatic experiences. Schimmenti and Caretti (2016) reported that dissociation connects the overpowering with the insupportable; it inextricably binds the experiences of abuse, neglect, and disrupted communication with attachment figures during childhood with the development of unbearable self-experiences that cannot be integrated into the consciousness and therefore continue to disturb the individual throughout their entire life. The unique complexity of this disorder also produces misunderstanding, misdiagnosis, and a misrepresentation of the individuals' true personality. DID is a mental disorder characterized by at least two distinct and relatively enduring personality states. Individuals with this disorder experience memory gaps beyond what would be explained by ordinary forgetfulness.

DID was also known as multiple personality disorder (MPD) up until 1994, when the name was changed to reflect a better understanding of the condition—namely, that it is characterized by a fragmentation or splintering of identity, rather than by a proliferation or growth of separate personalities. DID is one of the most controversial psychiatric disorders, with no clear consensus on diagnostic criteria or treatment (Brand et al., 2014). The *Diagnostic and Statistical Manual* (DSM-II 1968) used the term hysterical neurosis dissociative type. It described the possible occurrence of alterations in the patient's state of consciousness or identity and included the symptoms of amnesia, somnambulism, fugue, and multiple personalities (American Psychiatric Association,

1968; Brand et al., 2014). The DSM-III (1980) grouped the diagnosis with the other four major dissociative disorders (DDs) using the term MPD (American Psychiatric Association, 1980). A dissociative disorder is a generalized term to describe a loss of connection between thoughts, memories, feelings, surroundings, behaviors, and identity. The DSM-IV-TR (2000) made more changes to DID than any other dissociative disorder and renamed it DID. The name was changed for two reasons: (a) The change emphasized that the main problem is not a multitude of personalities but rather a lack of a single, unified identity and an emphasis on "the identities as centers of information processing;" and (b) the term "personality" is used to refer to "characteristic patterns of thoughts, feelings, moods and behaviors of the whole individual," while for a patient with DID, the switches between identities and behavior patterns is the personality (American Psychiatric Association, 2000; Spiegel et al., 2013, p. 74). DID is associated with overwhelming experiences, traumatic events, or prolonged abuse that occurred in childhood. More specifically, Spiegel et al. (2013) have provided this information about DID:

> Symptoms of dissociative identity disorder (which are the criteria for diagnosis) include the following: the existence of two or more distinct identities (or "personality states"); the distinct identities are accompanied by changes in behavior, memory, and thinking; the signs and symptoms may be observed by others or reported by the individual; ongoing gaps in memory about everyday events, personal information, and/or past traumatic events; and, the symptoms

cause significant distress or problems in social, occupational, or other areas of functioning. (p. 292)

In addition, the disturbance must not be a normal part of a broadly accepted cultural or religious practice. As noted in the DSM-5 (2013), many cultures around the world, experiences of being possessed are a normal part of spiritual practice and are not DDs (American Psychiatric Association, 2013). People who have experienced physical and sexual abuse in childhood are at increased risk of DID. The majority of people who develop DDs have experienced repetitive, overwhelming trauma in childhood. Among people with DID in the United States, Canada, and Europe, about 90% have been the victims of childhood abuse and neglect (Brand et al., 2014). In addition, suicide attempts and other self-injurious behavior are common among people with DID. More than 70% of outpatients with DID have attempted suicide (Brand et al., 2014).

However, misdiagnosis often occurs when evaluating individuals with DID. The findings of misdiagnosis increase the need for accurate and timely diagnoses to minimize suffering. Brand et al. (2012, 2013, 2014) detailed how people with DID are often misdiagnosed as having schizophrenia, because their belief that they have different identities could be interpreted as a delusion. They sometimes experience dissociated identities as auditory hallucinations (i.e., hearing voices). Their symptoms do not improve with antipsychotic medication, but the emotions they display become flatter. Because patients are often led to believe that they have schizophrenia, this can cause ineffective increases or decreases in the administration of medication. Another common

misdiagnosis is borderline personality disorder. Moreover, people with DID frequently also have depression, which can lead to diagnoses of depression.

Sagan (2019) presented a case study of a DID patient who shared their disappointment with their treatment. They said they were seen by more than six different therapists. Their journey to diagnosis had been turbulent. They stated, “Oh, lots, lots, and lots of comings and goings, changing opinions, different people with different views each time I’d be told I had something else and each time I’d feel less like anyone or anything” (Sagan, 2019, p. 25). They indicated that some discontinuity with therapists during and following diagnosis was a “downer” for them, with a reluctance at times to engage. They further indicated, “It was really hard, at the beginning…and now, really to engage with therapy that was about the parts being let down by people” (Sagan, 2019, p. 25). Additionally, Sagan further established the need for educated and trained clinicians in the knowledge, diagnosis, and treatment of DID.

Dorahy (2017) explained how the International Society for the Study of Trauma and Dissociation (ISSTD) has existed for more than 34 years and has focused on the intense study and treatment of persons suffering from DID. This organization has fought for the rightful identity and professional recognition of the existence of child abuse and organized perpetrator abuse, especially that involving satanic rituals and DDs. Dorahy further proclaimed that the fight has moved from conferences and the pages of journals to courtrooms, politically charged professional schisms, and personal attacks (e.g., the picketing of therapists’ offices, removal from or nonrenewal of academic appointments, and orchestrated media defaming). If people accept, rather than compartmentalize, the

fact that as a society they are capable of compassion, mistakes, humanity, cruelty, thoughtfulness, ineptitude, collectivism, determination, indifference, optimism, hubris, concern, narcissistic vulnerability, courage, shame, and genuine generative and shared pride, their past and present will not fall under the stability-weakening fissures of dissociation (Dorahy, 2017). Their identity will incorporate the pain, shame, fear, determination, and scars of lived experience and known inherited experience, along with the forward-focused exuberance of unknown inherited experience, to create a more flexible, freely operating international society that can respond spontaneously to present crises and plan advancements and expansion to better serve patients and the scientific field they represent (Dorahy, 2017). The society's growth can bloom from a fully acknowledged past. Thus, the importance of the work that is being done with DID patients is paramount and necessary for the furtherance of accurate diagnoses and effective treatment for these patients. Counselors should be equipped with knowledge, training, and experience in the areas of diagnostic and treatment of patients with DID.

Kumar et al. (2019) explained that in forensic cases, misdiagnosis may have serious ramifications. These researchers further explained counselors who have not been adequately trained in assessing and diagnosing trauma-related disorders could erroneously classify an individual who has experienced severe trauma as malingering, which could contribute to the person receiving a considerably harsher sentence and possibly even the death sentence. Kumar et al. affirmed that a lack of training is problematic because failing to recognize the symptoms could result in an inability to effectively treat these individuals, causing further harm. Unprepared counselors could

harm the patients' success and possibly cause vicarious traumatization and secondary traumatic stress due to a lack of training and proper preparation.

Kumar et al. (2019) confirmed that at the time of their publication, only 21% of postdoctoral or graduate internships across the United States (i.e., 171 out of 800) offered specialized training in trauma, posttraumatic stress disorder (PTSD), or sexual abuse and their treatment. Although some specialized classes were offered, they still did not adequately prepare students to treat persons with DID. Kumar et al. further asserted that most students had to independently seek education in trauma and its treatment by gathering professional literature and by attending conferences, workshops, and seminars.

The ISSTD (2011) offers extensive training in the study of trauma and DDs. Misdiagnosis is dangerous and traumatic for the patient, community, family members, and society. This has the propensity to create a public health crisis. My study addressed the serious ramifications that counselors' misdiagnoses can cause personally, professionally, and socially for clients with DID. In this chapter, I also include the overall framework for the study, including definitions, methodology, assumptions, limitations, delimitations, and the study's significance.

Background

The ISSTD (2011) reported that clients with DID spend on average of 5 to 11.9 years in the mental health system before they are ever diagnosed with DID. Several epidemiological studies have revealed that DID may have been previously under diagnosed, and many clients were receiving outpatient treatment without the benefit of a correct diagnosis (Foote et al., 2006). Misdiagnosis of DID is harmful and problematic

for client's due to the extended length of time and cost of counseling including hospitalization (Park, 2012). In their research, Brand et al. (2012) studied 36 experienced clinicians who were required, during their academic training, to have at least 9 years of experience working with DID patients. Outcomes from this study supported the need for specialized training in the detection, diagnosis, and treatment of DID. Floris and McPherson (2015) affirmed that there are no current guidelines for working with DID patients, which means there are no best practices for treating individuals with DID.

At least 1 in 20 American adults will experience the misdiagnosis of DID, and this number equates to about 5.08% or 12 million adults from the United States (U.S.) who will experience diagnostic errors specifically to DID (Singh et al., 2014). These findings are targeted to individuals with DID. This misdiagnosis is closely related to clinician incompetence. Diagnostic errors pose an important threat to healthcare quality and safety in outpatient settings (Singh et al., 2014).

Because DID is a trauma-based disorder, it is imperative that counselors be aware of this and other trauma-related disorders. About 71% of clients with DID have experienced childhood abuse, and 74% have experienced sexual abuse (Jacobson et al., 2015). The Counsel for Accreditation of Counseling and Related Educational Programs (CACREP) counseling standards in Section 5 (Clinical Mental Health Counseling) indicated the need for competence in trauma-related disorders (CACREP, 2016). The standards do not require that counselor training programs offer specific courses in trauma-based disorders and do not recommend how to structure preparing students to counsel persons with DID (CACREP, 2016).

Established in 1981, CACREP is the accreditation body that consists of standards to promote excellence in professional preparation through the certification of counseling and related educational programs. However, a lack of adequate education in DDs still exists (Jacobson et al., 2015). CACREP's mission is to promote the competence of practitioners. The most problematic area in counseling is counselor inexperience and lack of education (Jacobson et al., 2015). It requires a skillful counselor to notice the signs of DID. Descriptions of both diagnostic and therapeutic procedures show that counselors who are skilled in treating individuals with DID actively probe for alters, for example by asking if someone else is speaking when a patient reacts or talks a bit differently than usual (e.g., more assertive; Kluft, 2005). Controversy still exists suggesting that DID is an iatrogenic condition caused by medical examination or treatment (Floris & McPherson, 2015). However, research has shown that this is a legitimate disorder, albeit controversial and embarrassing for the individual.

The estimated lifetime prevalence of DDs in both clinical and community populations is 10%, and DID is estimated at 1 to 3%, making DID as prevalent as schizophrenia and bipolar disorder (Şar, 2011). Additionally, a meta-analysis by Dalenberg et al. (2012) revealed that a strong relationship between trauma and dissociation, even when trauma was objectively verified via court and medical records. One of the most significant difficulties in accurately diagnosing DID, especially by professionals with little training or experience in assessing dissociation, is that patients with DID typically manifest cross-cutting symptoms found in other disorders, most

notably schizophrenia, bipolar disorder, posttraumatic disorder, and substance use disorders (Brand et al., 2016).

Ongoing education and supervision are the key elements in decreasing misdiagnoses and increasing effective treatment for individuals with DID. Greene et al. (2018) mentioned that a part of being invested in clients with DID involves pursuing continuing education about DID to be able to use more techniques (i.e., having a more comprehensive methodology). In the study by Greene et al. the participants relied on education and maintained a broad scope of awareness and knowledge. Participants who were mental health professionals also pointed to having a passion for the population as necessary in providing best practices for clients with DID. That passion helps counselors to keep going despite frustrations and the length of treatment necessary to help those with DID. This type of investment of both personal time and professional development requires a lot of motivation, passion, and commitment from counselors who work with DID clients (Greene et al., 2018).

Despite an increase in empirical inquiry regarding persons with DID, the literature is limited when it comes to describing the lack of education, training, and experience of counselors working with DID patients. Furthermore, there is relatively little known about how to accurately diagnose the disorder and how to develop a definitive treatment plan to bring a person to full integration. Previous research has supported the need for counselors to have a better understanding of individuals with DID and other trauma-related disorders. Schimmenti and Caretti (2016) alleged the counselor's ability to recognize the dissociative symptoms, the extent of the unintegrated mental and bodily states, and the

developmental and relational processes that led a patient to organize this or their mental and behavioral functioning around pathological dissociation can make all the difference in the outcome of many treatments.

Problem Statement

DID is a psychobiological response to traumas suffered in a specific time frame in early childhood and is associated with a complex posttraumatic stress syndrome (Brand et al., 2014). The development of DID occurs when an important childhood development – the framing of a central, integrated consciousness -- is impeded or prevented by chronic trauma (Brand et al., 2014). The trauma causes the child to use drastic denial tactics and splitting to cope with the traumas. These coping mechanisms are carried into adulthood and lead to DDs. According to the DSM-5 (2013), DID is a disorder characterized by the presence of two or more identities or personality states that recurrently take control of the individual's behavior accompanied by the inability to remember important personal information (Brand et al., 2014; Kluft, 2005). Traditional clinical interviews, instruments, and assessment tools have failed to explore dissociative phenomena in depth, but these instruments, interviews, and assessments still provide crucial data (Kluft, 2005). Questionnaires and assessments, designed to help clinicians diagnose DID can be subjective at best (Pietkiewicz et al., 2021).

The dissociative experiences scale, the shutdown dissociation scale, Steinberg depersonalization test, the dissociative disorders interview schedule (DDIS), the dissociation questionnaire, the somatoform dissociation questionnaire along with clinician administered interviews all assist with the initial screening of a patient with DID

but are not effective in lieu of a clinician's experience and knowledge (Pietkiewicz et al., 2021). A new semi-structured interview called the trauma and dissociation symptoms interview was intended to identify DSM symptoms. However, patients often struggle with expressing their symptoms, thoughts, and feelings. The trauma and dissociation symptoms interview used for collecting clinical data about trauma-related symptoms and dissociation has not been validated to date (Pietkiewicz et al., 2021).

The prevalence of the misdiagnosis of DID is problematic and harmful for clients because the misdiagnosis causes an extended length of time in counseling and increases the cost of counseling and hospitalization (Park, 2012). More than 20% of all DID patients exhibit clear-cut indications of DID, and the other 80% exhibit some indications of diagnosability, revealing classic features of DID (Kluft, 2005). The researcher further articulated that DID has been misdiagnosed and underdiagnosed for decades due to clinician error or because the patient may be intertwined in a personality state that either does not have access to or will not share the data necessary for the diagnosis to be suspected or made.

Aside from clients hiding symptoms, counselor competence has been the primary reason noted for misdiagnoses and underdiagnoses (Brand et al., 2014). Historically, psychiatrists and psychologists have been the mental health professionals who have treated DID patients. However, more and more counselors are seeing clients with DID. Because of this increase, counselors need additional education, preparation, and knowledge about DID. Still, counselors lack education, training, and experience in the diagnosis and treatment of DID (Park, 2012).

Minimizing the misdiagnosis of DID could lessen the harm inflicted on clients and promote a healthier and more wholesome life for sufferers. Because the symptoms of trauma are so closely paralleled with symptoms of DID, clinicians have erred in making a proficient diagnosis of DID patients (Brand et al., 2014). Hence, it is imperative that counselors gain appropriate education, preparation, and knowledge of how to diagnose and treat clients with DID.

Compared to individuals with DID, trauma survivors are a distinct population of clients who need expert knowledge and multidimensional attention from counselors (Jones & Cureton, 2014). The 2016 CACREP Standards mandate across both master's and doctoral training phases the significance of understanding the consequences of trauma theory, research, and practice in counselor preparation and eventually practice. Even though the 2016 CACREP Standards incorporate trauma training within all eight core curricular areas; according to CACREP, not enough specialized instruction and demonstrated knowledge are required within each core-counseling track. Section II, Professional Identity, says that counselors should understand the "effects of ... trauma-causing events on persons of all ages" (CACREP, 2016, p. 11). However, counselors still complain that they lack adequate training in this area (Jones & Cureton, 2014). More than 60% of working mental health professionals have conveyed the desire for additional support and education in their trauma work (Cook et al., 2017). Trauma theorists have agreed that, except for DID, no other diagnostic condition in the history of the DSM has produced more debate about limitations of the condition, symptomatological profile, central suppositions, clinical efficacy, and occurrence than DID (Cook et al., 2017). To

address this problem, I explored with counselors the educational processes and experiences that could provide counseling students with appropriate training and preparation for diagnosing and treating persons with DID.

Kumar et al. (2019) reported that the academic training programs for mental health professionals rarely include comprehensive instruction on trauma, consequently leaving clinicians inadequately prepared to provide trauma treatment, specifically DID treatment. The researchers learned that 68% of the participants stated they were not adequately trained to assess trauma, and 75% stated they were not adequately trained to treat trauma. Ten percent stated they had not been trained in complex trauma, and 30% stated they had not been trained in treating patients with dissociative symptoms, specifically DID (Kumar et al., 2019). Society is experiencing an alarmingly high rate of systematic, intense, and severe trauma. Kumar et al. revealed that over 70% of individuals worldwide will experience a traumatic event at some point in their lives, and exposure to multiple event types is most common. Those who have experienced multiple and repetitive traumatic events, known as complex trauma, will suffer with a wider range of symptoms and polarities. Despite an exhaustive literature review, I did not find any research that explored the clinician's education, preparation, and knowledge of how to diagnose and treat clients with DID.

Purpose

The purpose of this interpretative phenomenological analysis (IPA) qualitative research study was to explore the lived experiences and training of counselors to help with both the diagnosis and treatment of clients with DID. The problem was that

counseling programs have not adequately prepared counselors to work with clients with DID (Cook et al., 2017). The reason for this study was to determine what experienced counselors believe is the essential training needed for those who treat people with DID, what skills are needed, and what these counselors do that works for this population. This research was designed to have counselors who work with clients with DID provide input on improving the education and training of counselors who will provide services to individuals with DID. These counselors provided me with information regarding the training they received, how they diagnosed the disorder, and their approach to treating individuals who have the disorder. I explored with participants the educational processes and experiences that could provide counseling students with appropriate training and preparation for diagnosing and treating persons with DID.

Research Question

What are the lived experiences of counselors who are experienced in providing accurate diagnostic and treatment services to individuals with DID?

Theoretical Framework

When using theory in a study, the researcher looks for explanations of why and how events occur (Creswell, 2014). Theory is applied differently, depending on which method a researcher chooses to employ. Qualitative researchers use theory as a broad explanation and a theoretical lens (Creswell, 2014). According to Smith et al. (2009), IPA is a popular conceptional framework that focuses on examining how individuals make meaning of their life experiences and conveys a detailed analysis of their personal

understanding followed by a presentation and discussion of the common experiential themes.

IPA is a compilation of phenomenology and hermeneutics (Smith et al., 2009). These researchers derived their work from Heidegger, who posited that the interpretative phenomenological approach searches for essential aspects of an experience by examining and explaining the thematic meanings or common structures of a phenomenon (Smith et al., 2009). Through this method of study, I examined and explored the lived experiences, education, preparation, and practices of clinicians who were experienced and successfully work with clients with DID.

IPA was the best approach for my study because it ensured trustworthiness, analysis was shared between researcher and participant, in-depth discussions were facilitated, researchers' perspectives were decreased, and participants' descriptions and assumptions were highlighted. Rodham et al. (2015) indicated when using the IPA approach, understanding of someone else's worldview or experience(s) is inescapably influenced by the researcher's own experiences, values, and preunderstandings. This process is known as the double hermeneutic: a researcher trying to make sense of the participants, trying to make sense of their own experience in the interview. The IPA approach is informed by hermeneutics (i.e., the theory of interpretation), positing that humans are sense-making creatures, and so the interpretations they share will reflect their attempts to make sense of their experience. The researcher takes on a dual role by engaging in the same sensible skills and abilities as the participants, but the researcher does so more consciously and systematically (Rodham et al., 2015). Trustworthy,

reliable, and valid analysis demands a close relationship between analyst and the text, and that the researcher needs to make use of their own interpretative resources.

The goal of an IPA researcher is to identify themes to ensure that each theme is represented in the transcripts being analyzed and is not a product of the researcher's over-interpretation (Rodham et al., 2015). The IPA approach is complex and challenging because its premise says there is no right or wrong way of conducting this sort of analysis. The IPA approach is a creative process but is also a flexible and fluid method, which pushes the boundaries in gathering the details of the experience while also maintaining the trustworthiness of the analysis. IPA was helpful here because of the painstaking attention it gave to enabling the participant to recount as full an account as possible of their experience.

The IPA also uses bracketing to prevent the researchers' perceptions from tainting the interpretations. Bracketing is the process of suspending judgment about the natural world to instead focus on the analysis. I refrained from using personal opinions or experiences to interpret the data. In interpretative phenomenology, previous knowledge is used intentionally to create new understanding. Bracketing entails researchers setting aside their preunderstanding and acting nonjudgmentally during qualitative interviews. The IPA approach considers the researcher's professional position, background, worldview, gender, education, and experiences because they can influence the analysis of the data (Rodham et al., 2015).

The transparency of the coding process is essential in presenting the analysis in an unbiased and objective perspective. Researchers must engage in reflexivity and become

mindful of their role in the creation of knowledge. This is done by self-monitoring the impact of their biases, beliefs, and personal experiences on the research (Rodham et al., 2015). Reflexivity is defined as the active acknowledgement by the researcher that their own actions and decisions will inevitably have an impact on the meaning and context of the experience under investigation (Rodham et al., 2015). Similarly, Shaw (2010) described reflexivity as a precise assessment of the self. In other words, the process of reflexivity is an essential part of engaging with the double hermeneutic and rather than putting to one side (i.e., bracketing) one's preconceptions, the focus is on becoming aware of them and their potential influence. An IPA researcher is said to engage in double hermeneutic in that the researcher is making sense of the participants' sense making. The researcher assumes a central role in analysis and interpretation of the participants' experiences.

I used a thematic coding process in this study. Thematic coding is a form of qualitative analysis that involves recording or identifying passages of text or images that are linked by a common theme or idea allowing researchers to index the text into categories and therefore establish a framework of thematic ideas about it (Gibbs, 2007). Coding is the process of labeling and organizing qualitative data to identify different themes and the relationships between them. When coding participants' responses, I assigned labels to words or phrases that represent important (and recurring) themes in each response. Those labels can be words, phrases, or numbers. Words or short phrases appear to be easier to code because they are easier to remember, skim, and organize. Coding qualitative research to find common themes and concepts is part of thematic

analysis, which is part of qualitative data analysis. Thematic analysis extracts themes from text by analyzing the word and sentence structure.

I used a form of thematic coding called narrative analysis. Some qualitative data, such as interviews or field notes, may contain a story. For example, there is the process of choosing a product, using it, evaluating its quality, and decision to buy or not buy this product next time (Gibbs, 2007). Narrative analysis helps researchers understand the underlying events and their own effect on the overall outcome. I manually coded my qualitative data using reoccurring themes and comparing each participants' responses.

In my study, I also used trauma-informed care (TIC) as a theoretical framework. Van der Kolk is the author of TIC in behavioral health services, developed in the 1970s. TIC started in medicine, as an approach to patient care that takes trauma into account when diagnosing and treating individuals. It had its genesis in patient care in the 1970s, when the physical and mental traumas experienced by Vietnam War vets necessitated it.

For the best practices and lived experience of counselors who work with clients with DID, I used TIC to explore themes and common occurrences. A trauma-informed approach is a promising model for organizational change in health, behavioral health, and other settings that promotes resilience in staff and patients (Conover et al., 2015). A trauma-informed approach views presenting problems as maladaptive coping and regards trauma not as a distinct event but as a framework for understanding experiences that can define and deeply affect the core of a person's identity (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). The three key elements in this approach are (a) realizing the prevalence of trauma; (b) recognizing how trauma affects

all individuals involved with the program, organization, or system, including its own workforce; and (c) responding by putting this knowledge into practice (SAMHSA, 2014). This theory was the best approach because DID is caused primarily by traumatic events in an individual's life. Trauma-informed approaches assume the realization about trauma and how it can affect people and groups, recognizing the signs of trauma, having a system which can respond to trauma, and resisting retraumatization. Misdiagnosis is a form of retraumatization. When clinicians misdiagnose DID, patients spend many unnecessary and unproductive years in therapy, and this is traumatic and problematic.

Nature of Study

The nature of this study was an IPA qualitative and hermeneutic approach. My goals for this qualitative research were to understand, through interviews, counselors' experiences, preparation, and training in the successful diagnosis and treatment of clients with DID. The concentration of this study was on how counselors make sense of their academic preparation in counseling individuals suffering with DID. My goal was to gather information from experienced counselors who work with DID clients and obtain the additional training they acquired to be able to effectively work with DID clients. In this research study, I used qualitative phenomenological research methods to explore the lived experiences of counselors who provide diagnosis and treatment for clients with DID.

Definitions

Below are definitions of words, terms, and phrases as I used in this study.

Alters: An alter is two or more distinct personalities or identities a person may express. These personalities or "alters" may be different ages and genders and exhibit different moods and favorites than the primary personality. Researchers believe that these alters often take turns being in control.

Depersonalization: Depersonalization is the feelings of unreality or detachment from one's mind, self, or body. An individual may feel as if they are outside their bodies and watching events happening to them.

Derealization: Derealization is the feelings of unreality or detachment from one's surroundings. An individual may feel as if things and people in the world around them are not real.

Diagnostic: Diagnostic is of, relating to, or used in diagnosis. Using the methods of or yielding a diagnosis.

Dissociation: Dissociation is an individual's inability to assimilate information and self-attributions that should normally be integrated. They may experience this dissociation as shifts of consciousness characterized by a sense of detachment from the self or the environment.

Dissociative amnesia (formerly known as psychogenic amnesia): Dissociative amnesia is the temporary loss of recall memory, specifically episodic memory, due to a traumatic or stressful event. Researchers consider it the most common dissociative disorder amongst those documented.

Dissociative fugue (formerly fugue state or psychogenic fugue): Dissociative fugue is a dissociative disorder and a rare psychiatric disorder characterized by reversible

amnesia for personal identity, including the memories, personality, and other identifying characteristics of individuality. The state of dissociative fugue can last days, months, or longer.

Dissociative identity disorder (DID): DID derives from a person's devastating experiences, traumatic events, or abuse that occurred in their childhood. This disorder was previously referred to as MPD. It is the most severe of all DDs.

Fusion/integration: Fusion is the goal of treatment for DID and consists of a full integration of all alters. A person with multiple identities may feel like several different people, each having their own distinct personalities complete with individual names, memories, likes, and dislikes. Fusion occurs when identities merge together and become a unified whole. Integration occurs when the individual accepts a dissociated personality, part, or aspect of themselves and brings it into normal awareness.

Malingering: Malingering is the deliberate creation of false or grossly exaggerated physical or psychological symptoms, driven by external enticements such as evading military duty, escaping work, attaining financial return, eluding criminal prosecution, or acquiring drugs.

Trauma: Trauma is a deeply distressing or disturbing experience. Examples of trauma are domestic or family violence; dating violence; community violence (shooting, mugging, burglary, assault, bullying); sexual or physical abuse; natural disaster such as a hurricane, flood, fire, or earthquake; or a serious car accident.

Treatment: Treatment is the act or manner or an instance of treating someone. The action or way of treating a patient or a condition medically or surgically. The

management and care to prevent, cure, ameliorate, or slow progression of a medical condition.

Assumptions

I made several assumptions regarding the design of this study. First, I assumed that I would be able to secure the necessary sample for the study. I also assumed that all the participants would be truthful in their identification as skilled clinicians with experience working with persons with DID. However, I had no verifiable method to determine if this was false. In addition, I assumed that the participants' experiences would be similar enough so that I could achieve saturation. Given my identity as a practicing mental health clinician and one who has a passion and concern for persons with DID, it was assumed that I would be perceived as a safe and understanding agent who would accurately describe the participants' experiences. Finally, I assumed that the participants would be able to clearly articulate their experiences.

Scope and Delimitations

I recruited eight participants, at which time, saturation was achieved. Saturation is the state or process that occurs when no more of something can be absorbed, combined with, or added (Creswell, 2014). I recruited counselors who, outside their master-level academic programs, sought additional education, training, and experience working with individuals with DID. These mental health professionals have gained specific and specialized training in DID. I limited the participants in the study to experienced counselors who had worked with and successfully treated persons with DID. The participants in this study (a) had obtained, outside their master-level academic programs,

additional education and training treating persons with DID; (b) had a minimum of 5-years of postmaster's degree professional experience; (c) had provided counseling services for five or more clients clinically diagnosed with DID within the last 5 years; (d) were licensed as a counselor in the state in which they practiced; and (e) held a master's or doctoral degree from a CACREP accredited program and trained in the United States. Participants included any race, gender, ethnicity, or socioeconomic background. Myrick et al. (2015) suggested that choosing experts with 9 years' experience in treating DID patients would be a good criterion to use in developing a sample size. I screened the participants to determine if they met my study's criteria of at least 5 years of experience working with DID clients.

I excluded counseling interns or those who had never had experience with working with individuals with DID. The choice of excluding counselors who were considered inexperienced was made due to the time constraints of the study and the need for definitive answers and struggles that can be articulated by those have had experience working with clients with DID. The study was limited in the fact that it did not include psychiatrists, who normally treat DID clients. The expectation of transferability in qualitative research is distinctly different than in quantitative inquires. In quantitative studies, there is an expectation that the findings from one study can be applied to a larger population (Tuval-Mashiach, 2021). In qualitative research, it is expected that the findings may only be applicable to a small number of participants.

Limitations

A limitation of my study was that I would only recruit counselors and no other mental health professionals such as psychiatrists or psychologists. My goal was to determine what these counselors did, beyond their academic programs, to prepare and train to diagnose and treat individuals with DID. Finding people who met my inclusionary criteria and were willing to be interviewed was a huge challenge. An additional limitation to the study was the lack of inclusion of counselors without formal training or expertise in the area of DID.

Researchers can establish credibility for their study by providing their connection to their qualitative study. This includes divulging any personal or professional information that could potentially influence the collection, analysis, and interpretation of data (Crowther et al., 2017). In Chapter 3, I disclose my personal experience and connection to the topic. If I did not expose my connection to the study, the interpretation of the data could be questioned. Transparency in research can increase the credibility for a study. Researchers work to ensure the quality of the study by not using their biases and values to shape the findings from the data (Crowther et al., 2017).

Significance

This study is significant because the misdiagnosis of DID has been an ongoing and chronic problem (Brand et al., 2014). Although the professional literature has not been able to determine the numbers of individuals with DID, it does support the fact that DID is chronic for its sufferers (Brand et al., 2014; Kluft, 2005; Lilienfeld et al., 1999). Many individuals have suffered from being misdiagnosed and mistreated, resulting in a

poor quality of life. In my study, I sought to understand counselors' experience that might lead to possible changes in education and training programs. Only 30% of psychiatrists and psychologists who normally receive more training and education in DID work felt sufficiently trained to assess or treat trauma and its after-effects (Kumar et al., 2019). There were no recent studies addressing the percentages of counselors who provided information about their expanded or specialized training and education in DID work. Furthermore, over 81% of mental health professionals surveyed believed that more trauma training would be beneficial to their practice (Kumar et al., 2019). Clients often terminate counseling either because of a lack of accurate diagnosis or a failure to connect with the clinician (Brand et al., 2014). Thus, advocates are needed to combat the problems and challenges clients diagnosed with DID experience every day.

My desire was to see a positive change in those clients, and I sought to find answers about the training needs of counselors who work with clients with DID. According to the ISSDT (2011), clinicians are untrained, uneducated, and uninformed about DID. Moreover, individuals with DID are a challenging population for counselors to diagnose and treat (Brand et al., 2014). In this phenomenological study, I investigated the experiences of counselors who had expertise working with this population to more fully understand how counselors who are experienced in working successfully with clients who have DID.

The lack of specialized trauma education and training of counseling students creates a public health issue, given that individuals who have experienced trauma are more likely to use mental health and medical services than those who have not

experienced trauma (Kumar et al., 2019). Society could benefit from the increased numbers of counselors who have been adequately educated and trained in working with clients with DID. Hence, a proposed change in master-level counseling programs academics and a change in CACREP requirements of counselors may be needed to ensure proper preparation of counselors to work with clients with DID.

Summary

In this chapter, I focused on the background of the research problem. Counselors, counselor educators, and researchers are ethically bound to increase their trauma-informed competencies (CACREP, 2016). Illuminating the experiences of clinicians who successfully work with persons with DID can not only serve to fill the gap in the literature but can provide a base for further exploration of the experiences of counseling students and academic programs in the study and training of trauma-related disorders. The main treatment objectives for patients who have suffered from DID are the integration of self-experiences that have previously been dissociated on a mental, physical, and relational level, but still pertain to the patients' history, behavior, and way of processing thoughts and feelings (Brand et al., 2014). Specialized training, knowledge, and experience working with trauma and trauma-related disorders is essential to accurate diagnosis and useful treatment resulting in a better life for individuals with trauma-related disorders.

It was expected that the narrative data would likely focus on theoretical and practice approaches used by study participants, treatment issues related to transference and countertransference, supervision, and the lack of guiding literature. I used the current

literature on mental health practice with DID to guide this research. It is noteworthy that there is very little research related to the treatment of DID and even less research on counselors treating DID, especially when compared to the literature for other disorders. Following a qualitative approach to the methodology, narrative data were examined and organized into thematic categories. In Chapter 2, I provide a more in-depth discussion of the literature relevant to the current study.

Chapter 2: Literature Review

Introduction

Park (2012) reported that the prevalence of the misdiagnosis of DID is problematic and harmful for clients because the misdiagnosis causes an extended length of time in counseling and can increase the cost of counseling and hospitalization. Kluft (2005) explained 20% of all DID patients exhibit clear-cut indications of DID, and the other 80% exhibit some indications of diagnosable revealing classic features of DID. Additionally, Kluft claimed that DID has been misdiagnosed and underdiagnosed for decades due to clinician error or because the patient may be intertwined in a personality state that either does not have access to or will not share the data necessary for the diagnosis to be suspected or made.

Aside from clients hiding symptoms, counselor competence has been another primary reason noted for misdiagnosis and under diagnosis (Brand et al., 2014). According to Park (2012), clinicians lack education, training, and experience in the diagnosis and treatment of DID. Minimizing the misdiagnosis of DID can lessen the harm inflicted on clients and promote a healthier and wholesome life for individuals with DID. Because the symptoms of trauma are so closely paralleled with symptoms of DID, clinicians have erred in making a proficient diagnosis of patients with DID (Brand et al., 2014). However, despite an exhaustive literature review, I could not find any research that addressed the clinician education, preparation, and knowledge of how to diagnose and treat clients with DID.

DID is part of the trauma family of disorders. Compared to individuals with DID,

trauma survivors are a distinct population of clients who need expert knowledge and multidimensional attention from counselors (Jones & Cureton, 2014). The 2016 CACREP Standards mandate across both master's and doctoral training phases the significance of understanding the consequences of trauma theory, research, and practice in counselor preparation and eventually practice. Cook et al. (2017) mentioned although CACREP (2016) standards incorporate trauma training within all eight core curricular areas, not enough specialized instruction and demonstrated knowledge are required within each core counseling track. More specifically, Section II, Professional Identity, expressed counselors should understand the "effects of ... trauma-causing events on persons of all ages" (CACREP, 2016, p. 11). However, counselors still complain that they lack adequate training in this area (Jones & Cureton). More than 60% of working mental health professionals have conveyed the desire for additional support and education in their trauma work (Cook et al., 2017). Trauma theorists have agreed that, with the exception of DID, no other diagnostic condition in the history of the DSM has produced more debate about limitations of the condition, symptomatological profile, central suppositions, clinical efficacy, and occurrence (Cook et al., 2017).

Schema therapy seems a viable option for the treatment of DID given its emphasis on the consequences of early childhood neglect and abuse and the explanation within the therapeutic model of the patient's experience of drastic shifts between states, unlike the ISSTD guidelines that tend to ratify the idea of severely dissociated identities with amnestic barriers. Schema therapy aims to normalize for the patient the different identities by reframing them as modes (or as parts of modes), which are common in all

humans, though different in their degree of intensity, and amnestic barriers are not assumed. However, understanding the diagnosis and treatment of DID continues to be a controversial topic.

To address this problem, I explored the educational processes and experiences of counselors who have experience counseling individuals diagnosed with DID. I provided information about training that could be helpful and could lead to counseling students being given more detailed and enhanced training and preparation for diagnosing and treating persons with DID. Huntjens et al. (2019) explained how patients may stay in Phase 1 of DID for long periods of time, sometimes even for the entire course of treatment, which may last 10 years or longer. This unique disorder requires an understanding of its causes and affects because it demands a specialized and lengthy treatment period.

My purpose for this study was to explore the lived experiences of experienced clinicians who work with clients with DID and the additional training these clinicians sought to become better prepared to work with DID clients. The results of this study identified the training needs of counselors to help with both the treatment and diagnosis of clients with DID. According to Cook et al. (2017), counselor educators and supervisors do not know how to best prepare themselves to train counselors to work with clients with DID. Thus, I asked participants what they believed is essential training for those who treat people with DID, what skills are needed, and how they effectively work with this population. This study was designed to improve the education and training of counselors who provide services to individuals with DID. I explored with participants the

educational processes and experiences that could provide counseling students with the appropriate training and preparation for diagnosing and treating persons with DID. This study contributes to the literature by helping fill in the gap surrounding the research on the experiences of therapists who treat clients with this disorder.

In Chapter 1, I provided detailed information on the purpose of this study. In Chapter 2, I provide a succinct but comprehensive summary of the relevant literature, which explains why the chosen problem needs further exploration. My summary gives context to potentially emerging themes that may be found while conducting the study. Most of the literature in this chapter was published within the last 5 years; however, to address historical concepts, I included information published more than 5 years ago. I also discuss the literature strategies I used, including key words and phrases, databases, and the theoretical orientation. Finally, I present the literature that supports the chosen theory and the rationale for the study.

Literature Search Strategy

The literature I reviewed for this study was secured primarily through the electronic library databases at Walden University. I searched the following databases: ERIC and Education Source Combines Search, SAGE Journals, Science Direct, Thoreau Multi-Database Search, Psychology Databases Combined Search, EBSCO, Mental Measurements Yearbook with Tests in Print, Merck Manual, National Science Foundation, Neuroscience Information Framework, ProQuest Central, ProQuest Dissertations and Thesis Global, ProQuest E-book Central, PsycARTICLES, PsycEXTRA, Psychiatry Online, Psychology Databases Combined Search,

Psychtherapy.net, and PsycTHERAPY. All works that I cited originated from peer-reviewed sources. To identify relevant research, journal, and books to this study, I used the following search words: *dissociative identity disorder, dissociation disorders, treatment, education, training, preparation, teaching, master-level counseling programs, clinical experience, college experience, counselors, counselor educators, psychologists, psychiatrists, counselors and DID and training*, *counselors and DID, counselors and training, counseling programs, CACREP and counselor training,* and *clinicians and misdiagnosis*.

In my initial search, I found very little on the lived experiences of counselors who work with and treat persons suffering with DID. Due to the scarcity of literature, I expanded my search to include the preparation and training of counseling students in CACREP programs. A search on the significance of the misdiagnosis of DID resulted in a number of articles in peer-reviewed journals.

Theoretical Foundation

A theoretical foundation supports the issues and problems presented in research. It is the driving force that grounds the research and provide purpose and directions.

IPA

For this study, I chose a theory that was appropriate when exploring and understanding the lived experiences of the participants. I used IPA as my framework for this study to explore the lived experiences of counselors who work with clients with DID. The IPA approach was originated by German philosopher Husserl. Other individuals associated with IPA include German philosopher Heidegger, who had significant

influence on the study of both phenomenology and hermeneutics, and Merleau-Ponty, a French philosopher who had a great interest in understanding how people perceived their experiences (Smith et al., 2009).

The IPA approach is a psychological research method that focuses on understanding how a participant perceives the events that have been experienced. Instead of highlighting how the researcher sees the event, or how most people would see and react to a given event, the researcher endeavors to expose and comprehend how it affected the individual. The method acknowledges that it is impossible for one person to understand another person's experience, but the researcher attempts to remove any personal and experimenter's bias from the interpretation. My goal was to learn how successful each counselor was in diagnosing and treating the individual with DID. The purpose of this study was to examine and interpret the way clinicians treat patients diagnosed with DID and how they assign meaning to their personal experiences working with these patients' diagnosis and recovery process, using IPA for the analysis. The IPA approach assists in interpreting the experiences of DID patients and the counselors who treat them. The use of a phenomenological framework better explains the clinical experiences of counselors working with clients diagnosed with DID. I chose a phenomenological method to examine this phenomenon due to the scarcity of research focusing on the experiences of DID through the eyes of counselors and to allow the exploration of the depth of the experiences of counselors who treat clients with DID (Creswell, 2013; Hays & Wood, 2011). Treating a complex disorder such as DID involves complex and responsive treatment (Brand et al., 2013), and a phenomenological

approach not only allows for that complexity to be explored but also for the participants to share the meaning they have created from their experiences (Hays & Wood, 2011).

The IPA phenomenon has been applied in Le Boutillier's research, stating that the IPA process moves back and forth through different phases to ensure in-depth and systematic examination of individual's experiences (Le Boutillier et al., 2022). A layered approach to analysis is adopted to explore the parts, that is individual, concrete, and unique and how this uniqueness is relevant to others with breast, prostate, or colorectal cancer experiences (Le Boutillier et al.). My goal was to acquire the unique richness from each individual to be used in this study and in the future studies of DID. Moyo et al. (2022) conducted a study using IPA to design to gain insight into the lived experiences of healthcare workers who contracted COVID-19, proving further why IPA is a viable approach to gathering data for this study. This study gathered rich and robust individual experiences to facilitate an in-depth exploration of narratives detailing the lived experience of suffering from COVID-19. My study benefitted from this framework by providing rich information from a person who has experienced a phenomenon as opposed to scientific facts and figures.

TIC

To address the best practices and lived experience of clinicians who work with clients with DID, I used TIC theory to explore themes and common occurrences. TIC is a promising model for organizational change in health, behaviors, and other settings that promote resilience in staff and patients (Conover et al., 2015). Key principles of this approach include organizational safety, trustworthiness, transparency, cultural sensitivity,

collaboration, and empowerment among and between staff and patients (Conover et al., 2015). This approach recognizes the role trauma plays in the lives of patients and consumers and seeks to shift the clinical perspective from “what’s wrong with you” to “what happened to you” by recognizing and accepting symptoms and difficult behaviors as strategies developed to cope with childhood trauma (Conover et al., 2015, p. 1004).

Van der Kolk is the author of TIC in behavioral health services, developed in the 1970s. TIC started in medicine, as an approach to patient care that takes trauma into account when diagnosing and treating individuals. It had its genesis in patient care in the 1970s, when the physical and mental traumas experienced by Vietnam War vets necessitated it. For the best practices and lived experience of counselors who work with clients with DID, I used TIC to explore themes and common occurrences.

A trauma-informed approach is a promising model for organizational change in health, behavioral health, and other settings that promotes resilience in staff and patients (Conover et al., 2015). A trauma-informed approach views presenting problems as maladaptive coping and regards trauma not as a distinct event but as a framework for understanding experiences that can define and deeply affect the core of a person's identity (SAMHSA, 2014). The three key elements in this approach are (a) realizing the prevalence of trauma; (b) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (c) responding by putting this knowledge into practice (SAMHSA, 2014).

This theory was the best approach because DID is caused primarily by traumatic events in an individual’s life. Trauma-informed approaches assume the realization about

trauma and how it can affect people and groups, recognizing the signs of trauma, having a system that can respond to trauma, and resisting retraumatization. Misdiagnosis is a form of retraumatization. When clinicians misdiagnose DID, patients spend many unnecessary and unproductive years in therapy, and this is traumatic and problematic. Research on the effectiveness and efficacy of DID treatments is still in its infancy, partly because patients with these disorders are often excluded from treatment studies (e.g., due to their complexity, poly-symptomatology, and the long treatment length they are supposed to need), even when these studies involve the treatment of patients who have faced chronic childhood abuse.

Literature Review

Researchers have a responsibility to explore the experiences of individuals who have suffered from DID and those who have diagnosed and treated them. Studies have been conducted to discover the meaning for this disorder and present evidence of the cause. In this section, I presented a comparison between the opinions and presentations of DID, while also sharing information about those who suffer with the disorder and those professionals who treat them. There has been much controversy and debate over the validity of this disorder, but most researchers have agreed that there is evidence of its legitimacy in the mental health field (Brand et al., 2014; Golebiowska et al., 2017; Kluft, 2005; Raison & Andrea, 2023). In this section, I explored the controversies surrounding the diagnosis of DID, followed by a discussion among researchers of the proposed causes and treatments.

DID

DID is a psychobiological response to traumas suffered in a specific time frame in early childhood and is associated with a complex posttraumatic stress syndrome (Brand et al., 2014). The onset of DID occurs when an important childhood development -- the framing of a central, integrated consciousness -- is impeded or prevented by chronic trauma (Brand et al., 2014).

The trauma causes the child to use drastic denial tactics and splitting to cope with the traumas. These coping mechanisms are carried into adulthood, attributing to DDs. A person with DID may not experience denial until years after this or their DID diagnosis (Brand et al., 2014). It is even possible for a person to deny their diagnosis, accept it, and then experience denial again at a later time. Patients may also experience splitting, where they may relate themselves at various moments in an entirely different way to their person or others. They split reality with delusions. One moment the psychiatrist may be the patient's respected friend, but at another moment, if they interfere with the patient's delusions of grandeur, they are hated as a rival.

According to the DSM-5, DID is a disorder characterized by the presence of two or more identities or personality states that recurrently take control of the individual's behavior accompanied by the inability to remember important personal information. In traditional clinical interviews, instruments, and assessments tools, there is a lack of dissociative phenomena in depth, but these instruments, interviews, and assessments still provide crucial data (American Psychiatric Association, 2013; Brand et al., 2012; Brand et al., 2014; Kluft, 2005). Additionally, Golebiowska et al. (2017) shared the length of the

treatment process, which lasts for the whole life of the patient, makes it hard to identify the cases that reach full integration of identity and full recovery. The most severe type of dissociative disorder is DID; thus, proper and very extensive differential diagnosis must be made prior to diagnosis of DID.

Current Research

Raison and Andrea (2023) explained that DID continues to be understudied and also notated that DID remains a disorder that is still under-recognized and contested. Nevertheless, it would seem the trauma theory has more evidence to support it than the iatrogenic theory (Raison & Andrea, 2023). Moreover, distinguishing DID from PTSD and personality disorder, for instance, would further demonstrate its validity. Raison and Andrea's study results revealed that complex, prolonged, and intense sexual and physical abuse are proven causes of DID, further reiterating the need for accurate diagnosis early on in the life of the individual. Raison and Andrea further posit that the Multidimensional Inventory of Dissociation (MID) helps to distinguish between DID and other pathologies, such as PTSD, borderline personality disorder, DDs, and somatic disorders.

Crellin and Temple (2021) believed that the diagnosis of DID remains a contentious area in mental health and patients experiencing such difficulties are often harshly identified as suggestible neurotics and interested clinicians as fanatics. The purpose of their study was to challenge psychiatry's dismissive and disbelieving attitude towards DID. This study included a person with DID and a clinician to get both perspectives, insight, and lived experiences. Crellin and Temple also said there is still limited understanding of DID's aetiology and the paucity of associated neurological

findings. The researchers further explained they call for UK psychiatric practices to move on from the debate and for the royal college of psychiatrists to take the lead, with inclusion of DID in core psychiatric training and guidelines on approaches to diagnosis and treatment.

The participants shared similar beliefs for mandatory courses/classes be implemented in all counseling programs in complex trauma, trauma specific, psychodynamic psychotherapy, neurobiology of trauma, history and continuum of DID, developmental trauma disorders, abnormal psychology, trauma framework where they sought to understand how trauma affects the central nervous system and how the brain tries to cope with the trauma, and finally mandatory courses in DDs and dissociative phenomenon. Crellin and Temple (2021) further indicated that the damage arising from misdiagnosis of DID is diagnosed as better-known conditions such as psychotic, mood and personality disorders. Such misdiagnosis can result in cycling through services, leading to iatrogenic harms from medications, from a lack of understanding of the impacts of interventions such as restraint and from boundary transgressions arising because of the patient's interpersonal dysfunction (Crellin & Temple, 2021). In our experience (e.g., as patients and clinician), medications for ‘symptomatic’ treatment do little other than over-sedate and can be the cause of considerable side-effects. Adequate, focused, and specific training, education, and experience is vital in the recognition, diagnosis, and treating of DID. The following is a statement from a client with DID:

> Given my experience of symptoms for many years before contact with services or indeed therapy. I do not know any clinicians, past or present, specialist or

> generalist, who would try to or would know how to ‘create this disorder’ in their patients. Equally, for patients to be called suggestible and fantasy prone is insulting and unprofessional. Would this set of adjectives be applied to any other patient groups in the medical literature and, equally, would such comments survive peer review to edited print? So why for those with DID? What is it about the diagnosis of DID that seems to allow behaviors in clinicians that are not compatible with the guidance of the UK's general medical council on good medical practice for doctors? Why does the diagnosis of DID seem to raise so much objection in the medical community, allowing the dismissal of patients’ symptoms and a pejorative stance that includes the damning of medical colleagues as fanatics causing harm? (Crellin & Temple, 2021, p. 99).

Researchers van Minnen and Tibben (2021) addressed only the brief cognitive-behavioral treatment approach to DID. There appeared to be no recent articles or studies addressing misdiagnosis, lack of clinician knowledge and experience, and adequate academic changes to resolve the insufficiency. Gaining an improved understanding of DID involves more than the categorization of another mental disorder. Increased knowledge in this area would contribute to an improved understanding of the nature of consciousness and the mind-brain relationship as well (Slogar, 2011). Instruments or tests have been developed that were designed to help identify individuals with DID. The lack of training about complex trauma and DDs among mental health professionals contributes to difficulty in accurately diagnosing DDs, treatment delays, and patients feeling misunderstood and poorly treated.

It is imperative more clinicians are trained to treat dissociation and also insurers and health care systems recognize the need for specialized, dissociation treatment (Nester et al., 2022). DDs are characterized by interruptions of identity, thought, memory, emotion, perception, and consciousness. Patients with DDs are at high risk for engaging in dangerous behaviors, such as self-harm and suicidal acts; yet, only between 28% and 48% of individuals with DDs receive mental health treatment (Nester et al., 2022). Patients who do pursue treatment are often misdiagnosed, repeatedly hospitalized, and experience disbelief from providers about their trauma history and dissociative symptoms. Lack of dissociation-specific treatment can result in poor quality of life, severe symptoms requiring utilization of hospitalization and intensive outpatient treatment, and high rates of disability (Nester et al., 2022).

Given the extensive and debilitating symptoms experienced by individuals with DDs and the infrequent utilization of treatment, the current study explored barriers to accessing and continuing mental health treatment for individuals with dissociative symptoms and DDs (Nester et al., 2022). In order to identify and mitigate dissociation-related barriers, clinicians must be knowledgeable about trauma, dissociation, and the effects thereof; however, most mental health clinicians receive little systematic training in assessing for, diagnosing, and treating trauma-related difficulties (Nester et al., 2022). A total of 91.30% (n = 252) individuals reported having received mental health treatment in their lifetime, and 70.29% (n = 194) were receiving mental health treatment at the time of the study (Nester et al., 2022). The average number of years receiving any form of mental health treatment was 8.52 (SD = 7.87; range, <1–40). Individuals receiving mental health

treatment were meeting with their provider anywhere from two or more times a week to less than once a month. Most participants in treatment were being treated in in a private practice (62.37%), outpatient clinic (23.20%), or higher level of care (9.79%) setting (Nester et al., 2022). These barriers included structural barriers (e.g., financial, insurance, time constraints), dissociation-related concerns (e.g., fear of communicating with parts), negative beliefs about the self-e.g., “I don't deserve help”, prior or anticipated negative experiences in treatment (e.g., provider not believing in dissociation), an individual's perception of the problem or the ineffectiveness of treatment (e.g., low or no perceived need for treatment), limited providers trained in trauma and/or dissociation, and stigma (Nester et al., 2022).

Given these barriers, it is imperative that more service providers are trained to recognize and treat dissociation and that health care systems become informed about the need for specialized, dissociation-focused treatment (Nester et al., 2022). Finance and insurance barriers were the most frequently endorsed barriers to both accessing (76.81%) and continuing (52.90%) mental health treatment. Finance-related barriers to mental health treatment are common across disorders and communities (Nester et al., 2022). Health care systems and policy makers need to be aware of the long-term financial benefits of providing specialized treatment to dissociative individuals, as well as the considerable improvements in symptoms, quality of life and daily functioning (Nester et al., 2022).

Urbina et al. (2017) indicated that full treatment takes many years and many sessions to accomplish, which means a clinician would need to be fully committed and

able to help these clients from the beginning to the end. Urbina et al.'s study followed only one case study of a 43-year-old, well-educated, Caucasian female. The researchers focused on the individuals' history of sexual abuse starting at 5-years-old. This individual had been in therapy for more than 3 years before they were accurately diagnosed with DID. In my study, I addressed this limitation by gathering information from several clinicians and about many individuals with DID. It is imperative that clinicians are knowledgeable, available, and capable of providing services to clients with DID so that individuals with DID may experience a better quality of life, decrease hospitalizations, and reduce the cost of their mental health treatment.

Urbina et al. (2017) addressed the problem of misdiagnosis and the negative impact that misdiagnosis has on effective treatment. Urbina further reported that research has not effectively addressed a solution for the lack of adequate preparation of counseling students to work with and treat persons with DID. In the literature, there continues to be talk about the problem of misdiagnosis and rarely offers options or solutions. Dorahy (2005), however, suggested that teaching methods and ways to better prepare mental health professionals to diagnosis and treat individuals with DID. The results of my study indicate options for changing the way counseling programs train, teach, and prepare counseling students about trauma and specifically, DID.

The Misdiagnosis of DID

The prevalence of the misdiagnosis of DID is problematic and harmful for clients because the misdiagnosis causes an extended length of time in counseling and increases the cost of counseling and hospitalization (Park, 2012). This researcher was the patient

and the author of an article in which they detailed their experience as a DID patient, chronicling their surviving and thriving after years of misdiagnosis. Kluft (2005) reported that 20% of all patients with DID exhibit clear-cut indications of DID and the other 80% exhibit some indications of diagnosability revealing classic features of DID. Kluft also shared DID has been misdiagnosed and underdiagnosed for decades. Barring clinician error, the patient may be intertwined in a personality state that either does not have access to or will not share the data necessary for the diagnosis to be suspected or made.

Aside from clients hiding symptoms, counselor competence has been the primary reason noted for misdiagnosis and under diagnosis (Brand et al., 2014). Clinicians lack education, training, and experience in the diagnosis and treatment of DID (Park, 2012). Minimizing the misdiagnosis of DID will lessen the harm inflicted on clients and promote a healthier and wholesome life for sufferers. Because the symptoms of trauma are so closely paralleled with symptoms of DID, clinicians have erred in making a proficient diagnosis of DID patients (Brand et al., 2014). Other researchers, alluded to similar conclusions saying misdiagnosis was a problem, due mainly to a lack of education and experience of clinicians. Despite an exhaustive literature review, I could not find any research that explored the clinician education, preparation, and knowledge regarding how to diagnose and treat clients with DID (Brand et al., 2014; Brand, 2019; Kluft, 2005; Park 2012).

Pietkiewicz et al. (2021) shared that the International Classification of Diseases-10 and DSM-5 provide inadequate criteria for diagnosing DID, basically limiting diagnosis to patients having distinct dissociative identities with their own memories, preferences,

and behavioral patterns, and episodes of amnesia. Pietkiewicz et al. explored meaning which patients with false-positive or imitated DID attributed to their diagnosis. To avoid misdiagnosis, clinicians should receive more systematic training in the assessment of DDs, enabling them to better understand subtle differences in the quality of symptoms and how dissociative and non-dissociative patients report them (Pietkiewicz et al.1). The researchers revealed that there are no qualitative analyses of false-positive DID cases in the past 20 years. Most research was quantitative and compared DID patients and simulators in terms of cognitive functions (Pietkiewicz et al., 2021). Additionally, Pietkiewicz et al.'s IPA was an idiographic study which explored personal experiences and meaning attributed to conflicting emotions and behaviors in six women who had previously been diagnosed with DID and referred to the Research Centre for Trauma and Dissociation for re-evaluation. Brand et al. (2012, 2014, 2019) and Pietkiewicz et al. shared similar assertions on how the misdiagnosis of DID is primarily the result of a lack of knowledge, training, and experience of clinicians.

There has been research that suggested that DID is iatrogenic, meaning it is a result of a clinician's medical examination and treatment. Brand et al. (2014) refuted this theory and reported that given the severe symptomatology and disability associated with DID, iatrogenic harm is far more likely to come from depriving DID patients of treatment that is consistent with expert consensus, treatment guidelines, and current research. Pietkiewicz et al. (2021) said while DID patients are usually reluctant to talk about their symptoms and experience their intrusions as shameful, people who imitated DID were eager to present their problems, sometimes in an exaggerated way, in an attempt to

convince the clinician that they suffered from DID. Researchers recognize the likelihood of false-positives, iatrogenic influence, and patients' self-diagnosis; but they are assured that DID is a legitimate disorder and deserves the attention that all other mental disorders have experienced throughout the ages.

Evidence-Based Practices in Treating Clients With DID

Brown (2011) provided guidelines that instruct clinicians on how to work with clients most effectively with DID. Brown conveyed the difficulties in diagnosing DID result primarily from lack of education among clinicians about dissociation, DDs, and the effects of psychological trauma, as well as from clinician bias. Most clinicians have been taught (or assume) that DID is a rare disorder with a florid, dramatic presentation. Instead of showing visibly distinct alternate identities, the typical DID patient presents a polysymptomatic mixture of dissociative and PTSD symptoms that are embedded in a matrix of ostensibly non-trauma-related symptoms (e.g., depression, panic attacks, substance abuse, somatoform symptoms, or eating-disordered symptoms (Brown, 2011). The prominence of these latter, highly familiar symptoms often lead clinicians to diagnose only these comorbid conditions. When this happens, the undiagnosed DID patient may undergo a long and frequently unsuccessful treatment for these other conditions (Brown, 2011). Furthermore, Brown notated that the phenomenal and empirical knowledge base and scientific scholarships about DID. This study also supports my concern that untrained clinicians need more education and training in working with patients with DID.

Brand et al. (2012) confirmed that there must be future training and research on

DDs. They further conveyed the use of exposure techniques, in moderation, is beneficial to patients with DID so as not to overwhelm them and provide them with core, foundational interventions. The last stage of treatment is rarely successful in the complete unification of alters, as only a small percentage of patients ever reach this stage. Brand et al. concluded that very little empirical evidence exists about the treatment of DID and DDs. They further postulated there were only a small percentage of clinicians who had any experience or training with DDs so the study may have limitations on its conclusions and recommendations. Brand et al. also affirmed that increased therapists' experience was closely related to an increase in client unification. Only a few experts were able to find specific training in DDs in organized education in internships, residencies, and post-doctoral fellowships, this kind of training is not common or readily available (Brand et al., 2012).

Because of the frequency of complex trauma and related psychological disorders, much more training in providing carefully paced, staged treatment needs to be made available to mental health professionals. Brown (2011) and Brand et al. confirmed that the lack of specialized education and experience of the clinician was responsible for the misdiagnosis of DID. Brand et al. and Brown also alluded to a macrocosm of misinformation, lack of education, and training of clinicians on trauma and DID. These authors appear to lean towards the thought that more specialized education is needed in preparing clinicians to work with persons with DID.

In their quantitative study, Myrick et al. (2015) quantified that an informed and staged treatment approach for patients with DDs have been available for two decades but

unfortunately, very few training opportunities exist for clinicians who wish to work with patients with DID. Myrick et al. used an expert clinical sample recruited to participate in an online survey about the treatment of DDs. The three recommended stages of treatment consist of focusing on symptom stabilization and safety, then a development of narrative of non-traumatic and traumatic experiences, next resolving trauma-based cognitive distortion, and then finally reconnecting within oneself, with others, and with current daily life (Myrick et al., 2015). The researchers focused on expert clinicians and therapists treating DD clients in the first two stages of treatment with those recommended by expert DD therapists. Myrick et al. did not specify if clinicians referred to psychiatrists, psychologists, or social workers. In the study, 298 therapists participated. The only inclusion criterion was that clinicians were treating an adult with DID or other DDs for at least 3 months. Most clinicians were in independent practice in the United States and reported an average of 13 years treating DD patients (Myrick et al., 2015). In this study, the researchers focused on expert clinicians which could have been non-counselors but was not specified.

Of all the major psychological disorders, DID has garnered the least attention in terms of empirically supported treatments (Mohajerin et al., 2020). Clinicians need to understand the complexity of DID symptoms and psychological mechanisms responsible for them to differentiate between genuine and imitated post-traumatic conditions (Pietkiewicz et al., 2021). Clinicians without experience of DID may therefore expect patients to present disruptions of identity during a consultation and spontaneously report memory problems. However, trauma specialists view DID as a disorder of hiddenness

because patients often find their dissociative symptoms bizarre and confusing and do not disclose them readily due to their shame and the phobia of inner experiences (Pietkiewicz et al., 2021).

In addition, Mohajerin et al. (2020), Myrick et al. (2012), and Pietkiewicz et al. (2021) shared similar assumptions that patients are harmed when not diagnosed accurately and early in the process as this impedes treatment and recovery. The authors also shared the lack of specialized education is a major conduit to the misdiagnosis, thus negatively affecting treatment. Pietkiewicz et al. explained how understanding the intricacies about DID clinical presentation, especially those which are not thoroughly described in psychiatric manuals, is important to come up with a correct diagnosis and treatment plan. Mohajerin et al. and Myrick et al. explained that treatment plans and goals are gravely delayed when misdiagnosis occurs.

DID Lived Experiences

Zeligman et al. (2017) chronicled the experiences of five men diagnosed with DID. The reoccurring themes were (a) history (with subthemes of personal trauma history, symptoms, and history of diagnosis); (b) alters (with subthemes of roles of alters, communication between alters, and female alter); (c) male gender expectations and identity (with subthemes of male gender expectations and gender identity); (d) challenges (with subthemes of representation/stigma, fears, significant relationships difficult, and roadblocks); and (e) strengths and support (with subthemes of significant relationships, therapy, and needs of the DID community).

Every participant described unique paths to their DID diagnosis, with most participants experiencing several misdiagnoses or comorbid diagnoses along the way (Zeligman et al., 2017). Therefore, a final subtheme of history of diagnosis emerged under this theme. Participants stated they were given previous diagnoses such as bipolar disorder, depression, schizophrenia, and PTSD. Several participants described the challenge of coming to terms with their diagnosis due to a lack of awareness or an uncertainty of their DID diagnosis. One participant elaborated on this challenge, "I didn't think I had DID…I'd occasionally asked, I'd occasionally wondered…and I thought 'Well no, that can't be because I'm married and I've got a responsible job, so someone would have noticed" (Zeligman et al., 2017, p. 7). Aside from the aforementioned reports of trauma, misdiagnosis, and limiting gender expectations, participants discussed a series of other challenges such as (a) representation of stigma, (b) fears, (c) significant relationships difficulties, and (d) roadblocks to information and support. Inaccurate representation of individuals with DID and the resulting stigma was perhaps the most salient subtheme within the theme of challenges. One participant described his struggles with encountering novel environments "I know that after a certain amount of time has elapsed and I have found myself in a new environment, a new community, you know, whether it's a work space or social thing, I get to a point where I'm comfortable enough with the people and I feel safe, and I know it's just going to be a matter of time before something will happen and I will switch…and so the way to protect them I typically sabotage my relationship…well, maybe I'm protecting myself too…I think I live a lot in fear" (Zeligman et al., 2017, p. 74).

Pietkiewicz et al. (2021) also presented research about the lived experiences of patients with DID and showed that some people with personality disorders enthusiastically reported DID symptoms quite accurately and use the notion of multiple personalities to justify problems with emotional regulation, inner conflicts, or to seek attention. Park (2012) and Kluft (2005) presented research revealing the lived experiences of patients with DID, further proving this disorder is legitimate and that it causes a severe disruption of a person's life. Conclusively, while psychoeducation is considered a crucial element in the initial treatment of DDs, patients whose diagnosis has not been confirmed by a thorough diagnostic assessment should not be encouraged to develop knowledge about DID symptomatology, because this may affect their clinical presentation and how they make meaning of their problems. Subsequently, this may lead to a wrong diagnosis and treatment, which can become iatrogenic (Pietkiewicz et al., 2021).

Meeting the Needs of DID Clients

In order to meet the needs of DID clients, clinician preparation and additional attention to specialized treatment modalities must begin. Ringrose (2011) mentioned that DID clients are comprised of multiple alters and personalities, therefore traditional individual therapy is inappropriate. Providing sufficient and adequate services to clients with DID entails a specialized and detailed approach. There are many considerations that need to be addressed when working with DID clients including the following: psychotherapy work is long-term as some cases have been between 2-10 years; therapy

sessions are usually longer comprised of one and a half hours; and sessions are also more frequent, sometimes 2-3 times per week.

Lloyd (2016) shared that a well-organized and stabilizing long-term treatment for DID, with a longer time frame than most traditional services offer, can gradually bring about significant improvements in quality of life for individuals with DID and decrease the cost of services offered to them. Lloyd conducted a study about the length of time DID patients were in treatment and shared the importance of providing long-term therapy, as it can take years before clear reductions in service use and treatment costs can be seen. Brand et al. (2012) alleged that due to the long-term therapy needed for patients with DID, it is unlikely that patients will achieve full unification of all alters.

Brand et al. (2014) further suggested that effective treatment that is mistakenly presumed to be lethargic or worse can result in missed opportunities for accurate diagnosis. These inaccurate conclusions contribute to patients being deprived of effective treatment, spending months or years needlessly suffering from significant symptoms, functioning poorly, and subjected to therapy that is not beneficial compared to the treatment erroneously described as harmful. Years of patients' lives and professionals' time are wasted, along with unnecessary loss of crucial health care dollars. According to the following researchers, Brand et al. (2012), Brand et al. (2014), Lloyd (2016), and Ringrose (2011) suggested that misdiagnosis leads to failed treatment goals, frustration, and emotional pain for the patient, years of additional therapy time, and a negative view of the mental health field.

Counselors' Experiences With DID

In this study, I focused on counselors' experiences specifically, as opposed to other clinicians, because counselors provide the majority of talk-therapy with clients. Psychiatrists are provided with detailed and specific knowledge in this area, and counselors are not, thus the need to focus on the problem and solutions.

Rottman et al. (2009) conducted a study of how effective clinicians are in recognizing and treating personality disorders using the five-factor model. Psychiatrists identified as psychotherapists by the American Psychiatric Association, practicing psychologists from the American Psychological Association, and social workers from the 2005 Register of Clinical Social Workers were recruited by mail (Rottman et al., 2009). Fifty-eight psychiatrists, 64 psychologists, and 65 social workers participated for a response rate of 12%, 26%, and 17%, respectively. this study focused on non-counselors. In the current study, practicing clinicians had difficulty recognizing even prototypic personality disorder cases when presented in the style alone.

Fan et al. (2011) conducted a study to analyze the agreement rate between American experts and Chinese psychiatrists on clinical diagnoses of DDs. The clinical interviews were conducted at Shanghai Mental Health Center and based on DSM-IV criteria. The researchers' intent was to determine whether Chinese psychiatrists can be taught to diagnose DDs reliably with clinical interviews. The researchers focused on non-counselors and revealed that teaching psychiatrists how to recognize and diagnose DID is achievable. In this study, I focused on counselors, who are by far, the largest group that provides talk-therapy.

Blewis (2018) researched clinicians' knowledge, beliefs, and experiences related to DID. The clinicians' suggestions for future study asserted, while there were advantages to the mixed-methods design employed in the present study, a more comprehensive qualitative investigation involving interviews of clinicians would be useful in expanding upon these findings and generating new insights into how clinicians understand or make sense of DID. In particular, future research should consider interviewing clinicians who score both low and high on knowledge and beliefs about DID in order to better understand their perspectives as well as the similarities and differences between these groups. The findings in my study satisfied the need for a qualitative approach to discovering counselors' experiences.

Blewis (2018) further indicated that inquiry should involve empirically examining this study's preliminary finding that many clinicians may need to seek out postgraduate training related to DID. Future research should consider surveying graduate students across psychiatry, clinical psychology, and clinical social work training programs to obtain a better sense of the training they receive on trauma, dissociation, and DID. In addition, future research could examine whether clinicians receive adequate training in DID diagnosis and assessment by asking a large sample of mental health professionals to diagnose a series of clinical vignettes for various psychiatric disorders and comparing rates of accuracy in diagnosis for the DID case compared to other cases (Blewis, 2018).

According to Greene et al. (2018), the accurate and timely diagnosis of individuals with DID can be problematic for counselors. It is common for clients to spend between 5-12 years of unproductive treatment sometimes prior to correct diagnosis

(Brand et al., 2013; Lloyd, 2016). A lack of prior accurate diagnoses continues to be challenging and harmful (Foote et al., 2006). While researchers have made general recommendations for counselors regarding the treatment of individuals with DID, systematic research that investigates DID treatment outcomes are still in its early stages (Brand et al., 2013).

Furthermore, there was limited data that described counselor characteristics that are necessary for successful counseling and treatment outcomes. Brand et al. (2012) specified that due to the complex trauma and related psychological disorders DID patients suffer, much more training in conducting carefully paced, staged treatment needs to be made available to mental health professionals. According to Brand et al. the failure of most mental health training programs and their inability to provide systematic education about and support for treatment of patients with complex trauma or DID results in many potentially treatable patients spending years of clinical time misdiagnosed with other disorders and being treated with relatively limited response.

DID and Trauma Education in Counselor Education

According to Golebiowska et al. (2017), the education and training of counselors in master-level and doctoral-level counseling programs needs to be enhanced. A diagnosis of DID is controversial and prone to under diagnosis and misdiagnosis. From the moment of seeking treatment for symptoms to the time of an accurate diagnosis of DID, individuals received an average of four different diagnoses and spent 7 years, with reports of up to 12 years, in mental health services (Golebiowska et al., 2017).

Reindeers et al. (2019) proposed that a pattern of neuroimaging biomarkers that could be used to inform the identification of individuals with DID from healthy controls at the individual level. This is important and clinically relevant because a DID diagnosis is controversial and individuals with DID are often misdiagnosed. Ultimately, the application of pattern recognition methodologies could prevent unnecessary suffering of individuals with DID because of an earlier accurate diagnosis, which will facilitate faster and targeted interventions.

Brand et al. (2016) reported that many individuals with DID receive psychiatric disability benefits, making them among the costliest and frequently misdiagnosed psychiatric patients. They further require lengthy and intensive treatment and are often misdiagnosed and under diagnosed by clinicians. DID patients spend an average of 7-12 years in the mental health care system and often receive multiple inaccurate diagnoses before receiving an accurate DID diagnosis and appropriate treatment (Brand et al., 2016). For these reasons and more, accurate assessment and diagnosis of dissociate disorders are crucial. However, training and education on assessing DDs and complex trauma are limited.

A typical response of clinicians to the question of how many cases of DID they have encountered is as follows: “I've never seen it, and I've been in practice for so many years so it either has to be very rare, or non-existent” (Frankel, 2015, p. 82). DID is characterized by a need to not be seen or recognized (Chefetz, 2015; Frankel, 2015). Furthermore, few graduate programs offer training with childhood trauma survivors, and psychology textbooks often focus more on controversies surrounding DID and recovered

memories of abuse rather than providing important information on the etiology, impairment, and treatment of dissociation (Wilgus et al., 2015). For these reasons, it is not surprising to encounter comments from clinicians indicating skepticism about DID. The lack of training and familiarity with DID is associated with denying the existence of the disorder and misdiagnosis (Dorahy et al., 2005; Perniciaro, 2015).

Only 60.4% of clinicians who reviewed a vignette of a patient presenting with all the symptoms of DID accurately diagnosed DID (Perniciaro, 2015). Additionally, Perniciaro (2015) found that neither clinicians' age, professional degree, years of experience, nor certainty about their diagnostic accuracy were associated with an accurate diagnosis, suggesting that even experienced clinicians who are quite certain that a patient does not have DID may be incorrect. In fact, some researchers concluded that DID is not rare, iatrogenic, a fad, or over diagnosed (Brand et al., 2014; Brand et al., 2016; Şar, 2011).

Perniciaro (2015) conducted a quasi-experimental study to explore the influence of skepticism and clinical experience on the detection of DID by clinicians. The researcher used a non-random approach to recruit one hundred licensed mental health clinicians practicing in the United States who currently work or have worked with adult populations. Perniciaro used a survey created by Dorahy et al. (2005) which was originally created to examine clinicians' attitudes towards the existence of DID in Northern Ireland. Perniciaro also aimed to collect data on clinicians' experiences, situations, and perspectives on DID.

Perniciaro (2015) asked the mental health clinicians whether they believed in the validity of DID, inquired about their level of familiarity with DSM-IV1994 criteria for DID, and asked about their experiences treating individuals with DID. To determine the influence of clinical experience and the clinician's level of skepticism on the validity of DID and ability to accurately diagnose it, the researcher constructed a number of questions to fit like a Likert scale so that interval data could be collected. The findings in this study revealed the following hypotheses (a) a significant number of clinicians would not detect the DSM-5 criteria for DID and would not choose the accurate diagnosis of DID after reading a clinical vignette, (b) clinicians who endorsed a higher level of skepticism regarding the validity of DID and had less clinical experience would be more likely to provide an alternative diagnose instead of DID to the presented vignette, and (c) clinicians' who reported a lower level of skepticism regarding the validity of DID and had more clinical experience would be more likely to provide the accurate diagnosis of DID to the presented clinical vignette.

Dorahy et al. (2005) used a clinical vignette designed to assess how accurate mental health clinicians are in detecting DID and the results indicated that that participants who have treated a patient diagnosed with DID are less skeptical about the validity DID than participants who have not treated patients diagnosed with DID and participants who chose the accurate diagnosis of DID had a higher mean skepticism score, meaning they endorsed less skeptical beliefs about DID, than individuals who chose an incorrect diagnosis. The main findings of this study revealed that a little more than half of the participants accurately chose DID as the correct diagnosis after reading

the presented clinical vignette, and that there is a relationship between clinical experience, level of skepticism, and the accurate diagnosing of DID. There were several participants who chose the correct diagnosis without having ever treated a patient diagnosed with DID. Thus, clinical experience, as defined by treating a patient diagnosed with DID, is not the only means by which a mental health clinician can learn about DID, its symptom presentation, and treatment. The results of this study were significant because it revealed that teaching clinicians how to diagnose and treat DID is possible even if they have never treated someone with this diagnosis before.

The limitations of this study were the online survey for which several did not complete; it was unclear whether the scale measured all variables impacting one's level of skepticism; and the researcher only asked about knowledge and experience of DID and no other DDs, which would have allowed for more data collection on the influence of clinical experience on clinicians' ability to accurately diagnose DID. The researcher recommended further study to broaden the variable of clinical experience to include graduate course work, continuing education programs, and even supervision experience. In my research, I proposed to look at clinician education, knowledge, and experience in the diagnosis and treatment of DID.

The estimated lifetime prevalence of DDs in both clinical and community populations is 10%, and DID is estimated at 1-3%, making DID as prevalent as schizophrenia and bipolar disorder (Şar, 2011). Additionally, a meta-analysis by Dalenberg et al. (2012) found a strong relationship between trauma and dissociation when trauma was objectively verified via court and medical records. One of the most

significant difficulties in accurately diagnosing DID, especially by professionals with little training or experience in assessing dissociation and DDs, is that patients with DID typically manifest cross-cutting symptoms found in other disorders, most notably schizophrenia, bipolar disorder, post-traumatic stress disorder, and substance use disorders (Brand et al., 2015).

Kluft (2005) suggested that educators divide the goals of education into three domains: cognitive, attitudinal, and instrumental. Adult learners tend to absorb material best when it is oriented toward problem solving rather than the communication of information and abstract concepts. Therefore, teaching graduate students and professional counselors ideally should address several domains and include a large portion of material presented with the several principles of adult learning born in mind (Kluft, 2005).

Fan et al. (2011) indicated that in depth education about clinical dissociation and DID is not a regular component of many curricula. In their study, information collected from a sample of doctoral level psychology graduate students before an advanced workshop on dissociation was provided. Results indicated that prior to the workshop, students possessed limited comfort with working with clinical dissociation and DID. After the training, knowledge of dissociation increased significantly, as did comfort working with clinical dissociation. However even after the course, comfort levels were relatively low, indicating that further training in the area was necessary.

Fan et al. (2011) also explored possible reasons for the hesitancy of clinicians to treat individuals with DID. Clinicians felt inadequate to deal with the complex symptoms of DID. In addition, Fan et al. discussed implications for future clinical training and

research such as: advanced curriculum in DDs, workshops designed to teach clinicians how to diagnose and treat DID, and more intense internships providing experience with DID clients.

Fan et al. (2011) conducted a quantitative study to access the outcome of an educational effort by two North American experts in DD to teach Chinese psychiatrists to make reliable DD diagnoses. The researchers chose 569 patients at the Shanghai Mental Health Center to complete the Chinese version of the Dissociative Experience Scale (DES). The researchers assessed 96 patients with the DDIS and client diagnostic interviews. The diagnostic interviews revealed that 28 (94.9%) were diagnosed as having DD. Fan reported that there was an agreement between the American experts and the Chinese psychiatrists for presence or absence of a DD per Cohen's kappa (0.75).

Fan et al. (2011) was the first to analyze the agreement rate between American experts and Chinese psychiatrists on clinical diagnoses of DD. This stratified sampling approach was used in this study because DES scores are highly skewed. The researchers sought to identify as may DD cases as possible without having to administer the DDIS to all inpatients in the sample; so, to achieve this, they randomly selected in different proportions: 10 percent of patients were from those who scored 0 to 10, thirty percent were selected from those who scored 10 to 20, fifty percent were selected from those who scored 20 to 40, and one hundred percent were selected from those who scored above 40.

Fan et al. (2011) reported that they used no formal system for adhering to the DSM-IV criteria for DDs but stated they observed the familiarity with the criteria, and how to inquire about them, was based on training of the Chinese interviewers and the

American interviewers' knowledge of the DDs literature. The training of the Chinese psychiatrists was achieved in a series of steps that could be duplicated by investigators in other countries.

The American researchers visited China and conducted a workshop on DSM-IV DDs. The Chinese team read selected papers and books in the English-language DDs literature. The team translated the DDIS into Chinese and obtained a Chinese version of the DES. The researchers conducted a series of research studies. The American investigators returned for multiple visits to discuss research and provide further training. Chinese members of the research team conducted clinical interviews themselves and observed the clinical interviews of the American collaborators and Chinese team members wrote a series of papers in English on the research results with the American collaborators as coauthors (Fan et al., 2011).

The results indicated that DDs as diagnosed by clinical diagnostic interviews were not rare among Chinese psychiatric inpatients. However, none of the 28 (4.9% of the 569 patients) dissociative patients identified in the study a dissociative diagnosis recorded in their clinical charts. This study proved that advanced training in diagnosing DID is possible and achievable. One limitation of this study was the small number of patients receiving two clinical interviews. Another limitation was the lack of reliability and validity of the Chinese versions of the instruments, as their psychometric properties had not been studied. The findings in this study support my suggestion that advanced training in the diagnosis of DID is needed, should be offered in master-level counseling programs, and is possible to achieve.

Ross (2015) explained that there is no mystery why clinicians do not see cases of DID; because they do not ask about the symptoms or consider DID in their differential diagnosis. DID is more easily diagnosed in an emergency room because those individuals are in a crisis and the symptoms are detectable. Clients in outpatient care are more stable and functional so symptoms are not apparent. Clients with DID require more time in therapy, therefore need to establish a therapeutic relationship so they can begin to trust and share sensitive symptomatic information.

Ross (2015) expressed that clinicians can diagnose DID with the proper assessment tools (i.e., DES and DDIS). Many scholars and researchers lean towards the additional training and preparation of clinicians in diagnosing and treating DID. Ducharme (2017) proclaimed it is extremely important for clinicians to obtain appropriate education, training, and experience based on special populations or specialized techniques, and DID clearly fell within the category of special clinical populations that require competence beyond that typically accorded to graduate students and many practitioners. The practitioner must acquire clinical competence in this area and remain up to date with the current research. Clients who present with DID have many clinical challenges and often require follow-up with the client between sessions (Ducharme, 2017).

While all the above researchers suggest the lack of education, experience, and preparation are major causes for misdiagnosis, only a very few possible options to correct this egregious and reoccurring problem were suggested. Although it is unclear as to exactly how attitudes towards the disorder have changed, it appears that this relationship

between skepticism and misdiagnosis has held true. Perniciaro's (2015) quantitative study, for instance, mirrored the conclusions of a study conducted by Hayes and Mitchell (Hayes & Mitchell, 1994). The researchers examined the possible influence of skepticism towards the disorder on the detection rates of clinicians. Participants in this study consisted of 91 master's or doctoral level clinicians with varying degrees of experience treating the disorder. The findings showed three significant correlations within the sample: that those who had treated a client with DID were significantly more likely to correctly diagnosis the disorder; those who were more skeptical towards the disorder were more likely to give an incorrect diagnosis; and that those who had previously treated a client with the disorder were less likely to be skeptical towards it. The researchers concluded by recommending advanced training for clinicians to provide more accurate diagnoses.

Hayes and Mitchell (1994) conducted a quantitative study to correlate skepticism and clinician proficiency in diagnosing and treating MPD. The researchers used a survey instrument consisting of a Likert scale, open-ended questions, and demographic items. The researchers recruited three groups of mental health professionals to form the sample. The first group consisted of sixty-nine psychologists sampled randomly from the membership of Division 29 (i.e., Psychotherapy) of the American Psychological Association. The second group consisted of eighty-three social workers randomly sampled from those members of the National Association of Social Workers who identified themselves as currently practicing individual therapy. The third group consisted of fifty-five psychiatrists sampled randomly from the membership of the

American Psychiatric Association. The 207-sample size consisted of mainly female and Caucasian participants.

Hayes and Mitchell (1994) found support for the hypothesis that knowledge and skepticism about MPD are inversely related. This study also revealed in its results that MPD was misdiagnosed with a greater frequency than was even schizophrenia. Proving that MPD is one of the most difficult mental disorders to diagnose and few clinicians receive training in diagnosing MPD. The fact that only 21.9% of the MPD cases were diagnosed accurately supports the researchers' impression that the majority of MPD cases are undetected by mental health professionals.

Hayes and Mitchell (1994) also found that clients with MPD spent an average of 7 years in the mental health system before receiving an accurate diagnosis; for which most researchers agree. This study suggests that skepticism and knowledge about MPD were inversely related, promise may lie in educating both skeptical professionals and, more feasibly, trainees. Limitations of the present research include the low internal consistency of the knowledge scale, the small size of some correlation coefficients found to be statistically significant, the analog method of measuring accuracy of diagnosis, and the low response rate. Future studies should address skepticism. This study supports my theory of education being the missing link in accurate diagnosis of DID. This study does not suggest how this education should be disseminated.

Myrick (2015) reported that training is paramount in preparing mental health workers for treating clients with DID. A lack of proper training negatively affects treatment. Myrick et al. tested the effects of a therapist's experience and the effectiveness

of their treatment. The researchers specifically examined the interventions used by a sample of international outpatient therapists and a sample of dissociative disorder experts treating clients in the first or second stages of treatment. Although there were some similarities of treatment, it was found that those with more training for DDs had significantly better treatment outcomes. Again, Myrick attributed the misdiagnosis primarily with a lack of knowledge and experience on the part of the clinician.

Myrick et al. (2015) conducted a quantitative to study how training impacts accurate diagnosis of DDs. The researchers recruited both an expert clinical sample and an outpatient clinical sample. The 36-participant expert clinical sample was recruited to complete an online survey about the treatment of DDs. These experts had experience of treating DID for more than 5 years, coauthored in the latest version of ISSTD (2011) treatment guidelines, or were recommended by one of the authors of the guidelines.

The 298 participants were made up of therapists with the only inclusion criteria was that they had treated an adult with DID for at least 3 months. Myrick et al. (2015) provided the expert clinicians with a link to an online survey to complete the Dissociative Treatment Activities Questionnaire (DDTAQ). The DDTAQ is a measure of twenty-six treatment interventions discussed in the ISSTD guidelines for treating DID in adults. This data collection was chosen because Myrick posited that it would be the largest sample and the first time that therapist answered questions about interventions. There were twenty-three DDTAQ interventions reported by the top clinicians as compared to the experts' recommendations. Profile analysis was used to determine profiles of top clinicians versus DD treatment experts. Myrick evaluated the DDTAQ ratings as

dependent variables in a mixed-design analysis of variance indicating statistically different profiles across the two groups. Results indicated that experts and top clinicians shared many similarities in their treatment approaches. Myrick further determined that education was a key element in accurately diagnosing DD. The findings in this study suggested that advanced clinician education was needed to accurately diagnose and treat DD.

Some study limitations may include the patient demographic as some patients were typical DD patients, which may have led to discrepancies in between experts and top therapists, who reported interventions used with specific DD patients. Myrick also uncovered that some of the interventions used by the experts were different than those used by the therapist who did not participate. In conclusion, this study showed that additional training avenues, including certification for providing DD treatment, increased training of the graduate school faculty, continuing education opportunities, and the development of treatment standards with third-party payers, can assist in disseminating expert recommendations and empirical study results to clinicians working with DID patients. The results of this study further support my belief that master-level students are not adequately trained and prepared to diagnose and treat individuals with DID. Myrick did not suggest the best method of training to rectify the problem of misdiagnosis in the future.

History of Trauma

Carlson et al. (2011) established that exposure to sudden, highly stressful events is common among the general population in the United States and is even more frequent for

those seeking mental health treatment. Although information about individuals' exposure to highly stressful events such as traumatic stressors is often very useful for clinicians and researchers, available measures are too long and complex for use in many settings. Assessment of exposure to sudden, severe stressors is not routinely done in clinical and research settings because available measures take too long to complete and do not assess clinically important information about the emotional impact of events. Development of a brief assessment of sudden, severe stressors (i.e., or trauma exposure) that yields clinically useful results could expand assessment of trauma exposure to a wider range of settings.

A major challenge in assessing exposure to severe stressors and their impact is that their severity and emotional impact vary considerably (Carlson et al., 2011). Over the last 15 years, various assessments have been developed to learn about and discover traumatic events and stressors, but these assessments did not assess DID (Carlson et al., 2011). Academic counseling programs do not provide extensive study or instruction on the detection and treatment of DID specifically. In my study, I sought to learn more from experienced clinicians about effective treatment for individuals with DID.

Becker-Haimes (2021) indicated that trauma has not been treated accurately in the past because proper diagnosis has been a challenge. This study, as others, focused on trauma as it related to PTSD and did not include DID. Beck-Haimes (2021) and Carlson et al. (2011) reported that the failure to diagnose specific trauma causes prolonged hospitalizations and an inability to access accurate and efficient treatment modalities. Eighty years ago, Freud, proposed in his theoretical papers that explained the phenomena

of trauma. Tucker (2002) concluded that mental health professionals have not acquired adequate knowledge and experience in DID work as trauma continues to be a problem. The failure to recognize the traumatic etiology is not uncommon, as it leads to prolonged and ineffective treatment (Tucker, 2002). Therapeutic failure is a plausible cause of treatment resistance and the vicious cycle of misdiagnosis that continues.

Tucker (2002) declared that the consequence of inaccurate diagnosis causes patients in psychiatric hospitals generally to fail to respond to the treatments prescribed, which leads to a cascade of other problems. Those problems include (a) receiving excessive doses of medication, with the development of unnecessary side-effects, including tardive dyskinesia, (b) continued guilt and low self-esteem, (c) excessively long hospital stays, and (d) inability to access appropriate, available treatment in community settings (Tucker, 2002).

Summary

The literature suggests that counselors must increase their knowledge of DDs. Literature dictates that there is more research needed in the areas of how counselors are taught about DID and the means and avenues needed to teach them. Curricula support the teaching of PTSD, schizophrenia, and other trauma-related disorders, but DID tends to be overlooked and underrepresented. In this chapter, I provided a review of the literature on mental health practice with DID. It is noteworthy that there is very little research related to the treatment of DID, and even less research on counselors treating DID, especially when compared to the literature for other disorders. There also is a lack of research targeted at the resolution of this lack of adequate education and preparation of counselors

to work with DID clients. Changes in counselor programs, modification of the 2016 CACREP Standards, or additional education and training in DID may be the resolution to the problem I have presented in this proposal. In Chapter 3, I discuss the methodology used to collect and analyze data from participant interviews.

Chapter 3: Research Method

My purpose for this phenomenological study was to explore the lived experiences of experienced clinicians who work with clients with DID and the resolution to the lack of adequate education and preparation. In this chapter, I describe my choice of methodology, which informed this study. I also explain the chosen research design, my procedure for collecting data, and my method of analyzing the data. Finally, I provide information related to trustworthiness and other ethical concerns related to the study.

Research Design and Rationale

The research question for my study was as follows: What are the lived experiences of counselors who are experienced in providing accurate diagnostic and treatment services to individuals with DID? In my study, I followed the qualitative approach, specifically a phenomenological perspective. A qualitative design was the most appropriate because the goal of the inquiry was to describe the meaning of lived experiences related to a phenomenon. Present literature was scarce regarding the information on the lived experiences of clinicians who work with individuals who suffer with DID.

I used an IPA approach to gather information and interpret the data I collected in this study. IPA is a contemporary qualitative research method grounded in phenomenology, hermeneutics, and idiography (Smith et al., 2009). IPA focuses on the idiography, which means that the researcher targets the specific rather that the general. Through this analysis, I sought to obtain rich and detailed descriptions of an individual's subjective experience of the phenomena being studied (Sheridan & Carr, 2020).

Philosophical principles and rigorous methodology made this approach well suited for research in counselor education and supervision.

By using IPA, I was able to extract information that helped me understand the lived experiences of experienced counselors who work with and treat clients who suffer with DID. Additionally, I sought to learn what suggestions these experienced counselors had regarding the proper preparation they sought to become effective in treating clients with DID.

IPA is a conceptional framework that focuses on examining how individuals make meaning of their life experiences and also conveys a detailed analysis of their personal understanding followed by a presentation and discussion of common experiential themes (Smith et al., 2009). IPA is a combination of phenomenology and hermeneutics (Smith et al., 2009). Also, Smith et al. (2009) derived their ideas from Heidegger, who posited that the interpretative phenomenological approach searches for essential aspects of an experience by examining and explaining the thematic meanings or common structures of a phenomenon. This method of study helped me examine and explore the lived experiences, education, preparation, and practices of experienced clinicians who work with clients with DID.

Role of the Researcher

My role in the study was that of a participant-observer. When conducting a qualitative study, the researcher is typically the key instrument used to observe, collect, and analyze the data (Geraldi-Gauci, 2019). I used open-ended and semi structured interviews with experienced counselors with whom I had no personal or professional

connection or relationship. Although I had very little personal connection or familiarity with anyone who suffers with DID, I am and have been on a personal mission to learn more about this disorder and how clinicians can better help these clients. I recorded the interviews and had them transcribed. I used other methods to avoid biases that are summarized below under the section on trustworthiness. I also relied on feedback from my committee to address any suspected biases on my part.

Data collection was in the form of semi structured interviews where I used a flexible interview schedule, and the participant had an important stake in what was covered (Smith et al., 2009). I transcribed and analyzed the interview results through a systematic, qualitative analysis and then created a narrative account where my analytic interpretation was presented in detail and was supported with verbatim extracts from participants (Smith et al., 2009). Interpretations are all researchers can use and descriptions themselves are an interpretative process by use of the hermeneutic cycle.

The transparency of the coding process is essential in presenting the analysis in an unbiased and objective perspective. Researchers must engage in reflexivity and become mindful of their role in the creation of knowledge. This is done by researchers self-monitoring the impact of their biases, beliefs, and personal experiences related to the research project (Rodham et al., 2015). Reflexivity is further defined as the active acknowledgement by researchers that their own actions and decisions will inevitably have an impact on the meaning and context of the experience under investigation (Rodham et al., 2015).

Similarly, Shaw (2010) described that reflexivity as a precise assessment of the self. In other words, the process of reflexivity is an essential part of engaging with the double hermeneutic and rather than putting to one side (i.e., bracketing) one's preconceptions, the focus is on becoming aware of them and their potential influence. Double hermeneutics is the two-way relationship between common concepts and those from the social sciences.

Methodology

In the methodology section, I explain how I collected and analyzed the data. To reach common themes, I chose a specific demographic and population from a distinct group of professionals. In this qualitative study, I used thematic coding, which was an analysis of themes mentioned in text. I discovered these themes by analyzing words and sentence structures.

Participation Eligibility Criteria

For this study, I recruited and interviewed counselors from the registry of the ISSTD and those who obtained additional education and training outside their academic experience. Due to the inability to travel outside my area and COVID restrictions and precautions, I conducted these interviews via Zoom. The participants in this study (a) had obtained, outside their master-level academic programs, additional education and training treating persons with DID; (b) had a minimum of 5 years of postmaster's degree professional experience; (c) had provided counseling services for five or more clients clinically diagnosed with DID within in the last 5 years; (d) were licensed as a counselor in the state in which they practiced; and (e) held a master's or doctoral degree from a

CACREP accredited program and were a U.S. citizen. I provided potential participants with a prescreening questionnaire to determine qualification for this study. The rationale for the participation criteria was to explore and obtain information from counselors from traditional counseling programs and the additional education, training, and experience they need to obtain in order to work with DID clients.

Sample Size

Qualitative studies are concerned with finding and making sense of the meaning of the lived experiences of participants (Creswell, 2013). Therefore, researchers tend to use a smaller sample size than other research methods (Crowther et al., 2017). IPA favors purposive sampling where the choice of participants basically depends on how closely they fit the purpose of the study and its objectives. I also used a snow-balling effect to gather additional participants. Furthermore, because IPA points towards decoding the distinctive understanding of experiences of participants, the sample is predominantly homogenous. When using a phenomenological approach, researchers seek participants who have experienced the specific phenomenon being studied (Crowther et al., 2017).

Sampling, in qualitative studies, continues until data saturation is achieved. Starks and Trinidad (2007) suggested that the sample size for a phenomenological study can range from one to ten participants, while Englander (2014) explained five to ten participants would be sufficient. Adhering to the small sample size typical of the chosen approach and following the suggested range of sample sizes for phenomenological research, I interviewed until saturation was achieved.

Data saturation refers to the point when the collection of new data yields redundant information (Fusch & Ness, 2015). I interviewed eight participants to attain saturation. My goal was to gather sufficient data about the lived experiences of clinicians who work with individuals with DID and to determine if there were any themes, differences, or similarities in the lived experiences of the participants. A small number of participants who have experienced the particular phenomenon being studied is sufficient to reach saturation (Cleary et al., 2014). Thus, I interviewed eight participants, and saturation was reached.

I sent an email soliciting participation in the study to the members of the registry of the ISSTD. I retrieved the emails of members from the regional directory online. I also solicited additional participants through a snow-balling affect. The email included details regarding the study and my contact information so interested and eligible persons could reach me directly (see Appendix A). This process allowed me to reach many participants while protecting their personal identity. I selected participants based on their eligibility and they were provided a screening questionnaire (see Appendix B).

I determined eligibility through a screening questionnaire, which showed the number of years in practice, number of DID patients treated, their age, and their educational achievement. I informed the participants that there would be no compensation for their participation. I also informed participants that their participation would consist of one complete interview and a second brief meeting if more information was needed or if information needed to be verified.

The interview is the most accepted method of collecting data in a qualitative inquiry (Van Manen, 2014). The use of technology in research has increased the availability of participants and has made the collection of data easier. Computer and internet formats such as emailing have not only enabled researchers to reach a larger pool of participants but have also made it possible to conduct real-time visual interviews when the researcher is not physically in the same location as the participant (Aborisade, 2013). My use of audiovisual interviews via Face Time, Skype, or Zoom was beneficial when collecting data for this study. I assured that participants had the necessary capability to access and comfortably use any technological sources of communication.

Secured and encrypted emails were my method of reaching out to my participants, and they had the option to send additional information to support their responses. The participants were encouraged to share any assessments, skills, tools, or strategies they found helpful in working with DID. Each participant was interviewed lasting approximately 50 to 60 minutes, with the understanding that another brief communication may be necessary to address additional information. I used an open-ended structured format for my interviews. I provided all participants with referrals for free or low-cost mental health services should they be needed because of participation in this study. I referred participants to the Family Time Crisis and Counseling Center in Humble, Texas, or the Crisis Call Center (775) 784-8090, which is available 24-hours a day, 7 days a week, for 365 days a year and provides a safe source of support for individuals in any type of crisis.

Due to the current COVID-19 pandemic, I conducted all interviews via Zoom. However, visual, audio, or written interviews were an option if scheduling and geographical distance had become a problem. I used audio recordings to capture all interviews, including those done by Zoom platform. To obtain an unbiased and genuine perspective of the lived experiences of the participants, I provided an open ended and semi structured interview (see Appendix C). The interviews consisted of open-ended questions where I guided, rather than constrained participants, to follow the set of questions to answer the research question. I chose the questions that would be predominantly open-ended and aimed at encouraging research participants to relate their experience in their way.

Biggerstaff and Thompson (2008) referred to the interview plan using the IPA as a template, clearly demonstrating that it is not meant to be dictatorial but instead that it should be targeted at helping participants take control of the interview which allows for the emergence of the "phenomenon." The main research question for this study is as follows: What are the lived experiences of counselors who are experienced in providing successful diagnostic and treatment services to individuals with DID? There were several questions in the interview procedure that I used to understand those experiences. I sought to learn what those experienced counselors did to obtain additional education and training in DID.

I encouraged participants to provide any additional information they felt would add to the illustration of their experiences. I used the NVivo™ software to transcribe the interviews (Bazeley & Jackson, 2019). I manually coded the interviews to determine a

list of themes mentioned in text. I discovered those themes by analyzing participants' words and the sentence structures. I ensured that all items and data (i.e., collected via email or express mail) were protected by encryption and stored in a file accessible only to myself. Participants did not incur any expense should their documents need to be mailed. I used a lockbox to safely and securely store documents provided by the participants.

Analysis

Researchers who use IPA studies seek to gain a phenomenological understanding of individuals' experiences and perceptions of events. In comparison with other approaches, IPA manages to incorporate individual participants' distinctive understanding and the cognitions behind their views (Geraldi-Gauci, 2019). This approach was based on the assumption that human beings are constantly engaged in the process of interpreting their experiences and that such interpretations are necessary for them to reach an understanding of the events or experiences that mark their life (Geraldi-Gauci, 2019). In using IPA, the idea of objective truth is openly dismissed (Geraldi-Gauci, 2019). I used this approach to support the participants' subjective reality and how they interact cognitively. Therefore, IPA lends itself most straightforwardly to studies designed to thoroughly investigate the lived experience of participants (Geraldi-Gauci, 2019).

When using theory in a study, the researcher looks for explanations of why and how events occurred (Creswell, 2014). Researchers choose their theory contingent upon which method is employed. Qualitative researchers use theory as a broad explanation and as a theoretical lens (Creswell, 2014). According to Smith et al. (2009), IPA is a popular conceptional framework that focuses on examining how individuals make meaning of

their life experiences and conveys a detailed analysis of their personal understanding followed by a presentation and discussion of the common experiential themes. IPA is a compilation of phenomenology and hermeneutics (Smith et al., 2009). The researchers derived their ideas from Heidegger, who posited that the interpretative phenomenological approach searches for essential aspects of an experience by examining and explaining the thematic meanings or common structures of a phenomenon.

I manually coded the themes derived from the various lived experiences of my participants. Because of its subjective nature, qualitative studies have been subjected to a higher level of scrutiny. Issues related to credibility, bias, dependability, confirmability, and transferability of a study must be consistent and transparent for a study to be considered trustworthy (Creswell, 2013).

Discrepant Information

It is important to reveal not just common themes, but alternative perspectives, different explanations, and objectivity. Researchers must be mindful of contradictions that may be present, which may not answer the research questions at all. This may also include individuals who may report a different experience in treating clients with DID. I will report discrepant information in the limitations section of my study.

Issues of Trustworthiness

For this qualitative research including case study design, I heightened the trustworthiness through the use of multiple cases studies versus a single case study, the use of member checking to ensure accuracy, and the use of cross-case data analysis in

addition to with-in case data analysis (Creswell, 2013). I also included data that disputed my themes to interject other possible rationale for misdiagnoses.

Credibility

Credibility or confidence in the findings is one of the most important criteria of an empirical inquiry (Creswell, 2014). Credibility is established by sharing any flaws of the study, for example the subjective nature of qualitative inquiries. Transparency and coherence are also quite central in the case of IPA. Rodham et al. (2015) suggested that although this is something which most IPA studies appear to dedicate some space discussing, there appears to be a gap on how, for instance, the researcher's values and preconceptions about the topic under investigation will impact the analytical process or how a final agreement is reached in the development of the final agreed overview of how themes and subthemes fit together (Giraldi-Gauci, 2019).

Bias

The credibility of the researcher is extremely important in qualitative studies. The qualitative researcher is the key element that will collect, analyze, and interpret the data (Aborisade, 2013). Because researchers tend to come to the research process with their worldview and perceptions, protections must be implemented to limit researcher bias. One way bias can be managed is for the researcher to disclose any personal or professional connections with or about the study or its participants. I do not have any personal or professional affiliations or relationships with anyone who has DID or any clinicians who have clients with DID. To further address and limit any bias, I engaged in

self-reflection and provided information that would explain how my experience could influence the interpretation of the data (Aborisade, 2013).

Dependability

Dependability refers to the stability of the data over time (Creswell, 2013). Clear and concise presentation of the study's design, procedure, data collection, and analysis are essential to establish dependability. Burkholder et al. (2016) explained that researchers should keep a written notation of the research process. Detailed notes, referred to as process logs, are very important to maintain during the life of the study. The notes included decisions about the interview process such as who will be interviewed and the interview questions. Safeguards also included feedback from my chair and committee member.

Member Checking

Member checking entails allowing participants the opportunity to review the themes that were developed by the researcher for accuracy (Connelly, 2016). I provided a summary of the themes that I developed as a result of the interview process. Participants received a copy of their interview to check for accuracy and completeness. If their interpretation was not accurately portrayed, I asked them to provide additional information. I examined the data for accuracy and completed representation of the ideas, thoughts, and perceptions of the participants. I also provided participants with the themes I developed and asked them to respond regarding whether they believed the themes were accurate.

Confirmability

Confirmability means that participants confirm that the findings of a study are trustworthy and true to the participants' views and not based on the researchers' bias (Miles et al., 2014). I sent participants a summary of their interviews addressing the various themes of the study, asking for their confirmation of the accuracy of the summaries.

Transferability

Transferability means that the study can be replicated, and the same results and outcomes can be extracted. The results of my study should be able to be applied in other settings and with other similar populations (Creswell, 2013). I addressed this by adhering closely to my chosen design; obtaining rich, thick, and descriptive data; and, presenting the data in such a way that readers can determine if there is any similarity to their own experiences. Transferability is successful when the goal of the study is accomplished.

Ethical Procedures

In my study, I posited that the anticipated benefits of the study outweighed the risks associated with peoples' participation in it. My research complied with the university's ethical standards as well as U.S. federal regulations. I assured that my research would not be conducted without the IRB's ethics approval or otherwise failed to comply with IRB requirements. I obtained IRB approval # 01-24-23-0513327 prior to data collection. I adhered to all IRB guidelines. I followed all feedback from my dissertation committee and IRB to ensure participant confidentiality and minimize the

risk of exposure of participants' private data. I will destroy all data after 5 years in accordance with the ACA (2014) *Code of Ethics* and IRB guidelines.

A researcher should address ethical procedures from the very beginning of a study. Because qualitative research asks participants to reveal personal information, it is imperative that researchers develop and maintain respectful relationships, avoid any prejudice, and maintain integrity (Van Manen, 2014). Researchers act ethically when they consider vulnerable populations and avoid putting participants at risk. Researchers remain sensitive to the feelings of their participants by providing clear information about the study; allowing participants the option to opt-out at any time; providing resources for further mental health care, if needed; and, avoiding causing any harm (Van Manen, 2014). I was mindful of my participants' possible feelings of inadequacy when revealing personal issues that related to their studying and working with individuals with DID. I provided local resources for mental and emotional support.

I did not work with marginal or vulnerable populations. However, I did work with clinicians of various backgrounds, thus my focus was on their personal, distinct, and individualized perspectives on working with clients with DID. I gave participants full disclosure of the purpose of the study and how their contribution would help. I gave a consent document to read and sign and each participant will be provided with a signed copy. The informed consent was provided electronically and reviewed prior to the interview. Participants were assured that they could opt out of the process at any time with no foreseeable risk. After two attempts to reach out to participants, no further

attempts would be made to avoid perceptions of undue pressure to participate. I worked with my committee to determine what was reasonable.

When I have collected the data, I will store it in a locked file for 5 years as required and mandated according to the American Psychological Association. Data storage and maintenance requires that the data be secured for 5 years and remain confidential. The data will then be shredded as in accordance with established protocols. I did not use any participants' names. I picked a pseudonym for each participant, to protect their privacy. Once the study is complete, any identifiable information will be destroyed.

Summary

In this chapter, I discussed the methodology that I used in this study. I discussed the design and rationale for the study, my role as a researcher, and other specific information about the methodology. Qualitative research requires a detailed report on issues of trustworthiness, the dependability of the study, as well as safeguards to ensure that the study follows ethical procedures (Aborisade, 2013). In the next chapter, I provide a thorough discussion of the results of the study.

Chapter 4: Results

Introduction

The purpose of this IPA qualitative research study was to explore the lived experiences and training of counselors to help with both the diagnosis and treatment of clients with DID. The problem is that counseling programs have not adequately prepared counselors to work with clients with DID (Cook et al., 2017). My reason for this study was to seek to determine what experienced counselors believe are the essential trainings needed for those who treat people with DID, what skills are needed, and what these counselors do that works for this population. I designed this study to have counselors who work with clients with DID provide input on their lack of education, additional trainings they sought, and the challenges they face providing services to individuals with DID. These counselors provided me with information regarding the training they received, how they diagnosed the disorder, and their approach to treating individuals who have the disorder. I explored with participants the educational processes and experiences that could provide counseling students with appropriate training and preparation for diagnosing and treating persons with DID. The primary research question was as follows: What are the lived experiences of counselors who are experienced in providing accurate diagnostic and treatment services to individuals with DID? This research question served as a basis for the development of semi-structured questions for the participants' interviews.

In this chapter, I describe the strategies I used to recruit participants, the setting, the data collection and analyses procedures, and results of this study. I discuss how I

captured the lived experiences of expert counselors and their knowledge and perspective of the needed changes to education to better prepare counselors to diagnose and treat persons with DID. I also present the results of the data analysis. The chapter concluded with a discussion of data trustworthiness.

Setting

There were no significant deviations that negatively affected the role or well-being of the participants or the quality of the data and analysis. I completed each interview using Zoom in my home office. All interviews were proceeded as planned as described in the IRB documents approved by Walden's IRB in February 2023.

Demographics

The research sample consisted of eight counselors who obtained additional trainings in complex trauma treatment through seminars, classes taught by experts, additional readings, and collaboration with consultants and supervisors in treating clients with DID. Participants ranged from 37 to 64 years of age. One of the eight participants, or 12.5%, was a male, leaving seven, or 87.5%, female. All eight participants, or 100%, were White. Three of the participants were licensed social workers, one was a licensed mental health counselor, one was a psychologist, and three were licensed professional counselors. All participants exceeded the required criteria of the number years as a therapist and the number of years treating persons with DID. Years as a therapist ranged from 6 to 35. The number of years treating DID clients were 6 to 25. Even though each participant completed slightly different academic counseling programs, they all

experienced the same challenge in obtaining adequate education or instruction in recognizing, diagnosing, and treating persons with DID (see Table 1).

Table 1

Participant Demographics

Participants	Age	Sex	Ethnicity	Degree	Counseling Experience	DID Exp.	License
May	49	Female	White	Masters of Social Work	16yrs	15yrs	LCSW
Kate	64	Female	White	Masters in Counseling	35yrs	25yrs	Psyc
Elle	37	Female	White	Masters in Counseling	6yrs	6yrs	LPC
Leen	49	Female	White	Masters in Counseling	11yrs	9yrs	LPC
Rie	53	Female	White	Masters in Counseling	13yrs	13yrs	LPC
Rika	53	Female	White	Masters in Counseling	29yrs	25yrs	LMHC
Mark	49	Male	White	Masters in Social Work	16yrs	10yrs	LCSW
Josey	41	Female	White	Masters in Social Work	13yrs	9yrs	LSW

Data Collection

I recruited and interviewed eight participants for this study. I assigned a pseudonym for each of the participants to protect their identity. I interviewed each participant via Zoom from my home office. The interviews were conducted in privacy, and the participant's information was kept confidential. I conducted these interviews using the Zoom platform and transcribed them using NVivo transcription services. The ISSTD gave me permission to place study recruitment information on their site; however, because there were no timely responses, I asked IRB for permission to include

participants outside ISSTD who met the study inclusion criteria. Approval was granted.

I collected data via the snowballing effect because responses were coming in too slow via ISSTD's approved recruitment permission. I reached out via ISSTD's directory and obtained participants, and those participants referred other individuals who were vetted and allowed to participate. I digitally recorded each interview during the Zoom call for later transcription by NVivo services. I assigned each interviewee a pseudonym to protect their confidentiality and privacy. I transcribed each interview using the Microsoft Word format. During the interviews, I took minimal field notes so I could focus on the participants' stories and nonverbal communication as they shared rich and sometimes sensitive information. In my field notes, I captured nonverbal communication through observation. In addition, I stored log listing participants' names matched with pseudonyms on a password-protected USB drive in a locked filing cabinet along with transcribed interviews. There were no unusual circumstances or variations in data collection.

Participants

Eight professional counselors agreed to share their lived experiences for research purposes. Emerging from various educational and personal backgrounds, each participant shared their academic history and additional education and experience they incurred to better prepare them to work with persons with DID. While the stories and perspectives were individually unique, all counselors shared the common bonds receiving limited education for treating DID, acquiring important additional trainings, and the challenges they encountered while working with persons with DID. I was careful in protecting the

participants' identities by assigning pseudonyms in place of their real names.

- May: May was a 49-year-old licensed clinical social worker. She had 16 years of experience as a clinician and 15 years of experience working with and treating DID clients. She worked with DID clients exclusively.
- Elle: Elle was a 37-year-old licensed professional counselor. Elle stated she had been working with DID clients for 6 years and had found it to be the most rewarding work she had ever done. She said she was excited that someone was finally addressing the necessary changes that needed to be made in how master-level counselors are prepared and educated to work with DID clients. Elle reported that she had been working with DID clients since she graduated and completed ISSTD's intensive training.
- Leen: Leen was a 49-year-old licensed professional counselor. She reported seeing her clients was the highlight of her day because you never know what you are going to get. Leen shared that not only is she a counselor who treats clients with DID, but she is also living with DID. She shared that there are many professional people who live very successful lives while managing DID. Leen said she uses internal communication work with her clients and often facilitate lectures on this strategy at conferences.
- Rie: Rie was a 53-year-old licensed professional counselor. Rie shared that her caseload was 99% DID patients. She began working with DID clients in graduate school but could not find the help she needed from professors, colleagues, or supervisors during her internship. She said she had three clients

during that time and was unsure what she was seeing but knew it was something different and unusual. Rie said she was told by professors, supervisors, and other mental health professionals that she should not work with these individuals because she would be miserable and to just focus on dialectical behavior therapy (DBT) skills. Rie said she had about 17 or 18 DID clients on her caseload, and this number has been consistent the whole time.

- Rika: Rika was a 53-year-old licensed mental health counselor specializing in art therapy. She explained their entire career has focused on DID. She shared that working with DID clients has been interestingly different because she came from a background with a master's degree in art therapy as opposed to a master's in counseling. She expressed working with DID clients was normal because she sees all people as people, and she also discovered that the clients who come to her come with a myriad of diagnoses, and their system presentation is different.
- Kate: Kate was a 64-year-old licensed clinical professional psychologist. Kate was enthusiastic about the opportunity to talk about dissociation and the challenges working with people with DID. She shared that working with DID clients was worrisome, challenging sometimes, time-consuming, and complex. Kate said, "You feel such a responsibility especially with the cases that don't have a lot of social support."
- Josey: Josey was a 41-year-old licensed professional clinical social worker. She revealed working with DID clients has been the most exciting and

greatest experience of learning and growth both professionally and personally. She expressed working with DID clients can trigger their own "stuff" in ways that is challenging but rewarding because her clients were her greatest teachers in terms of helping her understand the complexities of the human experience. She conveyed the clients are confused about trance and the different ways dissociation manifest. She also revealed how the therapeutic relationship can be the greatest source of trauma and the greatest source of data and healing.

- Mark: Mark was a 49-year-old social worker. He was the treasurer and fellow at the ISSTD. They were also a certified and approved consultant in eye movement desensitization and reprocessing (EMDR) therapy and an approved trainer of EMDR therapy training for ISSTD. Mark presented as enthusiastic and very excited to participate in this study and eager to share his knowledge, skills, and experience. Mark's foundational framework is psychodynamic, and he was trained in EMDR, deep-brain orienting, clinical hypnosis, and ego-state therapy; these are the tools he used to work with clients. Mark shared that he appreciated that this study was being done, and he felt like it has been a luxury to share his work.

Data Analysis

To derive meaning from semi-structured interviews, I employed Van Manen's (1997) selective highlighting technique. With this method of data analysis, key phrases most revealing about the phenomenon are highlighted suggestive of thematic content. I

conducted in-depth, semi-structured interviews to explore the lived experiences of educated and trained counselors who treat persons with DID. Saturation was achieved as repeated themes continued to emerge during the interviewing process. Repeated themes were notated as each participant presented their rich and robust experiences.

Stage 1 of data analysis involved watching each interview twice and notating detailed and accurate statements from the participants. I also performed a careful reading and rereading of each transcript, reinforcing participants' verbal accounts and triangulating the data. I gathered the transcripts from all eight participants and examined them as a whole. I again watched the video interviews of each participant as well gathered visible signs of excitement, distress, and nonverbal communication. Significant segments and phrases were highlighted; in doing so, I began to identify themes. During this process, I considered the meaning of each highlighted portion of text as initial themes emerged from the rich and descriptive responses provided. During the interviewing process, I notated comments in the left-hand margin and highlighted included phrases, key words, and links to comments made through the course of the interview and minimal interpretation to preserve the integrity of the participant's experience. I identified similar concepts in the participant's responses in which I repeated in each of the eight interview transcripts.

During the second stage, I noted emerging themes on the right-hand margin as I continued to read, write, and rewrite, reducing all textual data until essential themes emerged, which were defined uniquely to the phenomenon of counselors who were trained and educated to work with DID. Using my initial comments noted on the left-

hand margin, I attempted to reflect and pull together a broader level of significance (see Langeland et al., 2020). I continued to review the video tapes to extrapolate direct quotes and other pertinent information.

The third stage involved listing the subthemes in the order they appeared during the interview session, which assisted me in better identifying commonalities. I notated the categories and themes as I organized and examined the similarities and differences among them. As I immersed myself in the data, it became apparent that I could cluster together similar categories. Throughout this process, I reviewed the entire transcript to ensure emerging themes were consistent with the words and meanings of the participants.

During the final stage, I placed subthemes that were linked to the data under the appropriate essential theme to ensure I remained close to the data. To determine which themes came from which participant, I used pseudonyms on each highlighted interview. In addition, I created a table of the essential and subthemes to better organize the data collected. Through the process of free imaginative variation, I identified essential themes.

Van Manen's (1997) concept of free imaginative variation uses the researcher to verify whether a theme is essential to the phenomenon or rather incidental adding no meaning to the phenomenon. My goal in this process was to remain as close as possible to the meaning of the participant's phenomenon. I identified and collaborated with my dissertation chair on themes based on how the data reflected the purpose of the study and the relevance of the research.

I transcribed all interviews using NVivo, and I found four essential themes and several subthemes (see Table 2). I manually analyzed and coded all the transcriptions of

the interviews identifying four essential themes and subthemes. Through coding, I identified the themes that emerged from the participants' narratives: academic unpreparedness, experts' postgraduate education and training experiences, recommendations for postgrad students, and challenges in treating DID. Each counselor revealed the same problems and challenges I sought to discover and unveil. There were no discrepant cases or occurrences. After each interview, I noticed reoccurring themes, and the eight participants who shared similar personal and professional experiences confirmed those themes. I achieved saturation of the data as reoccurring themes and subthemes continued to surface. After interviewing the participants, it became clear that their experiences were similar, and their stories were rich and robust.

Evidence of Trustworthiness

As I discussed in Chapter 3, Lincoln and Guba (2011) explained that qualitative trustworthiness is accomplished by applying methods to check the accuracy of findings. To establish trustworthiness, I implemented several strategies to maintain credibility, transferability, dependability, and confirmability in my research study. Adler (2022) expressed that trustworthiness is crucial to assessing qualitative research, and the most significant characteristic is transparency. Adler further iterated that qualitative, whether deductive or inductive, has a theoretical framework, and to be transparent, that framework should be spelled out for the consumers of the research. Trustworthiness begins with self-disclosure of assumptions of the exploration of the phenomena that may be part of the researcher's experience, which I incorporated in Chapter 3. Further methods implemented to ensure trustworthiness in my study included interview

procedures, the transcription and storing process, manual coding, and triangulation with my committee chair. Trustworthiness is paramount in qualitative research but so is credibility, transferability, dependability, and confirmability.

Credibility

Credibility for my interpretive phenomenology research occurred through interview protocol, triangulation method, and a detailed description of my study included in this chapter. To ensure credibility, interview procedures with each participant included my interview questions, Zoom video recordings, and a manual transcription of each video-recorded interview. Each of the NVivo transcribed interviews were then prepared for coding and data analysis. Triangulation was achieved by using three data sources to include the open-ended and semi-structured interviews, demographic questionnaires, and researcher reflective journal. I also used minimal field notes collected as a second input of data to confirm. Feedback provided from my methodologist established validity by analyzing participants' responses.

Transferability

I achieved transferability through rich descriptions obtained from participants that were repeated and confirmed by all participants. This enabled readers to understand my interpretation and reporting of the findings. These rich descriptions included themes derived from data and field notes which provide parameters from transferability. The results of my study should be able to be applied in other similar settings and with other similar populations (Creswell, 2013).

Dependability

Dependability in my study included multiple data checks to improve the accuracy of the data. Upon completion of my interview and coding, my methodologist and I reviewed themes analyzing consistency across the data collection to ensure findings could be repeated. I recruited eight participants and conducted eight interviews. All interviews were video recorded via Zoom platform generating reliable transcriptions of the data. Each interview focused on answering the research question to ensure data collected was accurate and pertinent to the study's purpose.

Confirmability

I obtained confirmability through careful documentation of coding the data, reaching saturation, and the development of themes. Confirmability involved findings being based on participant's responses while I remained mindful about potential bias and engaged in self-reflection in efforts not to skew participants' perspectives of their experiences working with DID. This was achieved by reading and rereading interviews for accuracy and creating an audit trail to record all steps taken and information gathered regarding decisions made about the study. I also used triangulation by asking my dissertation chair to review transcribed interviews for an additional perspective and method to strengthen the confirmability of the study. My dissertation chair examined my audit trail to determine that my coding, data analysis and research was consistent. The audit trail also was reflexive providing me the opportunity to outline my interest in DID.

Results

There were four essential themes that emerged from participants' narratives:

academic unpreparedness, experts' postgraduate education and training experiences, recommendations for post-grad students, and challenges in treating DID. Four essential themes comprised of several subthemes as shown below in Table 2. I selected quotes to illustrate the corresponding themes and subthemes. Subthemes are provided in more detail following the table.

Table 2

Essential Themes and Subthemes

Essential themes	Subthemes
Academic unpreparedness	Traditional counseling programs lack adequate instruction on complex trauma and dissociations
Experts' postgraduate education and training experiences	Completed trainings, education programs, consultation, and supervision
Recommended trainings for post-grad students	Education and training opportunities
Challenges in treating DID	Insurance; funding; socio-political challenges

Academic Unpreparedness

All the participants indicated that they did not receive significant, detailed, or adequate education or training in dissociations and specifically DID. Participants further shared they did not receive adequate instruction on complex PTSD, psychopathology, or dissociations. The participants stated they either received very little or no instruction to adequately prepare them to work with DID clients or any dissociative traits. The participants shared their personal educational experiences and the lack of instruction and training received on complex trauma and DID. The participants all agreed that whether

the counselor desires to specifically work with DID or not, there still needs to be an enhanced and improved preparedness in complex trauma because most clients show up to counseling with some form of trauma and in most cases very complex trauma.

Mark affirmed,

> I had no courses on trauma in grad school and I only had one course in psychopathology. I truly don't remember spending much, if any, time on the dissociative disorder section of the DSM, well it would have been the DSM four at that time and I would have said I didn't get any training at all in diagnosing, treating any of that; people with DDs or people with DID specifically.

May further explained,

> I don't think we talked about DID at all. I did not get any significant education on DID or working with these clients. I was oblivious to the disorder and had to learn more about it on my own. I graduated in 2005 and I had one class where they talked briefly about trauma but no emphasis on dissociation. I don't think it was in the one class we had on going through the DSM. And even then, that day, it was like just one time and it was just, let's talk about depression, anxiety, whatever, and they didn't get into this other stuff.

Kate indicated, "I never got a lot on dissociations, and I just received the basics on PTSD."

Leen asserted,

> When I was licensed in the state of Georgia, we were unable to diagnose DID and so I actually had to go back and retake the psychopathology course and even then,

> we only spent one day on trauma and DDs with that, with that professor, and I would not be able to recognize or diagnose. I did not receive education on the treatment of dissociation in my master's-level program and the topic was only briefly presented in a trauma course.

Elle affirmed,

> I got very minimal instruction, and I don't even know if it ever came up. I'm trying to even think about, like abnormal psychology, maybe it was mentioned as a potential like diagnostic option, I don't even remember that, like even then, I think like in terms of the chapters on severe mental health, they focused more on like schizophrenia and some other things, and very little on complex trauma or DID. The only sources I knew of when it came to multiple personality disorder or DID was like weird media stuff that's so extreme, right.

Rie expressed,

> I came in contact with DID clients when I started out after my graduate program and could not get the help I needed from supervisors or professors and now looking back on it, I know I had three clients at the time with DID. I was told that in my graduate program that that diagnosis didn't exist. And I was ticked because I knew what I was seeing in the room, switching, the child state and such, which isn't always the case, but that was my first experience. My graduate program did not sufficiently prepare me for working with DDs. Even though I attended a school that focused more on trauma than other traditional academic counseling programs; I was still ill-prepared to identify, diagnose, or treat persons with DID.

Josey explained,

> I did not get any preparation or instruction on complex trauma or DDs. My master's degree was in social work, but I opted to attend a school of critical social work, which allowed me to go and get any clinical training I wanted but none of the programs focused on dissociation, let alone dissociative identities. My master-level academic experience did not prepare me at all to work with individuals with DID. I received a master's in social work but in Ontario. I had the option of attending a school of critical work or a school of clinical social work and I made the decisions to go to the school of critical social work but none of my courses focused on dissociation, let alone dissociative identities.

Rika admitted,

> I mean having a master's in art therapy, I went to an art institute and all my psychology courses were at the Rushmore medical college, so it was a very, it was wild to have those two very disparate approaches. But I got nothing, nothing with complex trauma and they just went through the DSM but gave us nothing on dissociations. The psychopathology class was also not helpful in teaching me about DID or complex trauma. I didn't have significant exposure to trauma treatment other than a brief mentioning of the symptoms in the DSM.

Experts' Postgraduate Education and Training Experiences

The following training and additional education sought by the participants were vital in preparing and equipping them to diagnose and treat persons with DID. Each participant completed and graduated from a slightly different academic program, but they

all affirmed that their perspective programs did not adequately teach them about complex trauma and dissociations. Each participants' personal experience of how they acquired necessary trainings are included to give a different perspective to the same problem – academic unpreparedness. The rationale of including each participant's experience further supports the idea that there are no academic counseling programs equipped to adequately and ethically prepare students to work with complex trauma, dissociations or specifically, DID.

ISSTD's Professional Training Program

Six of the seven participants (i.e., experts) engaged in ISSTD's professional training program and said this was the best foundational training for anyone working with persons with DID. They postulated that this training does not just provide education but more importantly, teaches how to understand all the nuances that are prevalent in working with dissociations. The experts all reported that this is the only program that trains individuals foundationally in helping them understand what is happening with the client and their unique experiences. ISSTD's professional training program courses are designed to be heavily discussion based with minimal formal, didactic instruction. The courses are intended to offer insight, exploration, and critical thought opportunities beyond that of a typically structured post graduate program. Participants are encouraged to complete the assigned readings and attend every session prepared to engage in active discussion of the material in collaboration with expert insight and consultation from the instructor. The following ISSTD courses are also the same types of courses all the participants suggested would be appropriate and adequate for counseling programs: The

complexities of complex trauma part 1; The complexities of complex trauma part 2; From complex trauma to DDs 1; From complex trauma to DDs 2; Advanced topics in complex trauma and DDs; Master Seminar: Complex posttraumatic and DDs; Assessment and treatment of traumatized children and adolescents with dissociative symptoms and disorders; and, 2 other courses on dissociation in Spanish. ISSTD's Professional Training Program (PTP) courses strive to provide the most current, high-quality content and instruction, setting the standard for graduate and continuing education in the field of trauma and dissociation (ISSTD, 2011). While the courses are geared toward clinical practice, they also cover research findings, as well as legal and ethical issues within the domain of mental health practice.

May stated,

> I completed training in hypnotherapy, integral breathing, EMDR training and simply used those modalities to help me in working with DID clients. My training was not DID specific, but I used different techniques to help each client. I would like to get additional training in internal family systems (IFS) and Somatic Therapy, but they are too expensive. I also suggest multidimensional inventory dissociation (MID) because it is helpful when working with DID clients their many different parts.

Josey said,

> There are 25 theories of dissociation or conceptual models and not one theory is going to fit every client. The only program that trains you foundationally is the ISSTD's professional training program. And so, the idea here is it's not just

> training on what to do but how do I intervene. I started my journey on obtaining additional education and training by attending learning more about trauma and how you understand trauma, assessment, treatment, and therapy. I did some clinical work and started training in dissociation. One of the best trainings, and I may be bias, the only training that teaches you foundationally is the ISSTD's professional training program. Many trainings are more technique-oriented and not more focus in understanding all the nuances that are there with working with persons with DID.

Mark also stated,

> Even-though I did not attend ISSTD's professional training, I highly recommend this training for foundational knowledge of the history of DID and all the nuances that are uniquely associated with this disorder and how to treat it. I recommend this professional training program because it has been thought out by people that have been doing this for a long time now. I developed ISSTD's version of the EMDR therapy training and it was like, it's my baby. This training makes sure you are well informed, so it is front-loaded with information about complex trauma and dissociation.

Kate asserted,

> I didn't attend the ISSDT's training program, but I am familiar with its success, but I did attend, and am a member of the international society for traumatic stress studies and attended their conferences to learn about dissociations and complex trauma. My internship was in a combat trauma unit, so I was exposed to PTSD

> and child sexual abuse as I worked with trauma survivors and veterans. Specialized training that focuses on complex trauma and dissociations are key to preparing any clinician to work with DID.

Leen, a DID client and a DID clinician, stated,

> I agree that the ISSTD's professional training program is a very good training. I took the EMDR training from an expert who also is a DID client because their entire training is very dissociative focused. I did a lot of reading and of course, sought lots of consultations.

Elle also stated,

> I think that ISSTD's professional training program is great for the complexities of complex trauma, and that gave me, I think, really great foundations of understanding it with a lot of individuals like it came up in advanced EMDR training first.

Rie stated,

> I attended the ISSTD's professional training program, which was very informative and preparatory, but I also attended Delores Mascara's progressive method, which is to use EMDR in a very different way that's appropriate for clients with BPD or DID or DDs. I am disturbed with the traditional EMDR trainings that exists because they do not address the proper or most effective method when working with DID clients.

All the participants suggested specialized and focused trainings on dissociations, child abuse, complex trauma, and assessment are important in diagnosing and treating

DID. The following paragraphs explain the other recommended trainings that they found to be vital in teaching, training, and preparing them to work with DID clients and are also the recommended trainings for all graduate counseling students.

Consultation, Supervision, and Readings

All the participants expressed that consulting with an expert was paramount in the continual support and guidance needed to work with DID. They further asserted that consultation was huge and was ongoing.

Mark stated,

> I have been in a long-term consultation with someone who is a leading expert in the use of EMDR to treat DDs. Attending "tons" of ISSTD's conferences and reading whatever I could find was helpful in my knowledge and growth in this area. I joined ISSTD in 2012 and through this consultation with my peer, learned many things. I started going to ISSTD conferences in 2016 and gain knowledge fairly quickly because I did a ton of reading and going fairly deep into the literature. I continued to attend conferences, learning how to treat DID safely, and maintaining a collaboration with an expert.

Leen reported,

> I have been in consultation for years and feel I will always need to collaborate with the experts as working with DID is an ever-learning process. I was diagnosed with DID, and feel that continual supervision, consultation, and conference attendance are key components to understanding and treating this disorder. Attending the Healing Together conference is beneficial for clinicians, people,

> and supporters. This conference is unlike most conferences as the presenters are not just the experts but also professionals and individuals diagnosed with DID, who provide a rich and unique perspective on what it's like living with DID.

Josey indicated,

> I consult with an expert monthly and also meet with two other consultants on specific areas. Consistent consultation is important for one's continual learning and growing. Greater consultation support and being really consistent about that is important.

All participants stated that collaboration and consultation were valuable in this area of service. The participants also expressed supervision with an expert was also helpful in learning about and maintaining support on DDs. All the participants declared that having a mentor, supervisor or consultant was vital in learning about and working with DID. All the participants established that reading all the literature and research on DID was key to learning and understanding the complexities of DID.

Rie shared,

> I started working with Kathy Steel, who is known internationally for her work with DID, here in Atlanta, and I have been working with her as a consultant for 13 years as well as other consultants. Consulting with her helped me build my practice." To better learn and understand DID, I attended ISSTD's dissociative training program and many ISSTD conferences. I had four consultants I collaborated with because my learning was ongoing. My consultation is and always will be ongoing and its imperative in working with these clients. My

> learning does not stop, and I recommend those working with DID clients to keep an open mind and a willingness to listen to these clients, because they are the best teachers of their disorder.

Rika shared,

> I read everything I could on dissociation and consulted with someone experienced in the field. I got a supervisor and also sought everything I could base on the gaps in my knowledge in sitting with the people I was sitting with. I did lots of reading and sought many trainings on trauma. Going to the Healing Together conference and learning more from folks with lived experience as well as learned experience. Because I do think that there is an immense benefit from listening to professionals that have lived the experience.

Kate stated,

> I sought out my own research, continued doctoral studies, and completed internship exposure to combat trauma with veterans. A huge part of my dissertation research was on long term effects of child sexual abuse and was expanding my PTSD experience and working with vets as well as trauma survivors.

Josey stated,

> I sought out on my own journey of discovery about DID through reading literature that was sound and trauma focused. I'm constantly growing, constantly learning, constantly researching, constantly training, it gives me a framework that I can then walk away and then sit down with my client and say, okay, so I have

> this loose frame so then I sit with the client to figure out what's happening and where to go. So, the training gives me the frame and options in terms of interventions when and if I need them.

May expressed,

> I read more books on IFS as the training is "so damn expensive" and other literature on recent discoveries of understanding DID and other DDs. I've been doing my own little research and finding all the different assessments. I collaborate with my colleagues that are knowledgeable.

Hypnotherapy/Hypnosis

Several participants asserted that hypnotherapy has been beneficial in working with persons with DID. Hypnotherapy is hypnosis, also called hypnotherapy, is a state of deep relaxation and focused concentration. It is a type of mind-body medicine. A trained and certified hypnotist or hypnotherapist guides you into this deep state of focus and relaxation with verbal cues, repetition, and imagery. When you are under hypnosis, this intense level of concentration and focus allows you to ignore ordinary distractions and be more open to guided suggestions to make changes to improve your health. significant gains have been made in the past two decades regarding our understanding of the neurophysiological correlates of hypnotic responding (i.e., responding to hypnotic suggestions) and in our understanding of the efficacy of hypnotic treatments for various clinical conditions (Jensen et al., 2017). May stated, "I got training in hypnotherapy and not the typical hypnosis but the hypnotherapy going into the trauma."

Ego- State Theory (EST) (Training)

EST and therapy was developed by Watkins and Watkins (1997). The Watkin's postulated that EST is based on three pillars: psychoanalysis, hypnosis and Janet's concept of dissociation. EST has been a major theory and therapy for the treatment of complex traumatization, in particular DDs, and is also a therapy helpful for other types of difficulties and pathologies (Leutner & Piedfort-Martin, 2021). Several participants mentioned the benefits of using EST.

Elle explained,

> I use EST for my clients because some parts of them may want A and some parts of them may want B and those two things conflict all the time. There is more to working with DID than the psychological part, such as the biological and neurological ramifications that could occur after severe trauma has been experienced, especially in children. The central nervous system is affected when someone has been traumatized. I am astonished that we are not looking at all facets of psychological testing of traumatized individuals using polyvagal theory, attachment theory, adaptive information processing (AIP), parts mapping work therapy, and a more holistic view of what is happening in the physical brain and how it is receiving outside stimuli.

Eye Movement Desensitization Reprocessing (EMDR)

All the participants completed EMDR training and said it is beneficial for DID work but also indicated it needs to be modified for DID and other trauma work. Additionally, participants explained traditional EMDR can be more harmful for clients.

Furthermore, Brainspotting™ (BSP) therapy, may be a particularly promising improvement of EMDR. A key difference is that BSP requires attentional control while attending to a specific "spot" within the visual field that is linked to heightened physical sensations while recollecting a traumatic memory (Talbot & Jaworska, 2023).

Mark asserted,

> I was initially trained in EMDR, and I didn't really know anything about trauma and that doesn't qualify you to treat people with DDs and not DID. So, I had to learn the hard way by making mistakes, unfortunately, but then what I did was I started doing consultation with an expert, started attend all ISSTD conferences, ramped up my trainings in trauma. I now have advanced training in EMDR therapy, and I teach people fancy things you can use EMDR for in treating people with DID. I know and understand how to use things safely; and without that I would probably be doing a lot of damage.

Adaptive Information Processing Theory (AIP)

Rie stated, "I use AIP to help me manage the developmental needs of my clients. It helps me use EMDR in a very different way." AIP theory provides the theoretical underpinning of eye movement desensitization and reprocessing (EMDR) therapy. AIP theory was developed to explain the observed results of EMDR therapy delivered to individuals experiencing trauma and PTSD. The AIP model hypothesizes that maladaptively stored memories of trauma create obstacles to rational processing of information, which occurs in the prefrontal cortex area of the brain (Hill, 2020).

Cognitive Processing Therapy (CPT)

Elle stated, "I obtained my first training in CPT, and it helped me with the switching that happens in the room, accents, voices, and all the unique and strange occurrences that come with DID work." Like EMDR, CPT has not been used initially or designed to treat for dissociation. CPT is one specific type of cognitive behavioral therapy (CBT). It is a 12-session psychotherapy for PTSD. CPT teaches you how to evaluate and change the upsetting thoughts you have had since your trauma. By changing your thoughts, you can change how you feel. strong training in CPT may nullify potential effects of complicated trauma histories, as sufficient understanding of social-cognitive theory and the therapy allow providers to flexibly and effectively apply the protocol (Roberge et al., 2022).

Multidimensional Inventory of Dissociation (MID)

The MID is a 218-item, self-administered, multiscale instrument that comprehensively assesses the phenomenological domain of pathological dissociation and diagnoses the DDs. Most clinicians have received little or no training about dissociation and dissociative symptoms. This may lead them to fail to notice dissociative symptoms or to misclassify them in terms of a clinical diagnosis with which they are more familiar (e.g., depression, bipolar disorder, or psychosis). Questions about dissociative symptoms are absent from most standard clinical or psychological questionnaires and assessments. This makes the MID, a validated and reliable, 218-item self-report inventory, an essential addition to clinical practice – especially when a clinician is serving client populations known to be at-risk for complex trauma. The MID is used by clinicians and researchers worldwide (Dell et al., 2017). Josey stated, "I use the MID to screen for DID and to reach

a deeper place within the subject to reveal secrets, because "we know that DID is all about secrets." May stated, "I use MID to gain deeper meaning of the dissociation and when the client struggles with expressing those parts." Leen stated, "I use the MID because it is dissociative focused." Rie stated, "I use the MID because it is an advanced assessment tool."

Dissociative Tables Techniques

The most common place an eye movement desensitization and reprocessing (EMDR) clinician will introduce Fraser's dissociative table technique is in Phase 2 of the EMDR standard protocol. In this preparation phase for trauma reprocessing, the dissociative table helps stabilize the client by organizing and making sense of the internal experience. Identifying and working with emotional parts of the personality is essential when working with complex trauma and dissociation (Martin, 2012). Gaining access, identifying, communicating and working with these parts are necessary in preparation for effective trauma reprocessing. An easy yet profound way to identify these parts of the personality is a process called Fraser's dissociative table technique (Martin, 2012). Leen stated,

> I like the Frasier table work because it helps with the parts work, system mapping, and a lot of hands-on stuff. I gained more education and training by attending ISSTD's dissociation training, EMDR training that was DID focused, MID training, system mapping training, and the Fraser's dissociative table technique. With some of my clients I chose to use CBT and DBT to stabilize and then use

specific dissociative techniques to assist in their treatment. DID does not require medication and responds well to CBT.

Integral Breathing Technique

Deep, slow breathing - about ten breaths a minute - initiates a relaxation response in our bodies, and these physiological changes in turn have a measurable impact on our mental and emotional states (Kopplin & Rosenthal, 2022). One 2017 study published in the journal, Frontiers in Psychology, found that diaphragmatic breathing practice can improve cognitive performance and reduce negative consequences of stress in healthy adults, while a 2018 review of literature published in Frontiers in Human Neuroscience went even further, proclaiming that breath-control can change your life (Kopplin & Rosenthal, 2022). According to the study's authors, researchers from the University of Pisa, slow breathing techniques trigger changes in our cardiovascular, respiratory, and central nervous systems, which lead to increased comfort, relaxation, pleasantness, vigor and alertness, and reduced symptoms of arousal, anxiety, depression, anger and confusion (Kopplin & Rosenthal, 2022). May stated, “I think that integral breathing therapy works well with DID clients.”

Polyvagal Therapy

Polyvagal theory offers insight into how safety and connection can be fostered via cultivation of the social engagement system and coregulation. However, applying the principles of polyvagal theory requires more than a simple replication of listening behaviors. The implications of neuroception demand genuine engagement, empathy, and positive regard from the therapist to create the perception of safety. The true art of

therapy is tested in the recognition and handling of resistance. It is in this stage that the drama of change unfolds (Ryland et al., 2022). Reframing resistance as a protective behavior can help us refine our clinical interventions to promote safety and increase the client's awareness of the impact of these behaviors in their own relationships (Ryland et al., 2022). Resistance has traditionally been perceived as an unwanted barrier to change in therapy. Polyvagal theory suggests that resistant behaviors emerge from an adaptive, preconscious system that seeks to protect us. Acknowledging and normalizing protective responses in therapy strengthens perceptions of safety and the therapeutic alliances in individual and systemic therapy (Ryland et al., 2022). Rie stated, “I use Polyvagal therapy to manage resistance with my DID clients as some of them have never experienced boundaries, rules or critical change.”

Internal Family Systems (IFS)

IFS therapy focuses on three levels of a client's well-being; the intrapsychic, family, and societal levels (Jones et al., 2022). Influenced by models of therapy that rely on systems theory, IFS focus beyond the external system that affects the client to examine the internal system. IFS combine two theoretical paradigms from the world of psychology and family therapy: systems theory and the multiplicity of the mind (Jones et al., 2022). With a focus on the internal structure and external structure, an IFS therapist can connect and understand clients at every systemic level and free the oppressive beliefs that exacerbate the pain of sexual trauma (Jones et al., 2022). May stated, “I use IFS techniques to work with my DID clients as childhood sexual trauma involves the family systems and relationships.”

Attachment Theory (AT)

There is now a wealth of evidence supporting the importance of secure attachment in social and emotional development, as summarized in a recent meta-analysis by (Cobbett, 2022). Attachment has become increasingly incorporated into systemic therapy in the form of a variety of attachment-informed systemic models that have influenced this approach. Systemic therapy can help deconstruct attachment narratives about self and relationships. Attachment experiences shape the development of neural pathways in the brain so that securely attached children will have different neural pathways encoding different patterns of thought, emotion, belief, and behavior in comparison with insecurely attached children (Cobbett, 2022). Neuroplasticity also allows the brain to 'rewire' through the organization of different neural pathways in the context of a new experience such as a therapeutic relationship (Cobbett, 2022). Elle stated, “I think that attachment theory is important because it helps us understand the brain and how it is coping with the trauma.”

Psychodynamic Therapy

The use of psychodynamic psychotherapy interventions (holding environment, containment, and self-object transferences) can help create trauma-informed practitioners (Alessi & Kahn, 2019). Trauma-informed practice consists of (a) recognizing the impact of traumatic events on the functioning of clients and that their symptoms serve as attempts at coping, (b) viewing recovery from trauma as a primary treatment goal, (c) utilizing an empowerment model, (d) maximizing client control over their recovery, (e) relying on relational collaboration, (f) creating an atmosphere of safety, respect, and

acceptance, (g) focusing on adaptation over symptoms and resilience over pathology, (h) seeking to minimize the potential for re-traumatization, (i) conceptualizing clients' life experiences in a cultural context, and (j) soliciting client input and involving clients in the design and evaluation of services (Alessi & Kahn, 2019). Each of the participants agreed that psychodynamic work is necessary to adequately treat DID as it focuses on the whole individual and their relationships. The participants all agree that a psychodynamic course be reintroduced in counseling programs with the removal of old traditional books that dismiss DID. Josey stated, “I think that psychodynamics is incredibly important to give one a conceptual framework and an understanding of the phase approach to treating DID.” Mark stated, “I was trained n psychodynamic psychology. Psychoanalysis helps conceptualize things better. It helps you understand the actual psycho dynamics, which is critical because it’s all rooted in relational issues.”

Kate expressed,

> It’s been an evolution of training for me on how to understand dissociation and how does this fits and resonates for my client. Training in psychodynamics is beneficial. I used the DESII but now I am shifting to the MID-60 for adults, with kids the child dissociative checklist, child dissociative experiences scale, and then with adolescents the adolescent dissociative experiences scale, or the adolescent multidimensional inventory of dissociation.

Neurobiology and Trauma

Emotional and affective experiences exist in the body and is often manifested as biochemical and physiological reactions (Beaudoin, 2019). Every single emotion has a

biological connection. Therefore, engaging in therapeutic conversations without examining the links between experience and the body ignores a great deal of information. In therapeutic conversations, connecting to positive emotions and affective states involves asking clients to expand their preferred selves into unexamined territories (Beaudoin, 2019). Talking about a neuroplastic brain with various programs, and mindfully exploring sensations, adds an embodied dimension to clinicians work and further enhances the externalizing process, which is hope- promoting to many people (Beaudoin, 2019).

Rika shared,

> Neurobiology of trauma exists on a continuum and our minds adapt in ingenious ways. Everybody dissociates and everybody has multiple parts of self and if we are lucky enough to live a life where we're not abused and hurt, that looks different than in people who have had experiences where they have had to rely on that to survive. I am EMDR trained, sensory-motor psychotherapy, trainings in dissociation, and trainings in treating dissociation.

Elle stated, "We must address the neurological and functional levels to be able to talk to parts directly and identify them."

Recommended Trainings for Postgrad Students

The participants all indicated that the ISSTD's professional training program is a must for new grads and six of the experts engaged in this training for their foundational training in working with DID. ISSTD's mission is to advance clinical, scientific, and societal understanding about the prevalence and consequences of chronic trauma and

dissociation, underlies the courses that it offers.

EMDR training with a focus on DID is another recommended training the participants all agree is paramount in treating DID. ISSTD offers specific trauma informed and DID specific EMDR training. The participants all expressed that traditional EMDR training is not suited for the treatment of DID or DID symptoms and can cause more harm to the client overall. According to Gonzalez-Vazquez et al., (2018), EMDR is a psychotherapeutic approach with recognized efficiency in treating posttraumatic stress disorder (PTSD), which is being used and studied in other psychiatric diagnoses partially based on adverse and traumatic life experiences. Nevertheless, there is not enough empirical evidence at the moment to support its usefulness in a diagnosis other than PTSD. It is commonly accepted that the use of EMDR in severely traumatized patients requires an extended stabilization phase. Some authors have proposed integrating both the theory of structural dissociation of the personality and the adaptive information processing model guiding EMDR therapy. One of these proposals is the progressive approach. With this understanding that the participants in this study agree that EMDR training must include specialized caveats that can safely address DID symptomology.

Josey explained, “I am an EMDR trainer, and I only use it if it’s appropriate. It must be DID focus to be effective with DID clients” Elle stated, “Advanced EMDR addresses DID ego-states and parts of self.” May shared, “I attended a training that was specifically addressing EMDR and dissociation and how you do that well with DID clients.” Rie asserted, “EMDR must be used appropriately with DID clients and one of those discoveries is the progressive method by Delores Mascara, from whom I learned

and trained under." Kate affirmed, "I trained under Francine Shapiro, who is the originator and developer of EMDR, but my additional trainings, such as hypnotherapy, helped me apply EMDR techniques in a different way for DID clients." Mark expressed, "I am an advanced EMDR trainer and agree that this therapy is effective when used in creative ways along with other therapies, such as hypnotherapy, sensory motor psychotherapy, and deep brain reorienting."

The participants voiced that students should take the initiative to seek out consultants, conferences, trainings, books, articles, presentations, and resources to help them understand DID better.

Leen affirmed,

> I watched documentaries, read the recent literature, and attended retreats focused on complex trauma and DDs. I think so much harm gets done because when no one is prepared to work with DID, the first time they see it in a session when the client is saying they hear voices and so the clinician wants to go to schizophrenia cause that's easier – so that's why clients are diagnosed with seven diagnoses before they are accurately diagnosed and so lots of consultation and trainings are needed to do this work. I know this firsthand because I live with DID and I know the harm misdiagnosis causes because I was misdiagnosed for many, many years and I just don't want anyone else to go through that – and that is why I take insurance because I think it's a social justice issue.

Rika affirmed,

> The best training is seeking out training in the neurobiology of trauma, learning about dissociation as a part of PTSD, and there is a continuum of dissociation, finding a supervisor that is expert in dissociation, seeking out authors and other experts that would be willing to mentor and supervisor you and then keep an open mind to learn from your clients as they are the experts of their own experience.

Challenges in Treating DID

Most dissociative individuals reported barriers to accessing and continuing mental health treatment. The experts shared their collective and similar challenges with meeting the needs of clients with DID.

Mark stated,

> The cost of treatment and insurance are always a problem because of the nature and time involved in treating DID clients. I don't accept insurance, but I actually adjust my fees so a fifth of my client caseload pays a reduced fee and everybody knows that some people are paying the full fee so that other people can pay less. So, there are clients I would love to see more often but they just can't afford it and I can't give everyone a discount, or I couldn't afford to do what I do. I try to find a balance.

Leen said,

> I often use creative ways to see my clients when they use their insurance because 50 minutes is not enough time to work with DID clients. Depending on how severe the case, I see some clients five days in a row, so as to keep them supported and stable. Treating these clients is a social struggle because insurances

> don't pay enough for the services and restricts the time needed in sessions and the overall length and duration of therapy. I start to see some improvement with my clients after four to five years in therapy.

Kate also shared,

> Some of the challenges I've encountered have been the time consumption, setting boundaries, listening to horrific stories, clients getting too dependent on me, complicated transference, and case management. I try to not treat many DID clients at the same time, so my present client has been with me for 11 years and I see their 2 to 3 times a week. I have not successfully treated a DID client from start to full fusion or integration. I have a self-pay practice, so a lot of my clients have to be able to afford my fee. I do not take insurance or medicare in my private practice and charge a hefty fee for my services. We don't see any significant improvement before 5 years, and 5 to 8 years treatment time is common.

Elle also stated,

> Affordability is a huge barrier in clients getting the help they need. The time it takes to properly and effectively treat them affects things like finances. This type of treatment takes time and people just want to get better in a hurry because they need to survive financially and function better in this world. And that's the biggest challenge in that the brain can only go at the pace it's ready for, and people need to get better quicker than that for functional reasons. One of my biggest challenges is working with insurance companies and the limited amount they are willing to pay. With the need for longer sessions and longer times in

> therapy, cost can be a huge factor, as clients can't afford to pay for the needed session and the length time needed in therapy work. It takes a lot of patience and focus working with these clients because they want to get better quickly, and this process is long and arduous.

May stated,

> I think that costs, time frames, and insurance are all barriers to effective DID treatment. It takes time to get into serious deep trauma work for which my clients can't afford to pay for. I take insurance so I'm only allowed the 50 minutes. I have a client that I purposefully see at the end of the day because goes over 30 minutes but if I could see all my clients for 90 minutes regularly, I would love it, if not for the pushback from insurance. This is a huge barrier and I try and do what I can to accommodate but it goes back to copays and scheduling time or whatever.

Rie also expressed,

> Some unusual experiences working with my clients is they can be contradictory, forgetful, and may talk about themselves in the third person. DID clients will present with different body language, twitches, or jolts, and twitching of their eyes which can be very subtle. In addition, I notice these subtleties and I often address it with the clients. The challenge with treating these clients is the time and cost issues. My success rate is 95% in helping my clients reach a place of wholeness and functioning well with their parts. There are many successful professionals living with DID.

Josey shared,

> I go between seeing a client once a week for 75 minutes or 90 minutes to twice a week for two 60-minute sessions. It's a challenge because the cost factors are always an issue. I can't adequately service a DID client in 45 or 53 minutes, but insurance companies don't want you to spend that much time in trauma processing and you are prone to more audits when you do that. And then there's the people on public health insurance and some clinicians don't take that insurance so there is a real inequity in getting access to quality care.

Rika also shared,

> There are to a lot of barriers for people looking at this and working with this. Some of the unusual or strange occurrences while dealing with clients with DID is the fear of the unknown, which is a problem for people and clinicians need to learn that the DID client is the expert of their experience and problems. Some of the barriers of treatments are insurance restrictions, needing longer sessions, and the billing issues. Money is a huge barrier in treating these folks as some people can't afford the long-term care they need, and insurance companies have come up to the plate to provide needed assistance.

Summary

Data was collected through semi-structured interviews with a sample of eight mental health clinicians from the US ISSTD's registry and other clinicians who met the study's participant criteria. Interviews were conducted via Zoom platform. All interviews were video-recorded and transcribed verbatim by NVivo transcription services. In my

research, I discovered four primary themes: academic unpreparedness, recommendations for postgraduate education and training, recommended trainings for post-grad students, and challenges in treating DID. I was able to answer the main research question and interview questions seeking out the problem, gap in literature, and recommendations for change.

For the main research question about the lived experiences of counselors who treat persons with DID, I found that participants expressed similar experiences of not being adequately prepared in their master-level academic programs and having to obtain additional trainings and education to work with DID clients. When answering the question about recommendations suggested for how counseling programs should teach and prepare counselors, I found that all the participants suggested mandatory classes in psychodynamics, informed-trauma work, complex trauma and dissociations, in-depth instruction on what dissociation looks like, abnormal psychology, and a trauma framework where we look at how DID affects the central nervous system ad how the brain tries to cope with the traumatic content. Participants also suggested that academic programs employ experts in DID and also have guest speakers who are actively living with DID, come to share their rich and lived experiences. All the participants agreed that mandatory, informed, in-depth, and trauma-focused courses are essential to better prepare all counselors to deal with trauma which is evident, present, and everywhere.

In this chapter, I described the data collection and analysis procedures I used in conducting my investigation. Chapter 5 will include the conclusion of the study based on the findings discussed in Chapter 4. Chapter 5 will also include a discussion and

recommendations for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

I used a qualitative, interpretative phenomenological research approach to explore the lived experiences of counselors who treat persons with DID. In this interpretative phenomenological study, I attempted to provide suggestions to improve the recognition, diagnosis, and treatment of patients with DID. This group of patients presently have no evidence-based treatment available but are very much in need of effective and feasible clinical help (Huntjens et al., 2019). Evidence-based treatment is a prerequisite for the formulation and acceptance of evidence-based consensus treatment guidelines for this controversial disorder. The goal of this present study was to include the reasons for misdiagnosis, experiences of experts who work with DID patients, and the additional training obtained that adequately prepares counselors to work with DID patients. By changing the 2016 CACREP standards and qualifications for educating counseling students about the history, diagnosis, and treatment of DID, the academic professionals can begin to address this problem with viable and effective measures. Despite the refinements in diagnostic description and advances in neurological research on DID, there is still a dearth of research on this disorder. A recent meta-analysis by Dorahy et al. (2017) elaborated on this deficit. Thus, this study might contribute to the literature by helping fill in the gap surrounding the research on the experiences of therapists who treat clients with this disorder and the necessary changes needed in the 2016 CACREP standards and the academic undergraduate counseling programs.

Interpretation of the Findings

Participants in this study discussed their experiences as counselors who have obtained additional training and education after their master's studies to learn how to recognize, diagnose, and treat persons with DID. In my analysis, I identified four descriptive themes: academic unpreparedness, experts' education and training experiences, recommended trainings for postgrad counseling students, and challenges meeting the needs of DID clients. In the following paragraphs, I synthesize the findings presented in Chapter 4 with pertinent literature identified in Chapter 2.

Theme 1: Academic Unpreparedness

Aside from clients hiding symptoms, counselor competence has been the primary reason noted for misdiagnosis and under diagnosis (Brand et al., 2014). Clinicians often lack education, training, and experience in the diagnosis and treatment of DID (Park, 2012). All the participants agreed and concurred that their master-level counseling programs did not adequately prepare them to treat clients with DID. They further confirmed that the misdiagnosis is hugely related to clinicians not knowing what DID looks like and not having the knowledge about the history of DID and dissociation. Fedai and Asoglu (2022) confirmed that the combination of insufficient training in recognizing trauma-related dissociation, limited getting to accurate scientific information about DID, symptom similarities with other disorders (such as borderline personality disorder, schizophrenia, and bipolar disorder), and the aetiology debate has caused a deficiency when considering a diagnosis of DID. This leads to under- and misdiagnosis of the

disorder, inhibiting effective treatment (Fedai & Asoglu, 2022). The researchers further asserted that there are no formal, evidence-based treatment guidelines for DID.

Findings in the literature reported that there is a gross negligence in clinician preparation to work with DID, and the presentation of all the additional trainings that are available further attest that counseling programs are not providing adequate instruction. The 2016 CACREP Standards notate the protocol by which counselors are rated, but the continual academic unpreparedness is violating these standards and the ultimate counseling requirement – do no harm. This year, the CACREP board is preparing its third draft of its standards. CACREP Standards Revision Committee (SRC) is demystifying the 2024 CACREP standards revision process.

The SRC is an appointed body by the CACREP board. Their goal is to follow the charges set forth by the board and to provide revisions to the standards. They have stated in several forums that the 2024 CACREP Standards are written in a way that will stand the test of time: meeting the current state of the profession, higher education, and society as well as predicting what will hold through the 8-year duration of the standards until 2032. One of the charges and one of the most important aspects of the committee's work is to solicit feedback from constituents. The SRC received pages of narrative comments in response to drafts of the standards, as well as letters and messages from individuals and organizations about what they deem important for inclusion in the standards. Although the SRC attempts to address all of these comments and suggestions, there are elements that are outside of the scope of the revision committee and process. Even after they receive suggestions for changes, it is not always compelling enough for the

committee to revise standards in some areas. Some of the suggested changes were core faculty requirements, credit hours in entry-level programs, outcome and income-based standards, and foundational curriculum content area categories.

The problem with committees and boards is their closed-minded approach to future growth and change. As humans venture through the 21st century and prepare for the 22nd century with all its technology, innovations, and discoveries, the educational system must improve to meet the demands of society and its new challenges and crises.

In addition to the needed changes in the CACREP Standards, there is also the need of change in all university counseling programs core curriculum. Each university has a committee assigned to evaluate and prepare programs to meet state and federal standards. The University Core Curriculum Committee (University of Kansas, 2023) at all collegiate institutions, reports to the provost to develop, sustain, and oversee the university's core curriculum. This committee's responsibility is to

- oversee the composition of the core curriculum;
- certify (and recertify) courses and experiential learning activities nominated for inclusion as part of the university's core;
- monitor the achievement of learning outcomes through these courses and activities;
- review and recommend proposals for certificate programs (e.g., Graduate Assistance Program, Regional External Program, and Speech Language Pathology) and
- envision innovative ways to meet learning outcomes.

Shandomo (2010) reported that these standards, requirements, suggestions, curriculums, and programs are not adequate or meeting the needs of counseling students. If these counseling students are not being adequately prepared to serve mentally challenged individuals, then there will continue to be reports and studies postulating, yet again, the gross negligence of misdiagnosis and inappropriate preparation of counseling students to work with persons with complex trauma, dissociations, and DID. It was clear from the research and findings of this study that a change in standards and core counseling curriculums are necessary components in improving and changing the reported problems of misdiagnosis of DID, reportedly due to inadequate levels of education, training, and experience. Universities should strive for ethical, transformative, and compassionate forms of learning. The ultimate goal of higher learning is to foster deep reflection and critical inquiry to promote profound growth and change (Shandomo, 2010). Because the literature has shown that misdiagnosis is the problem and the primary cause is clinician inadequacy, it is neglectful and harmful to the mental health community, its professionals, and the patients and clients who are served. Mental health professionals and academia must be committed to addressing systemic oppressions, challenging individual biases, and working toward transforming the culture, politics, and practices to accelerate change.

Golebiowska et al. (2017) indicated that the education and training of counselors in master-level and doctoral-level counseling programs needs to be enhanced. The participants all agreed that counseling programs are not equipped or adequate in preparing counselors to work with complex trauma and dissociations and expressed their

respective programs did nothing to prepare them with the knowledge, skills, and abilities to diagnose and treat DID. Myrick et al. (2015) indicated that additional training opportunities, including certification for providing dissociative treatment, increased training of graduate school faculty, continuing education opportunities, and the development of treatment standards with third party payers, can assist in disseminating expert recommendations and empirical study results to clinicians working with DID patients. Myrick et al. further reported that although expert consensus treatment guidelines emphasizing a trauma-informed, staged treatment approach for DD patients have been available for 2 decades, per ISSTD, there are relatively few training opportunities for clinicians who wish to learn how to work with DD patients.

The literature, as presented in Chapter 2 of this study, has reported for decades the insurmountable challenges patients face when clinicians misdiagnose their disorder. To rectify this gross injustice and lack of care for mentally challenged individuals, the adequate preparation of clinician must be changed, improved, and ratified. All universities, colleges, and institutions of higher learning pride themselves in excellent education as their mission statements are filled with declarations of providing excellent education, guidance, and instruction in the advancement and dissemination of knowledge, the catalyst in the creation of a diverse student body. The institutions further declare their commitment in providing a challenging learning environment that prepares students to succeed academically, learn from their challenges, and explore who they are, who they will become, and how they will contribute to their communities and the world.

Theme 2: Experts' Education and Training Experiences

Brand et al. (2016) affirmed that very few clinicians receive training in assessing dissociation and complex DDs. Accurate assessment and diagnosis of DDs are crucial. However, training and education on assessing DDs and complex trauma are limited. A typical response of clinicians to the question of how many cases of DID they have encountered is as follows: "I've never seen it, and I've been in practice for so many years that it either has to be very rare, or nonexistent." DID is characterized by a need to "not be seen or known" (Brand et al., 2016, p.198). Furthermore, few graduate programs offer training with childhood trauma survivors, and psychology textbooks often focus more on controversies surrounding DID and "recovered memories of abuse" rather than providing important information on the etiology, impairment, and treatment of dissociation (Brand et al., 2016). Clinicians assessing DDs in clinical and forensic settings face multiple challenges, including a general lack of experience and training in dissociation and complex trauma, reliance on gold-standard and well-validated measures that were not designed to assess complex trauma and dissociation and have typically received little empirical validation with these samples, and difficult differential and comorbid diagnostic questions for individuals with complex clinical presentations (Brand et al., 2016).

Universities need to change the core curriculum to meet the needs of their students so they in turn can adequately meet the needs of its clients and patients. Medical students leave their undergraduate studies to attend med school so they can further prepare to work with various forms of illnesses, and legal students leave their

undergraduate studies to attend law school to further education in working with various legal issues (Brand et al., 2019). Psychiatrists and psychologists have access to advanced courses and internship requirements making them more adequately prepared to diagnose and treat various mental illnesses. However, counseling students, even though they have internships, are still ill-prepared to work with the many different disorders and mental illness (Brand et al., 2019). The literature has shown that counselors preform the majority of talk therapy in the United States, so their foundation, knowledge, skills, and abilities need to be comparable or better than other mental health professionals. It would be beneficial for all specialized programs to disseminate information that helps individuals discover, learn, innovate, solve problems, and change lives.

Theme 3: Recommended Trainings for Postgrad Counseling Students

Kluft (1990) explained in their research how teaching professional students and graduate therapists ideally should address the several domains and include a large portion of material presented with the several principles of adult learning born in mind. There needs to be a focus on techniques to bring about learning regarding the condition and its treatment within an andragogic frame of reference. Kluft notated ways for the clinician to gain competence: (a) The most frequent vehicle of education is the simple single lecture; it is brief, requires a minimum of commitment from both the sponsor and the attendee, and, therefore, is generally palatable; (b) next to be considered are workshops, which are offered at an increasing number of professional conferences; an increasing number of study groups are now available across the United States and Canada, and many of them are affiliated with the International Society for the Study of Multiple Personality and

Dissociation; (c) ongoing consultation or supervision is a format of incomparable value; as the literature has expanded, an increasing number of clinicians are learning about MPD from self-directed reading; and (d) a final format for learning is extrapolation. Many individuals assume that the best way to understand and treat MPD is to build an understanding of MPD based on theories and approaches that are accepted within their primary area of expertise. At best, these efforts are fascinating; at worst, they approach questionable practice (Kluft, 1990).

Mark, a study participant, conveyed that college education is expensive, and when a student must seek out additional training and education just to meet the foundational needs of the mental health community, it is an inconvenience, costly, stressful, and problematic. The participants shared that the most significant challenge associated with completing the necessary trainings is financial cost. In addition, these trainings are lengthy and sometimes provided at inconvenient times and locations. Colleges could provide much of the needed knowledge and skills that these trainings provide in a structured and organized way. Curriculums could be enhanced, and internships restructured to meet the needs of EMDR, IFS, MID, ego-state, hypnotherapy, and specific and trauma-focused dissociative knowledge and training. The NIMH (2018) reported that the mental health mission statement says in order to be committed to the wellness of individuals, their families, and the community through prevention, intervention, treatment, and education, they must better prepare professionals to meet the needs and welfare of their patients and clients. Additionally, the NIMH reported that their mission is to enhance mental health awareness, promote individual empowerment, and

increase access to treatment and services for persons living with mental illness. It is necessary to meet the goal of social change by serving mental health, special education, and community support needs through direct service, policy advocacy, and outreach.

Theme 4: Challenges in Treating DID

Lloyd (2016) explained how treatment for DID using the ISSTD guidelines resulted in improvements in dissociative and nondissociative symptomatology measured with self-report questionnaires and narrative accounts. However, by using objective contact data alone, it has been possible to show how specialized treatment can stabilize people with DID. In this study, I recognized the reduction in used services corresponded to a reduction in an individual's cost to a service. There are many challenges servicing DID clients: length of sessions, time spent in therapy, insurance hurdles, social stigmas, costs for treatment, lack of federal funding or social acceptance, and accessibility to quality and qualified mental health services.

The NIMH (2018) reported that half the people in the United States will be diagnosed with a mental disorder at some point in their lifetime. Their healthy 2030 goal focuses on the prevention, screening, assessment, and treatment of mental disorders and behavioral conditions. The NIMH objectives also aim to improve health and quality of life for people affected by these conditions. In order for counselors to meet these goals and its missions, they must be educated in a way that empowers, prepares, and fortifies them to deliver the best and most competent care. According to the NIMH, only half of the individuals with mental disorders obtain the help they need. This problem is likely to

continue if change does not occur in how students are educated and how counselors are trained to deliver mental health services.

Additional challenges in meeting the needs of individuals with mental health disorder, specifically, trauma and dissociations, are the cost, access, and availability of mental health services to this population. The participants discussed various challenges in meeting the special needs of DID clients as their therapy is more detailed, sessions are longer, and the time in therapy spans years. The NIMH (2018) revealed that there remains many areas needing improvement in order to meet the mental health crisis, such as (1) increasing the proportion of adults, adolescents, children, and homeless adults access to mental health screenings, diagnoses and treatment; (2) decreasing the emergency department visits related to mental health crisis; (3) decrease the suicide rate; (4) reduce suicide attempts by adolescents, LGBT high school students; (5) reduce the proportion of adults with disabilities who delay preventative care because of cost; (6) increase the proportion of women who get screened for postpartum depression; (7) increase the proportion of public schools with a counselor, social worker, and psychologist; (8) reduce emergency department visits for non-fatal intentional self-harm injuries; (9) increase the proportion of adults with mental health illnesses who actually get mental health services; and, (10) increase the proportion of children with autism spectrum disorder who receive special services by age 4 years.

There are a myriad of mental health and social needs in the community, and we need highly trained and qualified individuals to meet the needs. Langeland et al. (2020) discussed that the development of the skills for treating DID can improve the ability to

treat other disorders in which traumatic experiences have had an aetiological impact and that manifest with some expression of emotion dysregulation but, even with these additional gains, the comprehensive and effective treatment of DID will still have huge service implications. Training of staff to provide clinically relevant diagnostic formulations, and the appropriate treatments, could challenge individual ontological perspectives, and would require significant resources, but would benefit the many individuals who are burdened with the clinical manifestations of these severe post-traumatic states (Langeland et al., 2020). There is also the distinct possibility that appropriate treatment would not be as economically burdensome as feared when the costs to society of hitherto unrecognized disorders are compared with the costs to health services from the absence of appropriate treatment. Langeland et al. (2020) further postulated that the economic effects of accurately diagnosing and treating DDs have not been studied in randomized controlled trials. However, research shows that DD patients, particularly those with DID and related disorders, can improve with treatment models specifically designed to address the DD (Langeland et al. (2020). To our knowledge, no systematic review has been conducted to summarize the economic burden of DDs. Current information about the costs associated with DDs may help policymakers understand the need for accurate diagnosis and treatment, encourage development of efficient treatment methods, and lead to more research about the health care costs of DDs. Therefore, the aim of the current work was to systematically identify, describe data sources and methods, and summarize findings of studies on the economic burden of DDs among adults worldwide (Langeland et al., 2020).

Limitations of the Study

Findings in this study revealed valuable and rich in-depth data describing the lived experiences counselors who treat clients with DID; however, this study has some limitations. Given the small number of participants and the very restrictive inclusion criteria that participants had to meet, it was difficult to recruit participants for this study at first. The demographics of the participants and willingness to disclose had a direct bearing on the nature of the lived experiences recorded. Highly qualified and experienced counselors working with DID clients was difficult to access, limiting the sample size. Recruiting experienced counselors in the area of DID work was challenging, at best, due to the limited number of counselors that work with DID exclusively, as discussed in Chapter 2.

Participants were from the registry of the ISSTD and from participants' recommendations because these therapists have gone beyond their master-level programs to seek additional education, training, and experience in working with complex trauma, dissociations and specifically, DID. All the participants in the study obtained additional education/training in complex trauma and DID; all were White with one male and seven females; all had five or more years' experience treating DID clients; worked with DID clients in the last five years; seven master-level counselors and one doctoral-level counselor; two licensed social-workers and six licensed mental health workers; one psychologist; one counselor with a masters in art therapy; three expert trainers in EMDR; one participant was in their 30s, four were in their 40s, two were in their 50s, and one was in their 60s. All participants were in private practice and shared the same thought and

perspective on the challenges encountered while working with clients with DID. Lastly, caution should be taken in expecting that these themes will be true for participants who are of different demographics that those described in this study. Each of these participants graduated from slightly different counseling programs but their experiences were still the same in that their perspective academic background did not adequately prepare them to work with complex trauma or DID. Though I anticipate the results are transferable, especially in the light of the consistency of my findings with counselors and DID experts in general, the factors of education, age, race, geographic location and gender are important considerations. Based on the findings from the study, I have a number of recommendations for future research studies. These recommendations are addressed in the next section.

Recommendations

Based on the strengths and limitations of this study, some recommendations are proposed for future research. First, additional phenomenological studies should be conducted to examine changing the master-level academic programs and how they prepare counselors to treat clients with complex trauma and specifically DID. As illuminated in Chapter 2, there is a significant gap in the qualitative literature regarding the lived experiences of counselors who treat DID clients and what they needed to do in order to be able to adequately and accurately provide services to these clients. The prevalence rates of counselors not prepared to treat persons with DID is high, particularly in the area of DID. Kluft (2005) described the average patient with DID has been in the mental healthcare delivery system an average of 6.8 years and has received more than

three other diagnoses, reflecting either misdiagnoses or comorbidities, before receiving an accurate diagnosis of DID. Further, it has been established that misdiagnosis is the primary problem and clinician preparation is the vital in correcting this atrocity. Recommendations in research has not provided a solution or correction of the problem but continues to magnify the cause of misdiagnosis and the harm it continues to cause for DID clients. Much of the research regarding misdiagnosis has either been qualitative or from a researchers' perspective, usually from a dominate race or educational background. As a result, I recommend that more quantitative research is facilitated from the perspective of other demographic criteria to further explore the impact of the change in academic programs on counselor preparation. I perceived the participants to be expert in treating DID and their experiences were rich, informative, and addressed the misdiagnosis of DID and the recommendations of solutions to the problem for which previous research has not accomplished.

Second, while only a very few quantitative studies have been conducted many years ago, few phenomenological studies have been conducted on addressing solutions to misdiagnosis of DID and the problem of clinician lack of education or training in treating persons with DID. Brand et al. (2012) reported that their study revealed thirty percent of the participants had received training in DDs as a student, intern, postdoctoral fellow, or resident. Because therapists were required to have at least 9 years of experience treating patients with DD, this finding indicates that, for at least a decade, systematic training has been available to those seeking it. However, this additional training is outside the academic program all counselors must complete. The participants recommended

additional training be provided inside the academic counseling program at all universities. Generally, mores studies should be addressing solutions to resolving the problem and research into the major changes in academic readiness in counseling programs at the master and undergraduate levels. Additional research should also explore the health insurance challenges, cost of treatment, political influence, community health perspectives, governmental grants for specialized and extended treatment programs, and servicing underprivileged groups.

Lastly, I recommend future researchers extend the sample to include participants of a more diverse backgrounds who have not yet gained the additional education needed to treat DID. Research on this population should focus on multicultural needs, societal stigmas, and the lack of accessible mental health services for all trauma clients.

Implications

Several implications emanate from the study's findings regarding positive social change. Results from this study adds to the current knowledge base of qualitative research concerning the ongoing and repetitive problem of the misdiagnosis of DID and clinicians' lack of education and training. The purpose of this study was to discover the significant gap found in qualitative literature pertaining to concrete recommendations for the resolution of misdiagnosis and clinician lack of education and training. While the findings from this study will not eliminate misdiagnosis, having a better understanding of the impact enhanced education and training of complex trauma and DID on suffering clients can raise awareness around interpersonal problems experienced by DID clients as well as their family and the community. These findings can also serve as a foundation for

tailoring targeted intervention strategies of academic enhancements that employ the positive change needed to adequately serve all mental illnesses.

To date, very few phenomenological studies have been conducted on addressing the chronic problem of misdiagnosis with recommendations of academic changes in master-level counseling programs. Moreover, the sociocultural factors and stigmas impacting clients with DID have not been examined from a hermeneutical phenomenological standpoint. As mentioned previously, counseling experts in DID treatment are a hard-to-reach population to conduct empirical research due to the limited number of experts that exist as well as inadequate education that are apparent as described in Chapter 2. Generally speaking, the experts on DID are a small number of individuals who struggle with the challenges they face each day economically, culturally, and communally.

Results from this study has potentially broad implications for social and academic change. For instance, the findings from this study may aid in changing CACREP standards and all counseling academic program courses, classes, and internships. Findings from this study may convey implications for the mental health profession. Mental health professionals could consider the study's findings to develop new CACREP standards, new academic courses, cultural interventions, and promote changes in how complex trauma will be treated in the future.

In the same vein, findings from this research study have the potential to engender positive change for all DID sufferers and those struggling with complex trauma. Likewise, since the experts all state there is no complex trauma diagnosis; adding this to

the DSM-5 would also be a much-needed change. On an organizational level, a mutual collaboration between mental health counselors, counselor educators, DSM authors, insurance companies, and all stakeholders can make the changes necessary to address all the problems, challenges, and barriers that remain to exist. A clinical and academic partnership has the potential to increase awareness, foster new academic requirements, and referring these recommendations to college presidents and departmental chairs and deans.

Conclusion

In this research, I undertook a counselor's, interpretative phenomenological approach. It was difficult to find past research that was qualitative in nature and included both the misdiagnosis of DID and the recommendations for resolution, improvement, and change in academic coursework for counseling students. Most of the previous research focused on the misdiagnosis and the harm that is being perpetuated in the mental health community with treating complex trauma and specifically, DID. The major contribution of this research is the inclusion of recommendations for major and perhaps controversial changes to the academic counseling programs coursework and 2016 CACREP requirements for graduation. Participants provided rich and detailed data that illuminated their special experiences treating DID clients and the sacrifices they had to make to better prepare themselves to adequately service the trauma and DID community. Consistent with previous findings, DID is grossly misdiagnosed and not properly treated to the detriment and harm of clients everywhere. However, the participants provided radical and

much needed changes to a system that has been perpetuating consistent harm to trauma sufferers.

Throughout the research process, I became more resolved with the findings. My extreme resolve for those suffering with DID and other complex traumas, has propelled me to want to advocate for those suffering with DID. I have not been satisfied by the research I have found, and the inconsistencies influenced my desire to add to the literature a different and more conclusive answer to the problem of misdiagnosis of DID. The impact of changes to academic coursework has proven to be a unanimous recommendation from the experts. If we do not make these changes now, we will continue to harm the very people we promised we would protect and serve. Each participant all agreed that the present academic coursework is not adequate in preparing counselors to treat complex trauma and dissociations. All the participants agreed that their additional training, education, and consultations all contributed greatly to their ability to recognize, diagnose, and treat DID. Each participant's journey has been motivated and characterized by their lived experiences of educational lack, mistakes, personal growth, sacrifice, and unique forms of self-discovery.

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Appendix A: Invitation to Potential Research Study Participants

Greetings,

I hope this email finds you well. I am currently a PhD student in the Counselor Education and Supervision program at Walden University. I am working to complete my dissertation in fulfillment of the degree requirements by conducting a qualitative study designed to describe the lived experiences of clinicians who are experienced in providing diagnostic and treatment services to individuals with DID. The title of the study is "The Experiences of Counselors Who Treat Persons with Dissociative Identity Disorder." As part of my research study, I am looking for counselors who have obtained, outside their master-level academic programs, additional education and training in treating persons with DID; who are experienced in working with persons with DID, who have treated persons with DID within in the last 5 years, have a minimum of 5-years post-master's degree professional experience, have provided counseling services for five or more clients clinically diagnosed with DID, licensed as a counselor in the state in which they practice, and hold a master's or doctoral degree from a CACREP accredited program.

You will be invited to engage for approximately 30-minutes in an audio and/or video conference meeting that will be recorded. If you agree, I will provide you with a detailed informed consent document. Finally, I will schedule a date and time that we can connect by phone or video conference for the interview.

Also, if you know anyone who might be interested in participating in this study, please share my information or forward this invitation.

Thank you very much and I look forward to your response.

Appendix B: Demographic Questions

When I am scheduling interviews with potential participants, I asked them the following questions in an email message:

1. Are you a counselor who provides services to clients with DID? (yes or no)
2. Have you obtained additional education or training, outside your master-level program?
3. Are you listed in the ISSTD registry? (yes or no)

4. Have you treated DID clients in the past? (yes or no)

5. Did you graduate from a CACREP-accredited counseling graduate program? (yes or no)

6. Have you provided counseling services for 5 or more clients clinically diagnosed with DID? (yes or no)

7. Do you have 5 or more years post master's degree experience?

8. Have you successfully treated clients with DID in the last 5 years?

If "yes" response is provided to the questions, the participant will continue with the informed consent process. If participants provide a "no" response to one or more items, they will be asked to confirm the responses. If the "no" response stands they will be thanked for their time and participation. The participants will be informed that they will not be asked any further questions due to incompatibility with the research criteria.

Appendix C: Interview Questions

1. Describe your experience with working with clients with DID?
2. How do you perceive the level of training, education, and preparation in master's and doctoral level counseling programs have prepared you to diagnose and treat clients with DID?
3. After graduation, what additional courses or programs did you need to complete to enhance your ability and competence to work with clients with DID?
4. How has your additional education/training helped you work with individuals with DID?
5. What situations have you encountered while working with client with DID?
6. What would you recommend to counseling programs about how they teach and prepare counselors to diagnose, and treat DID?
7. How difficult is it working with DID clients/patients?
8. What has been some of your greatest challenges while working with DID clients?
9. What tools, techniques, strategies, or assessments do you use to help the client reach partial or full reunification?
10. How long is a normal session? (1hr, 1 ½, 2 hrs., etc.)
11. From diagnosis to the end of therapy or full unification; what has been the length of time in therapy? (1yr, 5 yrs., etc.).
12. How successful have you been in treating these clients?
13. What has been your success rate? (50%, 60%, etc.)

14. What would you recommend a clinician do to get more knowledge, training, and experience in working with clients with DID?
15. Do you have anything you would like to add that I have not inquired about when working with these clients that would be helpful for study?