

Volume 3

Frontiers in the Psychotherapy of Trauma & Dissociation

*The Official Clinical Journal of
the International Society for the
Study of Trauma and Dissociation*

**My First Case of DID:
Learnings From Treatment
Failure**

Kate McMaugh, MHSc



**International Society
for the Study of Trauma
and Dissociation**

Frontiers in the Psychotherapy of Trauma & Dissociation

The Official Clinical Journal of the ISSTD

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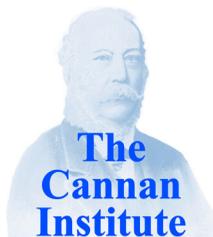
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ARTICLE

MY FIRST CASE OF DID: LEARNINGS FROM TREATMENT FAILURE

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This article describes working with a case, likely to have had undiagnosed Dissociative Identity Disorder (DID). It describes the struggles of a DID-naïve therapist in conceptualizing and treating the case. Learnings from the predictable unravelling of treatment are described. Suggestions for clinical training and supervision are outlined.

KEYWORDS *dissociative identity disorder; therapist training; trauma.*

In the last edition of *Frontiers*, Warwick Middleton writes about his first Dissociative Identity Disorder (DID) case and encouraged others to write about theirs (Middleton, 2019). Middleton entitles his article, “*The First Individual with Dissociative Identity Disorder (DID) That One Knowingly Diagnoses and Treats.*” Perhaps mine should unofficially be titled, “*The First Case of DID One Unknowingly Treats and Later ‘Diagnoses.’*”

In writing this I cannot help but reflect on a question Forner (2019) has recently posed to those who deny the existence of DID: “What if they are wrong?” This article describes just one example of what may go wrong when DID is denied at a broad training level, in supervision and in clinical practice.

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I stumbled across, what I now believe to be my first case of DID, when I was undertaking a post-graduate counselling placement in an agency servicing a complex clientele, many of whom had chronic mental illness, suicidality and severe financial and social problems. Having worked a variety of roles in disability services, drug and alcohol services, and community health prior to undertaking this further training, I had come to realize a commonality in all my work: most of my clients experienced significant trauma. I began to see my clients' presentations as more about "what happened to them" and less about "what was wrong with them." Consequently, I was delighted to get this placement and have access to a range of trauma-informed and supportive supervisors.

I soon realized that my academic trauma training was very inadequate. Much of my psychology teaching had not differentiated between adult single-incident posttraumatic stress disorder (PTSD) and chronic interpersonal trauma occurring during childhood. The word "dissociation" was not even in the index of my main clinical psychopathology textbook. Yet, in this job I began to see mostly complex trauma cases. It was a steep learning curve, requiring new training, but I found the work rewarding, and generally my clients were making slow but steady progress.

Then came a woman, Rosanna¹ who sought treatment for depression. Rosanna was from a poor, rural community, many hours away. As a teenager she had married a man 20 years her senior and came to the large urban community she still lived in. Now in her early 40s, she had three children in their 20s and had escaped the marriage, which had been violent.

Like many of my clients she was very poor. Although Australia has a "welfare safety net," people with complex mental health conditions often find the system to be unsympathetic or difficult to access. Rosanna had apparently, some years back, lost her Department of Housing rental property after uncharacteristically vandalizing it. This transgression had happened on the back of late or sporadic rent payments and was the final straw for the housing authorities. Mentally ill and traumatized, she was unable to negotiate her way back into public housing, nor afford private housing. When she came to see me, she had been living in an abandoned shed for several years, without electricity or toileting facilities.

Rosanna was very depressed, expressing hopelessness, lack of interest in life, and a strong desire to die. Her suicide attempts were too many to count, and she was well known to the acute care services and emergency departments. Much of our early therapy revolved around suicidal crises.

In her long contact with mental health services she had been given many diagnoses, including Bipolar Disorder, Borderline Personality Disorder, depression, psychosis and Generalized Anxiety Disorder. These diagnoses had been given, removed, and reinstated many times over the years.

¹All identifying details have been changed.

Other health professionals who had treated her, including her long-term General Practitioner, all agreed that no diagnosis quite fit. Rosanna felt demoralized and confused. Yet, with great bravery, she was trying again to find relief from her suffering.

Despite her depression and poverty, she presented as intelligent and articulate. She seemed to enjoy talking about therapy and psychological concepts. She told me she had been good at school when she had attended her small rural primary school, 40 minutes from her home. However, there was no nearby high school and, after some attempts at distance education, she had dropped out. This was not unusual in her community where education was not highly valued, or necessary for most jobs. It was clear, though, that she regretted her lost opportunities and took great pride in the studies of her children.

I noticed that, unlike a lot of my homeless clients, Rosanna took interest in her appearance, frequently telling me about shopping at second-hand stores for clothes. She took efforts with her hygiene, showering at a public shower at the beach. Upon retrospect, I recall that her clothing style could change quite dramatically. She usually wore conservative, feminine clothes but would sometimes present in ripped black jeans, a black leather-look jacket and boots, quite a tough look.

Rosanna also had a disparate range of social connections. She was heavily involved in her local church, attending most days. Yet she was friends with a biker group. The days she turned up in her black jacket she was usually dropped off at the center by one of these very “non-churchy” people. I suspect I was too pre-occupied with averting suicide attempts and getting her back into public housing to give these changes much attention.

As rapport developed, Rosanna began to tell me details of childhood trauma. She was the last-born child in a family of nine. Her mother committed suicide when she was two. Her father died when she was three, and she was left in the care of her oldest brother who was married with a baby of his own. He took her in, on the understanding that she would grow up and help care for his children.

Rosanna said her brother also began to sexually abuse her, starting from her first night in his house. She told me, “He could not really hurt me. I flew up to the ceiling. I stayed up there in my yellow dress.” She paused and said, very seriously, “Kate, the Lord has given me a special gift. I can fly.” Perhaps seeing some doubt on my face, she settled back into her chair and said emphatically, “Jesus told me I can fly. I’ll prove it.” She smiled in a dreamy way, “I’ll jump off a cliff. . . you’ll see. I’ll fly.” “And what if you don’t? What if you’re mistaken,” I asked. She smiled again, “Then the angels will catch me.”

I was worried and told one of my supervisors. “Rosanna just told me Jesus told her she can fly.” The supervisor looked up from her desk asking,

"I'm assuming you don't mean in a plane?" Rosanna got sent for a psychiatric review. At the local hospital the psychiatrist interviewed her with two students in attendance. She reported that my client was "stable and well," although she did have "very strong religious beliefs." Rosanna said to me, "You think I'm stupid, don't you? I know just what to say to her to make her go away. I don't want to talk to her and her stupid students. I only want to talk to you!"

We continued with therapy, focusing on safety and stabilization. She practiced grounding, mindfulness and calm-breathing exercises. She began walking, painting and joined a social group at the local mental health center. Occasionally she spoke of "the girl in the yellow dress" as if she was another entity, yet it was clear in other conversations she was also Rosanna, age three. She insisted the girl in the yellow dress could actually fly, but there was no more talk of walking off cliffs. In fact, her self-harm and suicidality declined almost completely, only surfacing when I was planning to be away on holidays or a training event. The local crisis team told me, "She's never been this well in all the years we've known her. Whatever you're doing, keep it up!"

Rosanna began to discuss with me the interface between her religious beliefs and her sexuality. She identified as a lesbian, something that did not conflict with her faith. She said, "Jesus himself loved women. Of course he wants me to as well!" She would also occasionally report being involved with a man, and at those times seemed attracted to men. When I reflected this to her, she brushed it off saying, "Some days I want one thing, some days the other. . . maybe I am really bisexual."

Then one appointment, after I had been seeing her for about 15 months, she came to me in tears. A friend was angry at her for sending an "inappropriate email." (Rosanna was learning to use the computer facilities at her local library.) Rosanna disclosed that she had sent a "romantic" email to one of her female church friends (who possibly did not share the same beliefs about Jesus and sexuality). She was distressed and stated that she could not remember writing it. She said this type of thing had happened before, when she had been in trouble about letters she could not recall writing. These incidents were infrequent, occurring perhaps once a year. Most of the letters were of a sexual or romantic nature and sent to females. Her embarrassment and confusion were intense.

I asked her about other things she forgot. She told me that she had a collection of dolls on a shelf in the shed. Sometimes she would "come to" on the floor, playing with them, but could not recall getting them off the shelf. Sometimes hours had gone by. She seemed embarrassed by this admission, but added defensively, "I like to play with toys. I'm not crazy though. I think it's just because I didn't have toys when I was growing up." She added that her children were upset by this. "They don't like it when I play with toys. It freaks them out."

Although university had not taught me anything about dissociative disorders, I had read *Sybil* and *Three Faces of Eve* as a teenager. I googled Multiple Personality Disorder and discovered it was now DID. I went to my supervisor. "I think she might have DID," I said. My supervisor looked very doubtful. She said, "I've been a trauma counselor for over 30 years, and I've never seen a case of DID. I am fairly sure that you haven't either. I think it's just her imaginative way of describing herself." She advised me not to pay too much attention to such talk, particularly given the "borderline" nature of my client.

I was not sure how to go about giving such a revelation of symptoms 'minimal attention'. Rather than ignore it completely I tentatively revisited it with Rosanna the next session. However, she was dismissive and angrily embarrassed, avoiding all discussion. This allowed me to also give it 'minimal attention', as instructed. A couple of sessions later Rosanna told me she had planned a trip to see family, her first in many years (her perpetrator was now deceased). The next couple of appointments focused on preparing for that.

When Rosanna came back a month later, something felt wrong. She was dressed in tight jeans and a very small clingy top, wearing strappy high heels. She looked so different. She beamed at me. "I feel wonderful!" she exclaimed as she sat down.

Rosanna told me that while she was away she had reconnected with old friends who practiced alternative therapies and, through them, had been to a shamanic healing ceremony, and she "no longer had any trauma." "I am completely washed clean, healed!" As she spoke, she perched on the edge of her chair, legs crossed, slowly swinging her foot back and forth. "Kate, I missed you. I realized how important you are to me." There was something sexual and flirtatious in her manner, which I ignored in my efforts to focus on the healing ceremony, the trip home and how it had resulted in this sudden change in my client. The appointment left me feeling uneasy.

The next appointment Rosanna came with her arms piled high with gifts for me and "all my family," even though I doubt she knew anything about my family. This was delicate. Workplace policy and my registration body forbade accepting anything but the smallest gift. I carefully explained the issue to her and asked if I could perhaps accept the card she had written. She walked out, leaving a pile of gifts. The center manager said they had to be returned to her.

The following appointment Rosanna told me she was in love with me. She wanted me to quit work and come away with her and live on a farm. I firmly explained this was not possible and spoke about the boundaries of our relationship. Although my supervisors attributed this to mania, the psychiatrist disagreed.

In one last appointment, I attempted to therapeutically address her feelings towards me. I proposed to her that she was mixing up feelings of

emotional connection with sexual attraction, just as her feelings of attachment to her older brother were also confused with sexual activity. I remember ending that comment with a statement that I felt it was very important that our relationship was able to be emotionally connected with the safe assurance that it would not be sexual.

However, I felt as if I was talking to a complete stranger. She looked different inside her eyes. She leaned across the small office and stroked my leg. "I just want to touch you," she said in a breathy voice I had never heard before.

I flinched away and snapped, "Don't!" She leapt onto my lap and began grabbing me, kissing my face and neck. With her weight on me I was struggling to breathe, let alone push her off, and she was ignoring my angry protests. I reached out and hit the duress alarm, but it flew off its mount onto the floor without ringing. Somehow, I got her off me and flung open the door. I watched, incredulous, as *she* stalked out, like she was the one offended!

I went to my manager and supervisor, both of whom insisted that therapy be terminated immediately. I felt helpless that I had no say in it and was also very concerned for my client's well-being, but the manager immediately took over finding referrals in another agency.

We were allowed one more appointment, one in which a senior psychologist would be present. It was a sad appointment. My "normal client" was back in the room, tearful, ashamed, regretful. The senior psychologist was very caring, but nevertheless it felt weird to have someone else witness this most distressing and awkward farewell. She must have sensed this as she said she would leave us for a few minutes to finalize the appointment, but stated the door was to be left open.

The moment she left, Rosanna leant forward and said, "I know you must have a husband and children! That's why you won't come away with me. I know how to make bombs. I can blow people up! I'll kill them all. Then you'll come away with me."

I was not scared. Firstly, I felt she had no way of knowing my family situation. And secondly, she sounded like an angry child, blustering with threats. Without thinking, I reacted to the age of the voice, "Stop it, Rosanna! I know you don't mean that." Even as I look back, I can hear myself sounding more like a cross adult speaking to a naughty child than a therapist to an adult client.

Then, just as quickly she changed again, back to the Rosanna I knew. She was momentarily disorientated, "Oh, yes. Yes. I didn't mean it," but she looked confused. It seemed she was not sure what she was agreeing with. I was reminded of how some people in the early stages of dementia attempt to hide their memory lapse with vague comment and agreement. We ended the session then, and I never saw her again.

I thought a lot about the case. I felt my client most likely had DID, but knowing no one else agreed, I did not mention it again. It was hard for me to disagree with my dedicated and experienced supervisors, as I looked up to them a great deal. It felt like I was saying, "I know better than you." But, how could I? I had much less experience than they did. I was the one on a training placement, not the supervisors.

However, the more I reviewed the notes, the more I could see the signs. It was all there. I had backed off, thinking I was the one in the wrong. I felt like a "not-good-enough therapist." While I understood that this behavior may have occurred anyway, I felt I had missed an important opportunity for correct diagnosis and intervention.

I worried that by missing the DID, I was unable to respond the best way to the rapidly unfolding crisis. Therapy had been appropriately bounded and professional. My client did not display sexualized behavior prior to the therapy break and the "healing ceremony." One, or both, had somehow triggered this change, but without having my client with me to explore these changes, or any knowledge of her internal dissociative structure, I can only guess at the internal dynamics and changes that led to this switch.

One possible conceptualization is that this client was confusing emotional connection with sexual attraction. These days I would conceptualize this as a result of disorganized evolutionary motivational systems (Cortina & Liotti, 2014; Liotti, 2017), where two systems (attachment and sex), rather than working in a hierarchical or harmonious way, have been confused, primed together and expressed through dissociative behavior. Possibly this client's sexual system was activated in a protective manner to avoid painful and frightening intimacy (Cortina & Liotti, 2014).

Therapeutically, an earlier clue was seen in the letters and emails Rosanna had sent to her female friends over the years, but we had not explored that. It is worth noting that not only was Rosanna sexually abused by her caretaker older brother, but she also suspected she had been abused by her father prior to his death, with snippets of vague memories. Such a family can only create severely disorganized motivational systems.

Furthermore, since this time, I have learned the benefit of titrating the "good stuff" in therapy: the empathy, the rapport, the attachment. Even these healing aspects of therapy can be overwhelming for the severely abused, and being overwhelmed may indeed trigger such confusion in motivational systems. Cortina & Liotti (2014) point out that the path to a secure therapy alliance for the severely traumatized "has to be reached through a circuitous route that tries to limit the premature activation of the attachment toward the therapist" (p. 892). But, in those days, such thinking was beyond me, this paper yet to be written. Naturally, I am also now much more proactive in learning about my client's internal world and internal experience. Such knowledge is key to being prepared, of course.

In any case, the abruptness and strangeness of the changes in this client triggered my curiosity about the validity of DID. I realized, working in trauma, I could not sit on the fence. If DID existed then I needed to become a very different therapist!

I turned to the internet and, not knowing where to start, began ordering books. I ordered the first one just because I liked the title. When *The Haunted Self* (van der Hart, Nijenhuis, & Steele, 2006) arrived in the mail I read it cover to cover. It was like everything fell into place. Dissociative disorders made complete sense as an adaptive response to trauma.

But, feeling completely untrained, I tried to avoid taking on any clients who could have a dissociative disorder, but this is not easy if you see clients with complex trauma. In one job I ended up being allocated a pre-diagnosed case of DID. I liked working with this client very much. A few more arrived the following year. All three were desperately unwell with long histories of serious self-harm, suicidality, hospitalization and incarceration. Clinical life felt very challenging, yet they eventually stabilized.

By this stage I had found *Trauma Model Therapy* (Ross & Halpern, 2009), and it was invaluable with its easy-to-read, no-nonsense structure and sample dialogues. *Coping with Trauma-Related Dissociation* (Boon, Steele, & van der Hart, 2011) gave me more ideas and structure. I began what was to be four years of training with Janina Fisher's webinar-based courses. Through talking to colleagues, I found DID-informed case consultation and, eventually, I found the International Society for the Study of Trauma & Dissociation (ISSTD).

In ISSTD I found an abundance of resources. I went to book clubs, did webinars, read papers, journals and books. When my supervisor gave me the website link to the *Dissociation* journal, I was in seventh heaven. I read every spare moment, even taking books to the beach on my summer holidays, which must have looked strange, given the size of the books! I talked and emailed with anyone who would listen. Fortunately, in the dissociation world, there are an abundance of kind and generous teachers.

Middleton (2019) ends his article with a list of lessons learned—pieces of self-advice, he calls them. I endorse them all and will add my own perspective. My lessons from my first client with DID were hard and painful. I have summarized these below, and they range from “small picture” clinical points through to broader organizational issues.

1. Listen to your own instincts when it comes to a client's presentation. It might be just the way your client looks “inside her eyes,” but it is still valid and worth paying attention to. There is something qualitatively different about a switch, even subtle ones, and I believe even DID-naïve therapists can sense this. My client's changes were explained away as “just mood changes” when I consulted about her case. But they were not, and I sensed that. She was not in a different *mood*, she was in a different *state*.

2. We do need to be careful in diagnosis and not assume every personality-disordered client has DID (as the nay-sayers accuse us of). However, I think there is a validity in training complex trauma therapists to trust their instinct and *assess further* if they feel there is something different about the so-called “mood change” they just witnessed. It is especially worth them doing this if the client has a long history of different diagnoses, none of which seem to “fit” properly.
3. Of course, having intuition or instinct about a client is not enough. We need to be educated about how to detect possible signs of dissociation in our clients. I suggest new therapists read as much as possible about these signs. Most books cover this, and Loewenstein (1991) and Chefetz (2015) also provide an overview of indicators that a formal assessment may be needed.
4. It is not okay to work in complex trauma and not be dissociation-informed and well-trained. We have to be, as these clients will have high rates of dissociation and dissociative disorders. We owe it to ourselves and our clients to get the very best training. It is not an optional extra. I would strongly urge all therapists with an interest in complex trauma, or who work in areas where there are high-trauma presentations (e.g., substance abuse), to become trained in detecting, assessing and treating dissociative symptoms.
5. I highly recommend ISSTD training to all clinicians new to this area. The webinars and online courses are accessible and affordable. The people providing the training have a high level of clinical experience, at a level that is often not accessible in one’s local region.
6. It is important to seek supervision with someone experienced in assessing and treating dissociative disorders. Even the very best supervisors, if not experienced in this area, will not be able to support you enough.
7. Network and seek other supports. I suggest to clinicians new to working with DID that they join the ISSTD and the DISSOC listserv (an online professional forum for therapists working with Dissociative Disorders). Both are full of kind, caring and supportive people who share their knowledge and expertise with a generosity not often seen in other professional arenas.
8. Accept that this work can, and probably will, stretch your skills and your distress tolerance. Burnout can occur, hence the importance of points six and seven. Self-care needs to be a high priority.

9. Although we do not have a wealth of randomized controlled trials and treatment manuals advising us how to treat DID, we do have expert consensus clinical guidelines (ISSTD, 2011) and other papers which overview the practices of experts (e.g., Brand et al., 2012). My client did get better, in some ways. I was working in the phasic manner recommended for complex trauma, and Rosanna certainly stabilized for a length of time, but this was not sustainable. Ultimately, I believe that with a DID case, such work will always be limited unless we learn to work, not just in a well-paced, phasic manner, but with the DID structure itself.
10. I have never been a huge fan of the Diagnostic and Statistical Manual of Mental Disorders (DSM). I have always thought there has to be a better way to talk about people than put them in discrete boxes. But through this experience I have learned to respect that there is now a lengthy process to including a disorder in the modern DSM. A disorder does not get in there by accident. If a disorder has been in the DSM for a long time, there is probably a very good reason for that. It most likely represents a real cluster of symptoms, a real “disorder.” I wish I had accepted that likelihood instead of being deterred from exploring a valid diagnosis.
11. When I was trying to get information about DID, after this case, it felt hard to get training and find a supervisor for this disorder. I know this is now some years ago, and things have improved, but I still think we overestimate how well known the “dissociative disorders network” is to the rest of therapy-world. In Australia, at least back then, mainstream complex trauma training did not include information about dissociative identities. While in reality things were happening in the dissociative disorders field in Australia at this time (Middleton, 2017), this was unknown to my network. In fact, to me the dissociative disorders field felt like a hidden world, with me as an outsider desperately trying to navigate my way without a map.

This divide must surely have been caused partly by denial of DID among some in the trauma world: their attention would simply not be on this other activity. However, I also believe that dissociation practitioners and organizations need to be more open about working with dissociative disorders, particularly DID. In the years since this case I have met many wonderful therapists who work with DID, including in my own city, but very few mention this work on their websites or professional bios. Perhaps that is a legacy of the 1990s: a feeling that we need to protect ourselves. Perhaps it is just that we quickly get booked out and do not want to promote ourselves. Whatever the reason, this does leave the next generation very vulnerable. It took me quite some time to find supervision and the ISSTD. It took me even longer to find other local therapists working with DID.

12. Working with DID has given me a renewed interest in clinical assessment and differential diagnosis, and an insight into the need to be able to make a correct diagnosis to best inform treatment. It is also important to be able to defend a diagnosis. My clients are often engaged with other professionals who may not “believe in DID” (at least initially). I must be able to defend my diagnosis and case conceptualization clearly and calmly. Now, if I suspect a dissociative disorder, my clients are very carefully assessed with standardized instruments like the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) and the Multidimensional Inventory of Dissociation (version 6.0; MID 6). Results are analyzed and discussed with my supervisor, and other colleagues, if need be. I have moved from thinking diagnosis is “not always that important” to feeling it is really important, at least for these cases.
13. Another key learning since this case is that therapy and client outcomes are immeasurably improved by accepting that DID is real and valid, and treating it accordingly. My work with clients who have DID is now much more effective and enjoyable. While treatment progress is typically slow, and I have had some very unstable clients, they do generally make progress. I now supervise other therapists and see that they do beautiful, powerful work, and likewise they see progress in their dissociative clients.
14. I think it is relatively unusual to see the kind of acting out behaviour that this client showed. My belief is that, while many of my clients have been very unwell at first, there is ultimately something containing in mindfully and respectfully observing parts and interacting with a person, acknowledging their dissociative structure. This very acknowledgment also provides the framework for integrative intervention. I cannot see how integration could occur by not acknowledging fragmentation. DID work is always up and down, but a parts focus leads mostly to an upward trajectory, not the increasing chaos of this first dysregulated and desperate client.

In fact, since this case, I have had one other incident when therapy boundaries were breached in a physical, although not sexual, manner. As I had already assessed this latter client as having DID and was working in a parts-based way, I was able to address this quickly and appropriately. The client responded well, and the aggressive part is now a therapy ally, with much increased stabilization. Had I had that knowledge, or the capacity to explore this way, with Rosanna, perhaps the ending would be different, but I admit this is an unknown.

15. Middleton (2019) states: "Take a long-term view and be patient." Nothing could be more true when working with DID. Progress with the disorder is slow and hesitant at first. It is hard not to get disheartened. It is hard to hear talk of "good therapists" whose clients get better in 10 sessions, when your client, by 10 sessions, is confusing, chaotic, has been in hospital twice and is threatening to sack you! For new therapists it is important to talk this through with supervisors, or colleagues with a similar caseload. They will understand and reassure you.
16. Slow progress can be frustrating, but it has its benefits for a neophyte. For every new therapist I would urge them not to automatically put a DID case in the "too hard basket" but to explore the option of continuing with the case, under close supervision, and getting extra training. I believe we do have time as therapists to learn this work.
17. Too often I hear from therapists, "I could never do that work" and that treating this disorder seems too arduous. This closes doors to a fascinating and rewarding type of work, with a diverse client group. It also narrows our field and marginalizes the treatment of DID to the "sidelines," the domain of a select few, rather than being part of broad-based trauma work. If you work in complex trauma and think you cannot do this work, you probably already are, but doing it in a conscious, informed manner makes it easier.
18. However, academic and clinical training, at least in Australia (I cannot comment on other parts of the world), needs to rapidly catch up to the issues we see in clinical presentations. As a society we are much more open to talking about the incidence and impact of complex trauma. The well-publicized work of the Australian Royal Commission into Institutional Responses to Child Sexual Abuse, widespread media reports of organized and institutional abuse across the world, and the conviction of some high-profile offenders have all combined to make discussion of child abuse much more open and frequent. As a result, more people are seeking therapy for complex trauma. Without a doubt a significant percentage of these clients will have a dissociative disorder, and some will have DID. It is negligent to turn out clinicians who have either never studied about severe dissociative disorders or have only learned that DID is a suspicious, possibly invalid disorder. This issue is still current. I am again studying and, once again, my advanced-level clinical psychopathology course did not cover dissociative disorders! At the end of the day this lack of training means that the most vulnerable of people get poor quality care.

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