

# **The fragmented self**

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## Introduction

A child, desperate to preserve sanity in the face of extreme maltreatment at the hands of those meant to protect and nurture her, dissociates to survive. Some eventually develop the most dramatic, controversial, and serious type of the dissociative disorders, Dissociative Identity Disorder (DID). The purpose of this paper is to introduce DID and delineate the steps necessary to set the stage for effectively healing DID in women.

## The Language

Labels tend to compartmentalize, dismiss and pathologize normal survival mechanisms. To this day labels continue to be used to dismiss women's reality, to oppress them and make them feel shame about normal aspects of the self. Therefore, as a rule I use diagnostic labels as little as possible. DID is the exception to that rule because it is important to give voice to its sufferers by giving their pain and courage a name. Splitting--dissociating--is a normal survival mechanism the self uses to deal with trauma. DID--the complete loss of integration of the self in order to survive-- is splitting in its extreme (Burstow, 1992). Women suffering from DID--living in a world unready for their revelations and stories--are greeted with contempt, disgust or incredulity. Acknowledging their reality by naming it can assist toward healing their fragmented selves. The term DID

thus can be used as a descriptive tool to explore and educate the woman about the realities of trauma and dissociation. It can be used to validate and acknowledge their pain. In counselling these women, it is not in whether to use the label DID that is essential, it is whether that label can be used for empowerment. For some women, having a name to call what it is they are experiencing is a source of comfort--for others it causes them to feel further isolated. Counsellors working with DID sufferers must assess this on an individual basis and use language that will empower each survivor accordingly.

The term DID is used here in a feminist sense to acknowledge, give voice to, and demystify a disorder that is cloaked in controversy. DID must be recognised, its causes remembered and validated, by not just the client and counsellor, but by society at large. For society to accept that its most tender population is being chronically abused by perpetrators who view children as sexual commodities, the symptomology of the pain and suffering these children survive must first be named.

### The Landscape

In order to understand DID, counsellors must recognise the sociological and emotional realities of sexual abuse. Sexual abuse--and its potentiality in the manifestation of DID-- is not a female-only problem. Societal constraints prevent men from disclosing both abuse and DID symptomology, causing sampling bias. DID sufferers may be prone to self-destructive tendencies and men may project their self hatred and shame outwards with sociopathic behaviours, resulting in incarceration (Austrian, 2000). This paper does not deny that boys are chronically sexually abused; it in no way attempts to minimise or ignore the psychological distress--including manifestation of DID--this causes. However,

due to the prevalence of the sexualization, objectification and oppression of women and girls, DID manifests itself nine times as often in women than in men making it a primarily female disorder (Austrian, 2000). Therefore, counsellors counselling women must understand the etiology of DID and how its origin is embedded in our culture's denial of the reality of sexual abuse.

Countless examples of atrocities perpetrated against children are documented throughout history demonstrating that child-abuse is not a new phenomenon. It is the conceptualization of child abuse that is relatively new to society. This is exemplified in psychology texts written as recently as 1975 that referred to the prevalence of sexual abuse as a one-in-a-million occurrence (Baker, 1998). Society today still struggles with its conceptualization and child abuse is understood and evaluated in terms of disbelief and denial. Denial takes the form of victim blaming and a refusal of making the perpetrators accountable for their actions. Through that denial, society condones the victimization of over 1/5 of our children (Shwartz, 2000; Malmö & Laidlaw, 1993). We are in the midst of a child sexual abuse pandemic in Canada--and throughout the world--which will remain unstoppable as long as society condones the abuse and encourages perpetrators by continually turning a blind eye to reality.

Psychology continues to be used to subtly and explicitly condone sexual abuse through survival blaming. Psychology's diagnostic tool, the Diagnostic and Statistical Manual of Mental Disorders (DSM IV)--and all its revisions--exemplifies how labelling has effectively been used to blame survivors and absolve perpetrators of sexual abuse (Caplan, 1995; Burstow, 1992). Psychology assists in society's pathologizing of the survivor through its theoretical descriptions and labels. It pathologizes the survivor in

several ways. She may have secretly wanted the abuse (the Oedipal approach); she may be manipulating both the therapists and perpetrators (the Borderline approach). Recently the woman has been described as unwittingly lying about the abuse with the False Memory Syndrome (FMS) approach (Shwartz, 2000).

Counsellors have an ethical responsibility to challenge--not reinforce--these conventional societal beliefs. Counsellors must educate themselves in the issue of child-abuse trauma in all its variations and must admit its effects and how it is embedded in our culture. That acknowledgement must include recognition of the existence of child abuse's extreme manifestation--DID. The denial of violence against children, along with failures within the counselling field in the diagnosis and recognition of dissociation, creates an environment where the DID sufferer is chronically misdiagnosed, dismissed and re-traumatised (Schwartz, 2000). It is easier to ignore the veracity of claims of child-abuse and its manifestations than to accept the necessity of societal change.

As feminism forced abuses toward women and children into public awareness, counsellors who authenticated the sexual abuse manifestation of DID were professionally attacked. These attacks came in the form of accusations of implanting false memories into women's minds causing FMS. For some, the problem of DID does not lie in an pandemic of child abuse; the real problem is the issue of FMS. FMS is based on the premise that it is impossible to repress memories of repeated childhood abuse and then have them accurately remembered in adulthood (Baker, 1998; Gleaves, 1996; Reisner, 1996).

FMS defenders contend incompetent and or overzealous therapists have implanted memories of abuse into clients. Using the media as its vehicle, FMS

proponents have been able to draw on a long history of dismissing and oppressing women; at the heart of this syndrome is the oppressive tenet that women are suggestible and unstable. The media's willingness to support and reinforce FMS--a label with little scientific backing--which puts forth a concept of the unstable emotional female who is easily swayed, reflects the cultural patterns and trends of a male-dominated society in denial (Reavy & Warner, 2003).

Despite popular thought amongst FMS supporters, clients with DID do not suddenly decide--after reading pop-psychology books or watching prime-time television talk shows--to come into therapy and begin disclosing chronic childhood maltreatment. In reality, survivors tend to minimise the effects of the abuse or come to therapy unaware of particular aspects of the abuse. Therapists do not routinely embed a client's memories with sexual and physical trauma; actual proof of outright memory implantation has proven to be elusive (Chu & Bowman, 2000; Baker, 1998). FMS reflects continued societal attempts to silence women and deny that child abuse continues to occur on a large scale. The twenty-first century is an era of Holocaust denial; survivors are told they did not suffer atrocities at the hands of other humans, that their reality was a myth. Therefore it is not surprising that that same society continues to debate, deny and dismiss the reality of child abuse, the veracity of survivors' memories and the psychological manifestations--DID--of chronic sexual trauma (Reavy & Warner, 2003; Schwartz, 2000). The heated debate over the prevalence and recognition-or denial-of DID and its etiology epitomises a society unwilling to recognise that child abuse has reached epidemic proportions.

This debate causes the agony of each survivor's reality to become lost. Because memory is reconstructive, the facts of the actual abuse often get lost in the emotional effects of abuse actually survived. If--as I believe--we construct our realities, the client's contextual reality of her past becomes more important than the factual reality (Peavy, 1998). Contextually she may be telling the truth even when factually there are inconsistencies. By the time DID manifests itself, the facts may have become deeply embedded in the reconstruction of memories too horrific for most people to comprehend.

Two main models of DID reflect this ongoing debate. The sociocognitive model believes DID to be an iatrogenic artefact of therapy, not a true disorder. DID is created by inappropriate therapy and highly suggestive clients, as proponents of FMS contend. Alters are conceptualised in terms of cultural scripts, clients attempting to please the therapist, media portrayals of the disorder, and sociocultural expectations (Banyard, Williams, & Seigal, 2001; Gleaves, Hernandez, Hernandez, & Warner, 1998; Gleaves, 1996).

While learning to treat trauma and dissociation, some therapists may have used suggestive techniques that allowed the inclusion and development of inaccurate reports of memories. Due to the media's fascination over FMS, social contagion and contamination of abuse memories may also occur. Both play a role in accounts of poorly corroborated memories that can include inaccurate memories of satanic ritualistic abuse and extreme chronic sexual abuse by multiple perpetrators (Chu & Bowman, 2000). False memories can occur, and some cases of DID may be iatrogenic. This does not obviate evidence regarding the chronic and severe maltreatment of children and must not be used to ignore that abuse's psychological consequences.

Some memories revealed by adult survivors of childhood maltreatment may be – in their entirety or in part--metaphorical or fantastical manifestations of chronic abuse actually survived. The issue of traumatic memory and memory retrieval is complex and not fully understood. This is in part because every human being constructs their reality, past and present. Also, normal memory is unreliable, easily distorted and often a convoluted mix of fantasy, belief and fact (Peavy, 1998; Freeman, 1995). After years of being misdiagnosed and discounted, it is not hard to understand why some abuse survivors, in a plea to be heard, would fabricate and believe abuses above and beyond the ones in which they actually survived. The abuses that are improbable could be a metaphorical attempt at trying to have someone *hear and acknowledge* the terrible suffering that occurred.

Others may become fixated on their abuse, embellishing their recall of childhood events. Some--such as those who are extremely vulnerable to suggestion--can begin to believe that they have been abused when they have not. A few may intentionally misrepresent their histories in an attempt to avoid dilemmas including the emotional and or legal responsibility of their actions (Chu & Bowman, 2000). These examples should not be used to obfuscate the fact that non-iatrogenic DID exists; it is as a result of severe trauma, can be diagnosed and successful integration of the self is possible.

DID is--as the second model, the posttraumatic model, theorises-- a result of severe and chronic trauma. Little girls internalize the dynamic patterns of intimate interpersonal violence. That violence, combined with forced submission to pedophilic authority figures who are condoned and encouraged by our society, causes many tender selves to see the manifestation of DID as the only way to survive. Surveys of DID

sufferers indicate 97% experienced severe childhood trauma involving sexual, physical or emotional abuse. Of that amount, 68% were incest victims who reported chronic sexual abuse and a large proportion witnessed the violent death of a close friend, relative or parent (Austrian, 2000).

Counsellors working with non-iatrogenic cases of DID often feel the need to reconcile the inevitable ambiguity of their clients' memories. However, due to the very reconstructed and contextual nature of memory, one cannot truly know objectively what has happened in a person's past. Regardless of whether the woman is suffering with actual DID, iatrogenic DID or presenting symptomology that is either factitious or a manifestation of other problems, the counsellor needs to acknowledge and recognise the woman's pain as both real and authentic. The therapist may be the first person in the woman's life who validates and accepts the woman's pain and symptomology as real manifestations of abuse survived at both the hands of a perpetrator and of a society willing to turn a blind eye.

## Dissociation

To understand how a woman develops non-iatrogenic DID, it is important to understand how the mind functions during traumatic episodes. Considering the relationship between traumatic events and dissociation, when counselling women who have been sexually abused, it is necessary to consider dissociative phenomena.

Dissociation is a process that has been demonstrated to be basic to normal human functioning; it is central to the stability and growth of personality (Pica, 1999). Described as existing on a continuum, one end of the spectrum consists of daydreaming and the

lapses in attention most people experience. Another part of the spectrum deals with déjà vu phenomenon. At the extreme end of the spectrum dissociation becomes pathological and develops into a failure to integrate thoughts, feelings and actions (Banyard et al., 2001).

During trauma, dissociation serves as a normal defence mechanism to control against panic, pain, terror and betrayal. This reaction of the mind allows people to separate from traumatic experiences by compartmentalising memories and perceptions (Cardenia & Weiner, 2004; Austrian, 2000; Schwartz, 2000). Thus, in the beginning, dissociation is a normal coping technique that allows children to deal with unpleasant aspects of reality. When children who suffer chronic abuse repeatedly deal with that abuse by dissociating, the integration of consciousness, knowledge, memory, emotions and bodily experiences is impeded. Because dissociation delays the putting into perspective of trauma, the belief-systems of the perpetrators and the pain of the abuse may continue to pervade the minds of survivors decades after the abuse has stopped (Austrian, 2000). As the women enter adulthood, this form of dissociation becomes disruptive; social and vocational roles demand a continuity of memory, behaviour and a sense of self.

### Dissociative Identity Disorder

In its most extreme form dissociating to deal with childhood trauma causes the self to fragment; as the self fragments, ‘alters’--alternate senses of self with memories, identities and consciousness--develop (Lury, 1998). Thus, DID is “a failure to integrate various aspects of identity, memory and consciousness . . .” causing the growth and

development of “two or more distinct identities or personality states that recurrently take control of behaviour” (DSM IV; American Psychiatric Association; taken from Banyard, et al., 2001). In reflection of psychology’s growing awareness of the nature and dynamics of dissociation, the DSM IV changed the criterion for the diagnosis of DID which was originally named Multiple Personality Disorder (MPD). The fundamental problem of DID is not that multiple personalities fight for space and control within a body as the name MPD implies; it is the difficulty in integrating various aspects of self into a cohesive core self (Phelps, 2000; Gleaves, 1996). In its essence DID contains a fascinating combination of different disorders. It can be seen as an amalgamation of a posttraumatic disorder, a disorder of consciousness and a disorder of self-representation.

Much is not understood about DID and the life course of its sufferers, but studies appear to indicate that as people develop different ways to adjust to and accept emotional turmoil, the symptoms diminish in intensity; this indicates that developmental psychology may explain the etiology of DID (Austrian, 2000). Individual passes through different stages ultimately leading to an integrated sense of self; part of the childhood developmental process is the engagement of fantasy play. Many creative children have imaginary friends that disappear as real friends take their place. Approximately 1/3 of children between the ages of 2 and 10 develop these imaginary companions. This is also the developmental period thought to be consistent with the age of vulnerability for developing DID (Pica, 1999). The development of alternate identities may in part be as a result of using normal childhood imaginary playmates to protect the self from dealing with the horror of abuse. Children suffering chronic abuse may find it adaptive to use imaginary friends to compartmentalise memories; this allows the child to put the

associated pain and trauma out of conscious awareness (Austrian, 2000). Not old enough to protect themselves or to understand why they are being hurt in such a manner, chronically maltreated children thus protect the core aspects of themselves; eventually these imaginary playmates become hidden from consciousness as the child grows and develops (Pica, 1999; Malmö & Laidlaw, 1993). As the girl matures, instead of disappearing into the realm of fantasy, the imaginary friends develop, eventually growing into a protective barrier that shields the girl from the emotional and physical pain that chronically occurs. Eventually these barriers fragment from the core self and the different fragments develop into distinct alternate senses of self. DID results as these 'alters' become more complex until they have diverse ranges of feelings, thoughts and memories.

#### Assessment

To date there is little in the way of large scale studies of the prevalence of DID; while rare, it is felt to be more prevalent than previously thought. The body of literature demonstrates that DID can be assessed and consists of a stable set of characteristics distinguishing it from other mental disorders (Cardenia & Weiner 2004, Gleaves, et. al., 1998). An immediate indicator would be women who report histories of the inability of the mental health system to successfully treat different diagnosis. Sufferers of DID often have long mental health histories full of inaccurate diagnosis. Studies have shown that women who have been diagnosed with DID have an average of 3.6 previous diagnoses (Austrian, 2000). Those who suffer DID are often ineffectively medicated for conditions that they do not suffer from. Clinicians fail to recognise DID through the simple fact that

they are not assessing for any type of dissociative disorder (Cardenia & Weiner, 2004; Scropo, Weinberger, & Eagle, 1998; Gleaves, 1996).

It is essential when counselling women who are exposed to trauma or chronic sexual abuse as children, that counsellors educate themselves in the valid forms of assessment and the conceptual framework underlying DID (Cardenia & Weiner, 2004). Afraid of the undue attention accurate assessment may cause, women with DID may seek out therapy presenting other psychological problems such as depression and anxiety. Trauma of the severity that causes DID is related to intense shame, and feelings of victimisation (Cardenia & Weiner, 2004; Baker, 1998)

Counsellors who decide to assess for DID need to ensure that the dissociative experiences being reported by the client are not a normal and appropriate aspect of her culture; these symptoms should also cause distress. When assessing for DID, it is important to rule out any other psychological or physical condition; symptoms of DID may be a result of either neurological disorders, or neuropsychological disorders. Thus, neurological and neuropsychological testing can be helpful in preventing an inaccurate assessment of DID (Loftus, 2000). Structured interviews such as the Structured Clinical Interview for DSM-IV (SCID-D) can assess DID accurately. However the counsellor must be aware of the limitations of psychological testing. A client may decide to skew the responses they give to such questionnaires depending on the level of shame they feel and the trust they have in their therapist. Studies have shown the SCID-D--which guides the counsellor through the assessment of five domains of dissociative symptoms--to be a highly reliable measurement of DID (Gleaves, et. al., 1998). Even those counsellors who

choose not to utilise the SCID-D should be aware of the range of dissociative symptoms to assist in an accurate informal assessment of DID.

### Counselling Strategies

Once the counsellor assesses--formally or informally--that the woman is a DID sufferer, establishing a strong therapeutic relationship is essential. The ultimate goal of the therapeutic relationship is the integration of the different alters and the empowerment of the woman. Integration must establish new adaptive ways of coping and of conflict resolution and assist women in getting in touch with the inner power they were stripped of at a young age. This prevents the woman from slipping back into the coping mechanism of dissociating (Austrian, 2000). Counsellors can implement the following suggestions to ensure an environment where the woman can safely work toward integrating her alters into a cohesive core self and developing more mature psychological defences.

1) Establishing a safe therapeutic environment. A strong therapeutic relationship cannot develop without a safe environment for the woman to work in. A safe therapeutic environment is one in which the woman is ensured of her complete emotional and physical safety, and is ensured absolute confidentiality. Counsellors must maintain the highest of ethical standards when working with women who have DID. This includes not becoming so fascinated with the phenomenology that the actual client gets ignored. Above all, clients should not be put on display to credit or discredit the disorder or for educational or sensational purposes (Gleaves, 1996). These women have been severely

traumatised and this type of behaviour --reminiscent of the power dynamics of their abusive childhood--can cause further victimization.

DID sufferers have been victimised and re-victimised, called crazy, been accused of lying, faking, or have been told they are so malleable that counsellors can make them believe anything. It is in this climate that the DID woman shows the courage to try and help herself. Thus, it is important that the counsellor maintains non-judgemental acceptance of the woman's contextual reality. Instead of a place to cast doubt on the veracity of her memories, a safe therapeutic environment needs to be a place where the woman can explore and heal the feelings, associations and manifestations that the abusive memory causes.

Establishing a safe environment is something that is consistently gone back to; the client needs to know that her reality will not be dismissed and ignored and that this is the place where she can reveal, explore and heal in a non-judging manner. A safe therapeutic environment also involves allowing the client the right to choose whether or not to verbalise all of her traumatic memories. While it is important that the counsellor bear witness to the client's reality, it is essential that the woman be given the power of choice as to what to disclose.

2) Development of contracts. Because of the nature of DID, it is important to immediately give women who suffer from it a sense of control and power over their lives. One way to assist in this is through the use of mutually agreed upon contracts giving the woman control over her therapy. This also serves to remind her that therapy is about her agenda, not the counsellor's and gives therapy a sense of stability and predictability (ISSID, 2005).

Counsellors should also include the woman in frank discussions and development of safety contracts to assist in preventing the woman from harming herself. 61-72% of people with DID attempt suicide; 34-48% self mutilate and these numbers may be on the low end of the scale (Brand, 2001; Austrian, 2000). It is essential that the counsellor develop no-harm to self-or-other contracts and be vigilant to self-destructive tendencies in the woman.

3) Establishing appropriate boundaries. Sufferers of child abuse have had their boundaries violated from the time of childhood; it is important that the counsellor establish and consistently maintain proper boundaries. Within the concept of boundaries for DID women is the use of therapeutic touch. While touch can be used to establish empathy and encourage open exchange between the client and counsellor, touch can be easily misinterpreted. Physical intimacy was used to oppress and violate the DID woman's sense of self from the time she was a young age; thus the therapist must ensure that any therapeutic touch is not construed as a further violation by the woman.

Touch can be helpful in keeping the client connected to the present while remembering painful childhood memories. If the counsellor decides to implement the use of touch, it should first be explored with the woman and she should have a choice as to whether touch should be allowed. Not only does this further empower the woman, it reinforces the nature of touch in the therapeutic setting. If the woman chooses to accept therapeutic touch in her treatment, then the therapist should be careful to use touch that is neutral. Briefly holding the woman's hand or lightly placing a hand for a short amount of time on her shoulder exemplifies appropriate therapeutic touch. Many clients are highly vulnerable; the relationship between client and therapist can be extremely intense in any

therapeutic relationship but is more so with the DID client due to the extreme nature of the disorder. Therefore the counsellor must be highly ethical in any situation touch is deemed necessary. Counsellors should continually assess personal desires to show physical affection to a client to ensure the use of touch is for the client's therapeutic benefit, not the counsellor's (ISSID, 2005).

Crisis will arise as the process of exploring and integrating alters begins necessitating the setting of clear boundaries regarding contact outside of sessions. Counsellors should offer limited availability, by phone. The woman and the counsellor should--before therapy is commenced--agree under which circumstances phone calls would be beneficial. Offering unlimited telephone contact or unlimited extra sessions fosters dependency on the counsellor. Due to the nature of the disorder, extra sessions may be needed. However the counsellor must assess both the necessity and frequency of these sessions to ensure that the sessions are being used for therapeutic purposes and not for the gratification of other emotional needs that either the woman or the counsellor may have (ISSD, 2005). Maintaining appropriate boundaries is not only for the benefit of the client; it helps to ensure that the counsellor does not become burned out or enmeshed in the reality of the client.

4) Education. Dissociation needs to be seen as something that is not pathological. While counsellors need to legitimise alters as the woman's genuine reality, they also need to educate the woman that alters are parts of the whole self in its entirety, not separate entities or personalities (Gleaves, et. al., 1998). Educating women that DID is a survival mechanism of a creative child normalises the dissociative process and sets the stage to developing more mature psychological defences. This education also prevents the

development of iatrogenic alters either as a method to cope with her diagnosis or as a result of attempting to please the therapist.

5) Hypnosis. When used by ethical and properly trained counsellors, hypnosis can aid in integrating trauma into the person's sense of reality. Hypnosis serves as a technique for ego-strengthening, and a way to safely express emotions such as anger. Hypnotherapy techniques can be used for cognitive rehearsal and skill building and assists in integrating alters in a liberating and empowering way. Because DID sufferers have struggles with issues surrounding control, combining stress reduction and relaxation exercises with self hypnosis techniques are beneficial. Using hypnosis as a tool to safely access painful memories and integrate them into a woman's reality is exemplified by CM, a chronic sexual abuse survivor who did not have DID. CM--actual client of mine-- agreed through the signing of a 'consent to release information' form to allow the use of her hypnosis experience for educational purposes on the condition that her anonymity be respected and maintained. This is an encapsulation of a great deal of therapy and is used here to demonstrate how powerful a tool hypnosis can be for some clients. While not quite a fictionalisation, a great deal of information was left out to both protect CM's identity and to shrink over a year's worth of therapy into a paragraph.

*Through hypnosis CM re-nurtured her little girl archetype and grieved the loss of childhood innocence. In trance, to deal with the pain of her mother hurting her as a child, CM visualised going into a beautiful blue box. Over time, CM recognised this box as a way for her mind to help her cope with, validate and acknowledge the abuse of her childhood. She spent time in trance thanking the 'blue box' for protecting her. She acknowledged its heroism, and its sacrifice in holding onto her pain and giving her a*

*place to put it. Eventually she told the blue box that she was learning different ways to deal with her pain and sadness; that the blue box did not need to protect the little girl any more. As she became comfortable with her new coping mechanisms and accepted and integrated her past into her current reality, the blue box shrunk until it became a locket that symbolised the strength she had to survive.* Trance gave CM an effective method to honour her childhood survival mechanisms and develop more mature psychological defences. To acknowledge the pain she survived, and congratulate herself on the fact that she was now able to thrive, CM bought herself a small locket with a tiny sapphire on it. In the locket she put a picture of herself as a child on one side and a picture of her daughter on the other.

The necessity of thorough and adequate training in hypnosis cannot be overemphasised. Clinicians should be able to use hypnotic techniques without interpretation or suggestion. The concern of using hypnosis is the reality that the client--especially those suffering from DID--will be highly vulnerable to suggestion during trance. The counsellor must take great care not to inadvertently create iatrogenic alters. Before using hypnosis, the legal ramifications must be discussed with the woman--especially in Canada. Also, the counsellor needs to educate the woman in the realities of hypnosis. It is essential that the woman understand that the counsellor has no control over her and that she can automatically leave a trance state anytime she wants. Hypnosis should only be used for the empowerment of the woman and counsellors must maintain the highest of ethical standards when utilizing this tool.

6) Counsellor self-care. In order to be empathic, available and reliable when crisis develop, counsellors must engage in activities that promote their own emotional

and physical health. Counselling DID women is long and challenging and the burnout rate is high (Austrian, 2000). Thus, having a professional and personal support network can prevent burnout and assist the counsellor in maintaining a life separate from that of his or her DID clients (Chapman, 1998).

Ensuring that case files are kept up-to-date assists in the counsellor processing life stories that were witnessed during session. Keeping accurate records is an effective way to prevent the counsellor from bringing negative emotions from work home. During record taking, I personally monitor how the session may have affected me personally. I use self-hypnosis and meditation to work through any feelings my clients' life stories may bring up.

Maintaining a healthy and proper diet is essential. If I do not have adequate nutrients in my body, I become more susceptible to unhealthily immersing myself in the experiences of my clients. Taking five or ten minutes between each client to perform a 'systems self check' ensures my nutritional needs are being met. This also gives a moment to centre my self ensuring my focus remains on the next client's reality.

Daily exercise is a way to not only treat myself but to burn away any negative energy remaining. Finally, it is important to remember to play alone, with your friends and your family. Enjoying quality time alone or with your loved ones puts life in perspective and assists in allowing the counsellor to fully engage in work without burning out. Self care tools such as these are essential for any counsellor but especially so when attempting to work with the unique challenge DID represents.

Conclusion

The issue of DID is too complex and ambiguous--like much that exists in regards to the fragility and wonder of the human psyche--to be reduced to belief or disbelief of the condition. While it is true that some people can be made to believe that they were abused when they weren't, society must not use this as an excuse to silence those who were. Society must transform from one that accepts, glorifies and promotes the domination and sexualization of children to one that gives human rights to all of humanity regardless of gender, ethnicity or age. In essence, our children--who are our future--must become the heart of our society; perpetrators must no longer be allowed to fragment and shatter the souls of the most innocent and precious members of our species. Perhaps, one day, our society will embrace the fragile beauty of our children and DID will become a fascinating psychopathology of the past. Until that day, it is our responsibility as counsellors, not only to bear witness, but to speak out against the atrocities that cause DID to manifest.

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