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RESEARCH ∙∙

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Dissociative disorders affect 29% of the clinical population, with women diagnosed 9 times more often than men. For this study, the authors used a phenomenological approach to uncover experiences of 5 men with dissociative identity disorder. Findings revealed 5 themes: history, alters, male gender expectations and identity, challenges, and strengths and support. Implications for practitioners are discussed.

Keywords: dissociative identity disorder, mental health, gender

Dissociative disorders—disorders distinguished by individuals experiencing disconnects from reality—affect approximately 29% of the clinical population (Foote, Smolin, Kaplan, Legatt, & Lipschitz, 2006) and from 12% to 28% of all individuals seeking treatment through outpatient facilities (Brand, Lanius, Vermetten, & Loewenstein, 2012). Prevalence in the general population is unknown (Gentile, Dillon, & Gillig, 2013) but listed as 2%–3% by the International Society for the Study of Trauma and Dissociation (ISSTD; n.d.). Recognition, diagnosis, and treatment of dissociative disorders have increased over the past 30 years (ISSTD, 2011), yet these disorders are still woefully underdiagnosed (Foote et al., 2006) and underserved (Brand et al., 2012). Of the dissociative disorders, dissociative identity disorder (DID) is the most severe and intractable. DID is diagnosed using five criteria in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013). Meeting

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these criteria requires the presence of at least two distinct identities or *alters* who (a) have a relatively stable personality and way of relating to the world and (b) take over or control the psychobiological function, which results in time loss for the main identity (Gentile et al., 2013). This loss of time and lack of control can be traumatic for individuals with DID.

Also to the detriment of those with the diagnosis, DID has been portrayed inaccurately and dramatically in the media (Bryne, 2001). Furthermore, the disorder continues to be controversial within the mental health community (Dorahy et al., 2014), with many people doubting its existence or believing it to be iatrogenic (Floris & McPherson, 2015). While dissociative disorders need to be better understood by the counseling field in general, DID is perhaps the most misunderstood dissociative disorder, as evidenced by mixed reviews on the very legitimacy of the disorder itself (Stickley & Nickeas, 2006).

Childhood abuse, particularly sexual abuse, is a risk factor for DID, and men who have been sexually abused report experiencing dissociation along with fear and rage (Sigurdardottir, Halldorsdottir, & Bender, 2012). Dissociation runs the spectrum from mild symptoms that mimic daydreaming all the way to the separate personalities that are the distinguishing factor of DID (ISSTD, 2011). Men diagnosed with DID indicate high levels of childhood sexual abuse, with 85% reporting a history of abuse (Loewenstein & Putnam, 1990). Allagia and Mishna (2014) indicated that up to 26% of men, and up to 36% of all men in clinical settings, reported sexual abuse as children. In the present study, each of the men interviewed reported a significant history of prolonged abuse. Additionally, the men in Loewenstein and Putnam's (1990) sample reported high rates of interpersonal violence, participation in homicides, and criminal behavior. This impact on the safety of others makes it critical to understand the treatment needs of men with DID. However, within the DID community—and the existent research literature—men with DID are a minority (Loewenstein & Putnam, 1990; Gentile et al., 2013), as women are diagnosed up to nine times more often (Levy & Swanson, 2008). Except for one phenomenological study of 21 men diagnosed with DID (Loewenstein & Putnam, 1990), the existing research regarding men with DID has been focused primarily on case studies with sexual offenders (i.e., Keyes, 1981; Ross, 2008).

Another challenge to treating individuals with DID is that the gender of both the host (i.e., main personality; ISSTD, n.d.) and the alters (Rosik, 2012) is likely to be different (Loewenstein & Putnam, 1990). Although Rosik (2012) reported that at least half of all individuals and two thirds of men with DID have an opposite-gender alter, this topic has not adequately been explored, resulting in an added barrier to promoting positive client outcomes. Through this research investigation, we seek to bring attention to the voices and unique experiences of men living with DID, with particular attention to the challenges of this minority group within a minority group.

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METHOD

We utilized a qualitative methodology, from a phenomenological paradigm, to give voice to the lived experiences of men living with DID. Phenomenological research allows individuals to assign meaning to their experiences regarding a particular phenomenon (Creswell, 2007). Through this approach, individuals' descriptions of their experiences add to the knowledge of a phenomenon that is not yet fully understood (Creswell, 2007). Phenomenology assumes there is no fixed reality; rather, reality is viewed through a social constructivist lens in which individuals make meaning of their own lives. In the present study, we investigated the phenomenon of how men living with DID experienced their diagnosis. In this sense, the investigation was guided by the research question "How do men with DID describe their experiences of living with the disorder?" Participants were first asked to describe their experience of living with DID and then prompted with additional questions.

Data Collection

Before beginning data collection, we received approval from the institutional review board at the third author's institution. Data collection took place over the course of 2 months and included individual interviews (N = 5) with each of the participants. Interviews lasted from 30 to 60 minutes and were audio recorded so that the interviews could later be transcribed verbatim. Members of the research team transcribed the audio, allowing them greater immersion in the interviews. Because the participants were located throughout the country, and one participant lived internationally, all five interviews were conducted via phone. After we obtained informed consent, we asked each participant a series of open-ended questions designed to elicit themes about the individual's experience of living with DID and the uniqueness of living with DID as a man. A semistructured interview approach was used to allow flexibility within the interview and emergence of a fuller story (Morrow, 2005). In addition to being interviewed individually, participants were given two instruments: a demographic questionnaire and the Dissociative Experiences Scale–II (DES-II; Carlson & Putnam, 1993). The first author e-mailed participants these instruments when finalizing interview times, with participants using e-mail to send the instruments back as well.

Measures

We used a short, researcher-created demographic questionnaire to collect information pertaining to the areas of participants' presenting identities. The questionnaire included items on sexual orientation, length of time since DID diagnosis, intimate relationship status, income, highest completed level of education, current employment status, presence of social support,

ethnicity, age, type of professional who diagnosed the individual with DID, co-occurring diagnoses, number of known alters, number of years in treatment for DID, and medication history. Four of the participants chose to respond to these demographic questions, and one participant abstained from providing this information.

To obtain a clearer sense of the levels of dissociation experienced by participants in the sample, we asked them to fill out the DES-II. The instrument consists of 28 items that require participants to self-report experiences of dissociation in their daily lives. Participants are asked to answer how often each experience happens to them, with response options ranging from 0% to 100% of the time. Sample items include: "Some people have the experience of finding themselves in a place and having no idea how they got there" and "Some people find that they are sometimes able to ignore pain," with each item asking participants to circle the percentage of time that the experience happens to them. A score of more than 20 is thought to represent the clinical threshold for the disorder, and scores over 30 are therefore highly associated with DID (Steinberg, Rounsaville, & Cicchetti, 1990). Participant DES-II scores from the current study ranged from 30 to 86, indicating participants were experiencing a high degree of dissociation in their daily lives.

Sampling and Participants

The sample was comprised of five men living with DID, which is in line with recommendations for phenomenological research (Creswell, 2007) and was further deemed adequate due to the limited population size being explored. Purposive sampling was used to ensure participants in the study represented the phenomenon being explored (i.e., men living with DID). Due to the limited population of men living with DID, no further inclusion criteria were placed on participants. Participants were recruited through an advertisement sent through a contact who oversaw a DID electronic mailing list. Recipients were encouraged to contact the lead researcher should they have interest in participating and sharing their story of living as a man with DID. Following this initial contact, prospective participants were given a written and oral description of the research, including areas of confidentiality and consent. Confidentiality was ensured by not asking for participant names at any point throughout the research. In addition, identifying information that may have been shared in interviews was removed during the transcription process and not used in subsequent writings (i.e., publications and presentations). Finally, audio recordings and transcribed interviews were kept on a locked computer belonging to the lead researcher to further maintain participant confidentiality.

The average age of participants was 56, with each participant reporting five to 15 known alters. Four participants had been diagnosed with DID primarily

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by a psychiatrist, and one participant reported being diagnosed by a mental health counselor. In addition to a DID diagnosis, participants reported having been diagnosed with posttraumatic stress disorder (PTSD), major depressive disorder, bipolar disorder, generalized anxiety, and schizophrenia. Each of the four men who participated in the demographic questionnaire identified as White (non-Hispanic) and reported being married. While the majority of participants reported identifying as heterosexual, one participant stated that this demographic question was complicated due to the differing sexual orientations of his alters and therefore identified as multisexual. Each of the participants reported at least some college experience.

Data Analyses

The goal of the qualitative process was to identify themes from the interviews in order to contribute to the understanding of the lived experiences of men living with DID. Colaizzi's (1978) nonlinear stages to phenomenological research (e.g., acquiring a sense of each transcript, identifying significant statements, formulating meanings, organizing these meanings into clusters, and identifying themes) were utilized to begin analyzing the transcripts. Three members of the research team made up the primary coding team, and each of these members reviewed the transcripts multiple times before beginning the coding process. This peer review coding process helped to ensure the quality of the analytical process and was strengthened through in-depth discussions surrounding the transcripts, the meaningful phrases found within the transcripts, and the phenomenon these phrases were conveying. Following the process of creating themes, a fourth member of the research team was asked to examine the data (i.e., the transcripts as well as the resulting themes and meanings) as an outside auditor to foster accuracy and validity of the study. As the final step of the data analysis process, the coding team, with the feedback from the outside auditor, compiled a list of identified themes that best encompassed the overarching phenomenon of being a male living with DID.

We utilized several strategies of trustworthiness in the study to enhance its credibility. First, members of the coding team recorded their positionality within the research and continued to bracket these biases as the coding progressed. All three members of the coding team had backgrounds in mental health counseling, with one member having significant experience in DID research as well. It is worth noting that all members of the coding team were female, and none identified as having DID. Second, we used an auditor in the data analysis process (Hill, Thompson, & Williams, 1997), as well as an audit trail documenting codes and auditor suggestions (Shenton, 2004). As a result of this audit, the definitions of two final themes (i.e., alters and challenges) were extended to allow a more inclusive description of the underlying significant statements and to better focus on their relevance to the

initial research question. Additionally, internal audits of the data (done by the first and second authors) took place to ensure results were cogent. Last, two participants spoke of relevant artifacts (i.e., an autobiography one had begun writing and personal art another had created while under the influence of an alter) during their interviews and were asked to share these with the research team. Both of these data points were then viewed and served to validate themes that had been found in the transcripts while further triangulating the existing data.

RESULTS

The coding process resulted in five overarching units of meaning (i.e., themes). These five 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/ 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). Each of these five identified themes is discussed in the following sections. To best represent the experiences of men living with DID, we also share some statements by participants that capture these themes. In addition, the themes, subthemes, and frequencies (i.e., the number of participant interview transcripts that were coded for that theme) are presented in Table 1.

History
Consistent with the literature surrounding DID, each of the participants' personal narratives included the theme of their history of abuse and trauma before and after their DID diagnosis. Participants discussed their approaches to coping with these experiences, including journaling, focusing on self-acceptance, meditating, suppressing alters, and using dissociation. Thus, a subtheme of personal trauma history emerged from the data. Participants also discussed challenges around having DID and trauma experiences. One participant stated, "Part of my healing process was to address the criminal content of some of the abuses that I lived through, which I know to be the reason that I have this splinter." Within this theme, participants also discussed varying ways they healed from their traumatic experiences. One participant discussed confronting the perpetrator of his abuse, "I'm nearly 50, and only now in the last 5 years have I been able to approach the perpetrator." Participants recognized the importance of acknowledging their traumas and their relationship to the development of DID.

Participants further endorsed a wide variety of symptoms related to their DID (e.g., losing time, memory loss, fragmented memories, shifting, dissociation, an

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TABLE 1

Summary of Themes

Theme and Subtheme	Frequency
History	
Personal trauma history	5
Symptoms	5
History of diagnosis	5
Alters	
Roles of alters	5
Communication between alters	3
Female alter	4
Male gender expectations/identity	
Male gender expectations	4
Gender identity	4
Challenges	
Representation/stigma	3
Fears	3
Significant relationships difficult	3
Roadblocks	3
Strengths and support	
Significant relationships	5
Therapy	5
Needs of DID community	4

Note. Frequency represents the number of participant transcripts that endorsed each sub-theme. DID = dissociative identity disorder.

inability to explore emotions, catatonia, shame, isolation, aggression, suicidal and homicidal ideations, and a tendency to self-harm), making a subtheme of symptoms part of this theme. Participants perceived the consequences of these symptoms to be significant and discussed a drop in cognitive skills, as well as having to face the consequences of their aggression and phobias. A participant who spoke of two alters who appeared as ghosts explained, "I never wanted to look at me, never wanted that person to look at me. I didn't look in mirrors. I was terrified of mirrors when it happened, because I didn't want to see myself as a ghost." The wide range and degree of severity of these symptoms created significant difficulties (e.g., relationship difficulties, legal concerns, fear of self) in the lives of the participants.

Lastly, every participant described unique paths to their DID diagnosis, with most participants experiencing several misdiagnoses or comorbid diagnoses along the way. 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, "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.'" In

struggling to identify and cope with their DID diagnosis, some participants discussed turning to various forms of self-medicating. One participant who coped with alcohol explained, "Real men . . . can drink and they might have blackouts, but real men don't get sick, so it's easier to just blame it on the alcohol." Participants noted that even after establishing that a DID diagnosis was appropriate, the challenges did not decrease, as they now had to adjust to a new normal and acceptance.

Alters

Precipitating a DID diagnosis is the presence of multiple alters, which each of the participants expressed had played a significant role in their lives. Three subthemes under the theme of alters included the roles of alters, the communication between alters, and female alters. The first of these subthemes was shown by participants discussing varying presentations and experiences of alters, with alters being described as "protectors," "aggressors," and "gatekeepers." The second of these subthemes was exemplified by one participant describing his alters, rather than himself, as having control over his sexuality:

> The older [alter] kept all of our sexuality as a group. I never had any confidence in that . . . I had zero self-esteem. I wouldn't try to ask people out, you know. I was incredibly lonely, even at a very young age. I knew that. And what I wanted was a connection with other people, but what would happen is that, at a certain point, she just kind of drove the bus, and I'm sitting in the back watching and not really in control.

Participants often pointed out that their alters had unique experiences and talents, such as different intelligence levels, abilities, ages, illnesses, or physical features. One participant described one of his alters as someone who "can't read or write, but is a wonderful artist" although he did not consider his host personality talented in this same way. Participants not only discussed their personal relationships with their alters but also their significant others' relationships with their alters. One participant discussed his wife's encounters with his alters as more like those of a friend or acquaintance, recalling that "she spent six days with '4:30 Guy,'" one of his alters. This relationship could be particularly complicated when alters took on a different gender than participants, such as noted within the third subtheme of female alters. A participant explained that his wife recognized his female alter, and further appreciated when this alter was present. Participants also pointed out that their female gendered alters had significant and sometimes very powerful influences on them: "My 'older sister' kept all of our sexuality as a group," said one participant.

Male Gender Expectations and Identity

Continuing with the idea of gender, the third theme describes those experiences most unique to being a male living with DID. Within these experiences rest the subthemes of male gender expectations and gender identity. For the first of these subthemes, participants stressed that male gender expectations greatly influenced the level of stigma they experienced surrounding both their trauma experiences and their diagnosis. For example, one participant mentioned that "Being strong, being all those things that men are told in this American culture that we must be prohibits us from getting timely help." Another participant encompassed this theme by simply stating, "Real men don't get sick." Therefore, being biologically male can potentially prevent men with DID from seeking and receiving services. Not being able to access services due to gender expectations can in turn have dangerous consequences. One participant painfully articulated the link between sexual abuse and DID as a "root cause" that exists for both men and women. The participant followed up by saying, "Look at how society views those root causes, and then you'll understand why there aren't very many of us guys left."

In the second subtheme of gender identity, participants suggested that gender presentation and identity could be influenced by their alters. A participant with a female alter explained that when he would "switch and start moving into that mode," it "terrified" him at first because he was "not a girl." Another participant pointed out, "I would describe myself as multisexual, it's not about bi or straight . . . I look at the world through completely different eyes, different skin, different forms of sexuality." This participant felt strongly that this multisexual experience was not unique; rather, it was an experience that could benefit all individuals (e.g., "We can as a society recognize the male and female within us all."). In turn, the gender and sexuality of men with DID is oftentimes fluid rather than static.

Challenges

Aside from the aforementioned reports of trauma, misdiagnosis, and limiting gender expectations, participants discussed a series of other challenges such as (a) representation or stigma, (b) fears, (c) significant relationships difficult, and (d) roadblocks. Inaccurate representation of individuals with DID, and resulting stigma, was perhaps the most salient subtheme within the theme of challenges. "They think that means Sybil . . . so I suppose I'd say the average person, if they know what DID is, they kind of have that Hollywood movie concept." The second subtheme, fears, included the fears participants sometimes had of themselves. One participant recounted, "When this first started happening, I assumed it was some, you know, like something demonic, because suddenly this apparently evil entity had taken over my body and was sort of screaming obscenities out of my mouth." Another common challenge

for the participants was maintaining significant relationships while living with DID, which also served as a fear. The men discussed the impact DID had on their personal and professional relationships. Participants felt that living with DID sometimes put a strain on their relationships and reported sometimes sabotaging their relationships out of fear of negative outcomes with family, friends, or coworkers. 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.

Although the therapeutic relationship often served as a source of strength and support to participants (as noted in the next section), many participants also experienced roadblocks to their treatment, such as therapists having a lack of DID experience. One participant stated, "It's really frustrating when I can look into someone's eyes, a professional, a new counselor, or something, and they glaze over when I start to talk about dissociation . . . it's like they don't even want to hear it." Participants felt that, although counselor support could be beneficial to their healing, even effective professional counselors evoked feelings of fear. Furthermore, these experiences of fear often stemmed from a fear of self-discovery and sometimes a worry that the counselor or the therapeutic environment would be triggering.

Strengths and Support

Despite the numerous tales of pain and challenge they reported, participants were also able to count a number of supports that provided strength during their journey with DID. These supports can be seen in the following sub-themes: significant relationships, therapy, and needs of the DID community. Participants reported some positive experiences receiving support from their family—specifically, from the support of spouses. In one case, a participant explained that his spouse had a relationship with each of his alters, stating that, "I have been extremely fortunate, *extremely* fortunate to have the wife that I do. My alters talked to her before I knew they were there." Identifying individuals who demonstrated an understanding of DID was identified by the participants as particularly helpful. For some participants, this support took the form of support groups specifically geared toward male survivors of childhood sexual

abuse; for others, this support was directly from the DID community. "It was a community where people sort of understood what was happening to me . . . and, you know, it sort of felt sage and okay." Several participants reported bringing their partners with them to their counseling sessions as a way to add comfort to the counseling environment. One participant explained that his wife went with him to every session and that when he went by himself, he didn't come home for 3 days "because the counseling sessions can become intense and trigger things."

Despite therapy being an oftentimes emotionally difficult experience, participants were able to discuss specific therapeutic interventions they found to be beneficial, such as (a) grounding techniques, (b) anxiety management, (c) medication, and (d) creative therapeutic approaches, such as music therapy. Participants had varying views on the overall effectiveness of treatment, as well as what types of treatment they found personally most helpful; however, all participants stressed the continued need for improved mental health treatment when working with men living with DID. Participants spoke of some of the needs of the DID community, which might inform therapists on ways to best advocate for these clients. For example, participants felt a need for pride within their community; as one explained, "It's kind of trite, but we need to get the pride out in these people in just really basic ways." One suggestion for supporting the DID community while also encouraging pride was "getting some organized safety, some sanctuary where DID people could meet."

DISCUSSION

Clinical Implications
Dissociative disorders continue to be misunderstood in the counseling field (Stickley & Nickeas, 2006), with research on men with DID being particularly underrepresented in the literature (Gentile et al., 2013). Hearing the stories of survivors, however, it becomes apparent how mental health counselors might play a role in the healing of men living with DID. Participants spoke directly on the helpful benefits of specific techniques they had experienced in counseling (i.e., grounding techniques, anxiety management, creativity in counseling, and medication). In addition, trauma and education are identified areas where counselors might be effective with male clients with DID.

Trauma. Participants' unanimous reports of trauma experiences are consistent with previous DID research which purports that childhood abuse is not only commonly reported from those with DID, but also potentially serves as a risk factor for the disorder (Ross & Ness, 2010; Sigurdardottir et al., 2012). Knowing that trauma is consistently referenced in the DID research, and that the current sample reported trauma so much that it resulted in a theme

in the data, it would behoove clinicians to recognize the trauma histories of their clients with DID. Likewise, considering the vast trauma histories this population likely brings into counseling, mental health counselors can begin to view dissociation as a coping technique the clients began utilizing in order to escape their painful realities (Courtois, 2004). Through this lens, dissociation is seen as a formerly adaptive quality the client likely used for survival. Being careful not to stigmatize the client's behavior, which was another concern from the data, the counselor can recognize the dissociation as a strength the client used to cope as a child, but a behavior that is now likely maladaptive and needing to be replaced with healthier ways of coping. This approach seems of even greater importance when recognizing the stigma surrounding male victims of abuse, and feelings of shame, which often accompany male trauma experiences. As opposed to sharing and processing details of traumatic memories, DID experts instead recommend educating clients on how to effectively contain these memories (Brand, Loewenstein, & Spiegel, 2014). Such containment allows clients to distance themselves from these moments and better regulate their reactions when such memories flood them.

Education. Frustration was reported from participants in reference to their experiences with mental health counselors, particularly when clients perceived counselors as inexperienced or unable to advocate for them. Participants reported that counselors' eyes seemed to "glaze over" when they spoke of their disorder, suggesting some mental health counselors continue to question the legitimacy of DID. In addition, participants reported feelings of fear associated with initiating a counseling experience. While these feelings were often connected to fears of counseling being triggering, the presence of DID stigma amongst the mental health community undoubtedly adds to the negative perceptions clients with DID hold of seeking treatment. Mental health counselors should work to educate themselves on the reality of dissociation, as well as the prevalence of such disorders within the community. Such continued education will also allow clients to feel a sense of universality in recognizing their counselor has seen and heard of their symptoms before. In addition to further educating themselves, counselors can work to educate clients. Client education is integral in demystifying the counseling process (Courtois, 2004) and therefore adding safety to a setting that participants reported brought about fear. Furthermore, education can be used to teach clients with DID skills for enhancing their own personal safety outside of the counseling space.

As counselors continue educating themselves on DID, they should strive to better understand the diagnostic criteria of the disorder as outlined in the *DSM-5* (APA, 2013). Numerous participants reported having received multiple misdiagnoses before the diagnosis of DID, which they felt most accurately reflected their experiences. In addition to becoming more familiar

with diagnostic criteria, counselors can begin to integrate formal assessment into their practice as well. Instruments geared at measuring dissociative symptoms include the DES-II (Carlson & Putnam, 1993) and the Multiscale Dissociation Inventory (Briere, 2002). Structured interviews, such as the Dissociative Disorders Interview Schedule (Ross et al., 1989), can also help to bring structure to the diagnostic process.

Limitations and Directions for Future Research

As with many phenomenological studies, the small sample limits generalizability of the results. In addition, the current sample was homogeneous in terms of sexual orientation, marital status, and education; future research is needed to replicate this question with a larger, more diverse sample. Further inherent to qualitative research is the reality that participants are able to disclose as much or as little as they choose. In disclosing, participants are also influenced by the extent to which they trust the researcher. We made multiple choices in an attempt to gain participant trust (e.g., recruitment coming from a trusted insider, methods of trustworthiness), but the research may have benefited from holding multiple interviews with participants or using member checking.

This exploratory study was focused on gaining an in-depth understanding of the experiences of men living with DID. Experiences of other men—particularly, men in different settings and stages of life—may be different and warrant further research. The present findings also serve to illuminate areas that may be worth exploring in more detail in future studies. Such areas include the individual paths to diagnosis and the impact of DID on multiple relationships (e.g., romantic partners, family members, friends). Given the significant impact of stigma within the sample, future studies to explore clinical approaches to combating stigma within this population would be beneficial.

Conclusion

DID remains underrecognized and underdiagnosed, leaving survivors with DID with limited resources (Brand et al., 2012). The nuanced presentation of DID also leads to the regular misdiagnosis of those living with the disorder. Further adding to the complexity of providing effective mental health services for clients with DID are the misrepresentation and stigma surrounding the disorder, leaving society and even some clinicians with conflicted feelings about the diagnosis. To answer our research question about their experiences, we conducted individual interviews with five men diagnosed with DID. The interviews revealed histories of trauma; experience with alters; challenges related to gender; fear of stigma; and acceptance of strength and support from family and community. Professional counselors

who desire to work with male clients living with DID should tend to the trauma histories of this population and continue to educate themselves about this complex diagnosis.

REFERENCES

Allagia, R., & Mishna, F. (2014). Self psychology and male child sexual abuse: Healing relational betrayal. *Clinical Social Work Journal, 42,* 41–48.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Brand, B. L., Lanius, R., Vermetten, E., & Loewenstein, R. J. (2012). Where are we going? An update on assessment, treatment, and neurobiological research in dissociative disorders as we move toward the *DSM-5. Journal of Trauma & Dissociation, 13,* 9–31.

Brand, B. L., Loewenstein, R. J., & Spiegel, D. (2014). Dispelling myths about dissociative identity disorder treatment: An empirically based approach. *Psychiatry, 77,* 169–189.

Briere, J. (2002). *Multiscale Dissociation Inventory*. Odessa, FL: Psychological Assessment Resources.

Bryne, P. (2001). The butler(s) did it: Dissociative identity disorder in cinema. *Journal of Medical Ethics, 27,* 26–29.

Carlson, E. B., & Putnam, F. W. (1993). An update on the Dissociative Experiences Scale. *Dissociation, 6,* 16–27.

Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle & M. King (Eds.), *Existential phenomenological alternatives for psychology* (pp. 48–71). New York, NY: Plenum.

Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training, 41,* 412–425. doi:10.1037/0033-3204.41.4.412

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches.* Thousand Oaks, CA: Sage.

Dorahy, M. J., Brand, B. L., Sar, V., Krüger, C., Stavropoulos, P., Martinez-Taboas, A., . . . Middleton, W. (2014). Dissociative identity disorder: An empirical overview, *Australian & New Zealand Journal of Psychiatry, 48,* 402–417. doi:10.1177/0004867414527523

Floris, J., & McPherson, S. (2015). Fighting the whole system: Dissociative identity disorder, labeling theory, and iatrogenic doubting. *Journal of Trauma & Dissociation, 16,* 476–493. doi:10.1080/15299 732.2014.990075

Foote, B., Smolin, Y., Kaplan, M., Legatt, M. E., & Lipschitz, D. (2006). Prevalence of DID in psychiatry outpatients. *American Journal of Psychiatry, 163,* 623–629.

Gentile, J. P., Dillon, K. S., & Gillig, P. M. (2013). Psychotherapy and pharmacotherapy for patients with dissociative identity disorder. *Innovations in Clinical Neuroscience, 10,* 22–29.

Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist, 25,* 517–572. doi:10.1177/0011000097254001

International Society for the Study of Trauma and Dissociation. (n.d.). *Dissociation FAQ's.* Retrieved from http://www.isst-d.org/default.asp?contentID=76

International Society for the Study of Trauma and Dissociation. (2011). Guidelines for treating dissociative identity disorder in adults, third revision. *Journal of Trauma & Dissociation, 12,* 115–187.

Keyes, D. (1981). *The minds of Billy Milligan.* New York, NY: Random House.

Levy, B., & Swanson, J. E. (2008). Clinical assessment of dissociative identity disorder among college counseling clients. *Journal of College Counseling, 11,* 73–77.

Loewenstein, R. J., & Putnam, F. W. (1990). The clinical phenomenology of males with MPD: A report of 21 cases. *Dissociation, 3,* 135–143.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52,* 250–260.

Rosik, C. H. (2012). Opposite-gender identity states in dissociative identity disorder: Psychodynamic insights into a subset of same-sex behavior and attractions. *Journal of Psychology and Christianity, 31,* 278–284.

Ross, C. A. (2008). Case report: A convicted sex offender with dissociative identity disorder. *Journal of Trauma & Dissociation, 9,* 551–562, doi:10.1080/15299730802140962

Ross, C. A., Heber, S., Norton, G. R., Anderson, D., Anderson, G., & Barchet, P. (1989). The Dissociative Disorders Interview Schedule: A structured interview. *Dissociation, 2,* 169–189.

Ross, C. A., & Ness, L. (2010). Symptom patterns in dissociative identity disorder patients and the general population. *Journal of Trauma & Dissociation, 11,* 458–468. doi:10.1080/15299732.2010.495939

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22,* 63–75. doi:10.3233/EFI-2004-22201

Sigurdardottir, S., Halldorsdottir, S., & Bender, S. S. (2012). Deep and almost unbearable suffering: Consequences of childhood sexual abuse for men's health and well-being. *Scandinavian Journal of Caring Sciences, 26,* 688–697. doi:10.1111/j.1471-6712.2012.00981.x

Steinberg, M., Rounsaville, B., & Cicchetti, D. V. (1990). The Structured Clinical Interview for DSM-III-R dissociative disorders: Preliminary report on a new diagnostic instrument. *The American Journal of Psychiatry, 147,* 76–82. doi:10.1176/ajp.147.1.76

Stickley, T., & Nickeas, R. (2006). Becoming one person: Living with dissociative identity disorder. *Journal of Psychiatric and Mental Health Nursing, 13,* 180–187. doi:10.1111/j.1365-2850.2006.00939.x