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A Survey of Practices and Recommended Treatment Interventions Among Expert Therapists Treating Patients With Dissociative Identity Disorder and Dissociative Disorder Not Otherwise Specified

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Little empirical evidence exists about the treatment of dissociative identity disorder and dissociative disorder not otherwise specified. Thus, we must rely on the clinical literature, which advocates a staged course of treatment. A survey of 36 international experts in the treatment of dissociative disorder (DD) was conducted to learn what treatment interventions they recommended at each stage of treatment. These highly experienced therapists recommended a carefully staged treatment consisting of three phases. In the initial phase, they advocated emphasizing skill building in development and maintenance of safety from dangerousness to self or others and other high-risk behaviors, as well as emotion regulation, impulse control, interpersonal effectiveness, grounding, and containment of intrusive material. In addition, they recommended specific trauma-focused cognitive therapy to address trauma-based cognitive distortions. They uniformly recommended identifying and working with dissociated self states beginning early in treatment. They advised the use of exposure or abreaction techniques—albeit modified to not overwhelm these complex dissociative patients—balanced with core, foundational interventions for the middle stage. The last stage of treatment is less clearly delineated and more individualized. Unification of self states appears to occur in only a minority of patients with DD. This study provides directions to pursue for future training and research on DD.

Keywords: dissociation, treatment, dissociative identity disorder, trauma, posttraumatic stress disorder, exposure

There has been a significant increase in research involving dissociation over the last two decades (Dalenberg et al., 2007), including a clinical literature describing assessment of patients with dissociative disorders (DD; Brand, Armstrong, Loewenstein, & McNary, 2009a; International Society for the Study of Dissociation [ISSD], 2006) and an emerging literature that suggests an underlying neurobiological basis for dissociation (e.g., Lanius et al., 2010; Vermetten, Dorahy, & Spiegel, 2007). However, systematic research on treatment outcome for dissociative disorder patients is in its infancy. Case studies, case series, and uncontrolled inpatient studies of patients diagnosed with dissociative identity disorder (DID) and/or dissociative disorder not otherwise specified (DDNOS) have emerged from North America, Europe, and Puerto Rico (e.g., Ellason & Ross, 1997; Coons & Bowman, 2001; Coons & Sterne, 1986; Kluft, 1984; Şar & Tutkun, 1997; Şar, Öztürk, & Kundakçii, 2002; van der Hart & Boon, 1997). These studies show that DID and DDNOS are complex trauma-based disorders (Herman,1992; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). A systematic review of the treatment literature on a variety of DD (Brand, Classen, McNary, & Zaveri, 2009b) found that

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treatment was associated with significant improvement, with effect sizes ranging from 0.36 to 1.82 ($M = 0.71$) using either posttreatment or follow-up data. Cross-sectional and longitudinal data from a large, observational international sample of DID and DDNOS patients indicated decreased symptoms of dissociation, posttraumatic stress, depression and general distress, reductions in rates of self-injury, suicide attempts, and hospitalization, and improvements in adaptive functioning over 30 months of treatment (Brand et al., 2009c; Brand, et al., 2011). Together, these studies provide preliminary evidence that treatment is effective in reducing a range of Figure 1 symptoms associated with DD.

The primary goal of this study is to systematically investigate the structure and techniques of treatment that DD experts believe are important at various treatment stages. Although general treatment guidelines have been developed by a consensus of experts (ISSD, 2006; International Society for the Study of Trauma and Dissociation [ISSTD], 2011) and suggest a phasic, multimodal, trauma-focused psychotherapy, the trauma field has yet to develop an empirically supported, criterion standard set of interventions that are effective at the various stages of treatment for DD (Chu, 1998; 2011; Courtois & Ford, 2009; Herman, 1992; ISSD, 2006; ISSTD, 2011; Kluft, 1994a, 1999).

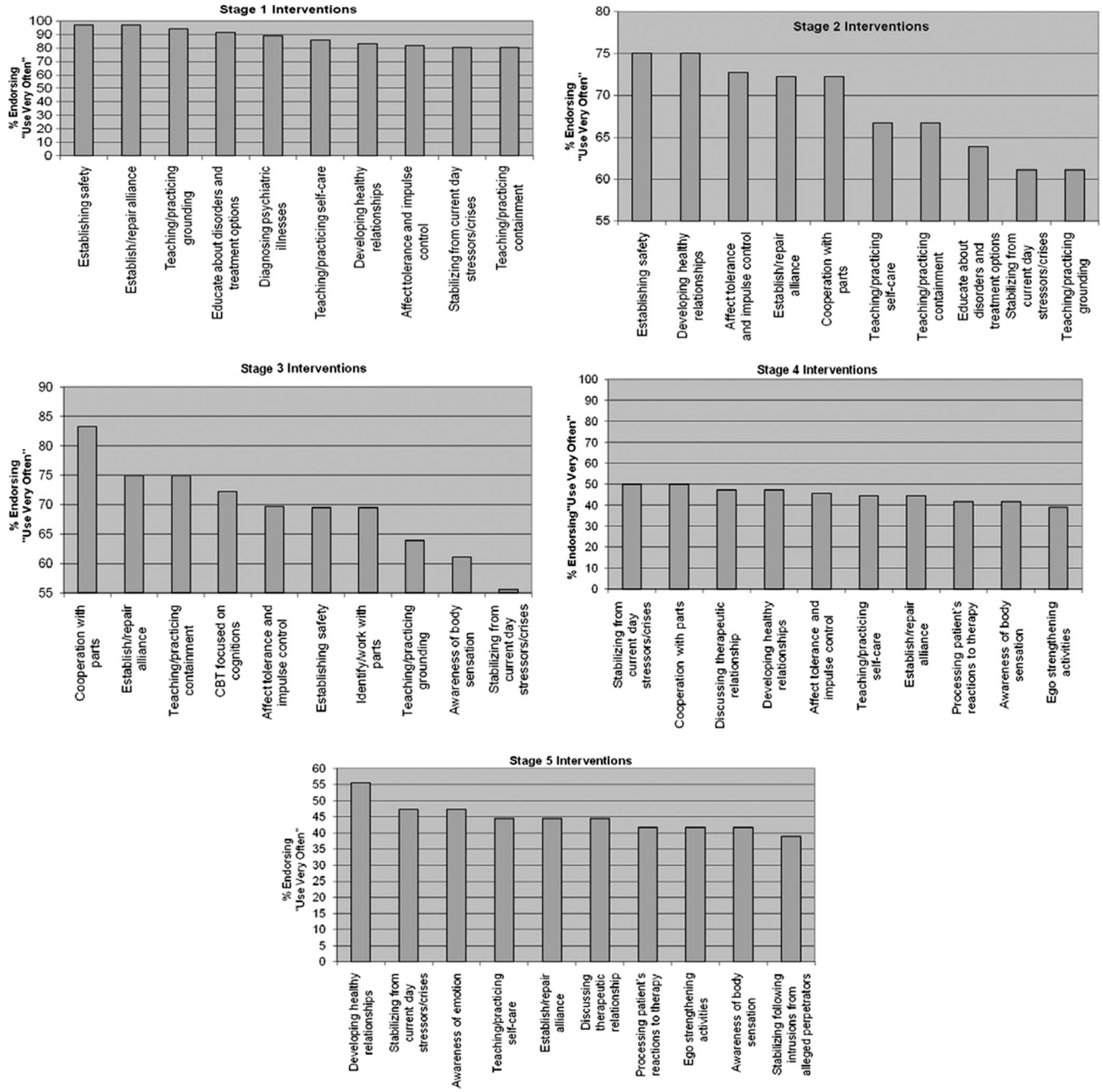

Figure 1. Top 10 interventions by stage.

Three overarching phases of treatment are described for complex posttraumatic stress disorder (PTSD; Courtois, 1997; Herman, 1992; Kluft, 1993a). First, treatment focuses on symptom stabilization and safety with a focus on enhancing symptom control, education about trauma treatment and complex trauma disorders, and the establishment of a collaborative working relationship (Chu, 2011; Courtois, 1997; Gold, 2000; Herman, 1992; Kluft, 1993a). Patients begin to understand that self-injurious behaviors, suicide attempts, substance abuse, aggression toward others, and current abusive relationships are reenactments of trauma and disrupted attachments (Brand, 2001; ISSTD, 2011; Foote, Smolin, Neft, & Lipschitz, 2008). Patients with DD are taught affect and impulse regulation skills as well as internal communication with dissociated self states.

With sufficient stabilization patients may move into the second phase of treatment, which involves processing of traumatic material and associated intense affects. As these traumatic memories are explored, trauma-related cognitive distortions and reenactments can be resolved, and previously avoided emotions such as grief, betrayal, terror, helplessness, rage, and shame expressed. Patients develop a narrative of their nontraumatic as well as traumatic experiences, a sense of mastery over their memories, and a sense of themselves as being worthwhile and strong (Courtois & Ford, 2009). The third phase entails "reconnection" in which all disowned aspects of self are fused together so that no dissociated self states are present; alternatively, some patients achieve a state of "resolution" where self states remain unfused in a cooperative system (Kluft & Loewenstein, 2007). Also in the third phase, clinical attention focuses increasingly on current and future life issues and goals such as developing a sense of purpose in life supported by healthy relationships and engagement in meaningful activities (Courtois, 1989; Herman, 1992; Kluft, 1984).

In this article, we use *unification* to describe the process of a person's sense of self shifting from that of having multiple self states to that of a unified self (Kluft, 1993b; ISSTD, 2011). Many patients achieve some fusions yet they do not become fully unified. Clarity about the terms is important because different terms have been used to mean different processes in the treating DD (Kluft, 1993b; ISSTD, 2011).

Although there is a general consensus among experts about the overall structure of treatment for DID, there are differences of opinion about several treatment issues. A secondary goal of this study is to document the treatment recommendations of experts in the field of DD on three such issues: (a) the extent to which full reexperiencing of emotion during traumatic memory processing is necessary; (b) the degree to which dissociated self states should be worked with directly in treatment; and (c) whether physical touch (such as shaking hands or hugging) should ever be used when treating patients with DD. The use of emotional reliving of traumatic experiences, called *exposure therapy* in cognitive behavior therapy and *abreaction* in psychodynamic therapy, is an intervention that sometimes receives a mixed response. A discussion of the necessity of using full, emotive abreaction or exposure in DD treatment parallels a similar ongoing debate in the field of simple PTSD (Jaycox & Foa, 1996; Lauterbach & Rieland, 2007; Rosen et al., 2004), although no research has been conducted on this issue in patients with DD. Some practitioners do not utilize exposure-based techniques or do so infrequently, believing that exposure evokes too much distress (e.g., reviewed in Chefetz, 1997; Gold, 2000, 2009; Gold et al., 2001; Feeney, Hembree, & Zoellner, 2003; Becker, Zayfert, & Anderson, 2004; Lanius et al., 2010). Only one study has systematically investigated the impact of dissociation on the efficacy of exposure therapy (Hagenaars, Minnen, & Hoogduin, 2010). The authors concluded that dissociation did not interfere with response to exposure therapy. However, study subjects had primarily experienced single episodes of adult traumatization and individuals with current suicidality, ongoing traumatization, or substance dependence were excluded, making it unlikely that participants were suffering from DD or complex PTSD (Courtois & Ford, 2009; Herman, 1992). Nonetheless, 69% of the study participants who scored high on a measure of dissociation still met criteria for PTSD at follow-up, compared to only 10% of low dissociators still meeting PTSD criteria after exposure therapy. A couple of case reports detail successful treatment of DID patients to the point of unification without doing any abreactive work (Gold et al., 2001; Şar et al., 2002). However, neither Gold's team or Şar's team did not define specific criteria for assessment of initial or maintained unification.

Another area of debate is the extent to which dissociated self states need to be targeted directly in therapy. The clinical literature on DID encourages therapists to work with self states, as well as to talk openly to increase internal awareness and cooperation among them (e.g., Kluft, 1994a, 1994b; Putnam, 1998). However, some clinicians support a more indirect approach and rarely, if ever, attempt to work with self states other than those spontaneously presenting in therapy sessions. The Guidelines for Treating Dissociative Identity Disorder in Adults (ISSTD, 2011) state that while clinicians may talk to alternate identities as if they were separate, this is to be done with the goal of decreasing all aspects of dissociative dividedness and encouraging the patient to increasingly see him- or herself in more unified terms. The Guidelines discourage contributing to self states' functioning more autonomously than they already are as well as ignoring self states. Some researchers have expressed concern that working directly with self states will reinforce or further develop them, thereby hypothetically making the patient more dissociative (Lilienfeld et al., 1999). There exists no published, empirical data demonstrating that direct intervention with self states worsens DID, although there is a clinical literature that describes negative outcomes of inappropriate interventions with self states (Kluft, 1989a).

Discussion of the use of touch during general psychotherapy is controversial and it is even more controversial when considering treatment of trauma survivors. A subset of clinicians support the use of touch with general psychiatric patients as a means of conveying genuineness and support or of correcting problematic childhood experiences by teaching patients that safe touch is possible in relationships with healthy boundaries (see Hetherington, 1998; Kertay & Reviere, 1993; Zur, 2007). However, trauma survivors may experience touch as confusing, overwhelming, and intrusive, particularly when further complicated by the power differential between patient and therapist (Ogden, Minton, & Pain, 2006; Rothschild, 2002).

A third goal of this study is to explore therapist and treatment characteristics related to the reported number of patients clinicians treated to unification as well as to characterize training and practice patterns among DID experts. It seems likely that years of experience and the number of patients successfully treated to unification might be associated with differences in treatment in-

terventions. A final objective of this study is to describe the training and current caseloads of the experienced therapists.

Method

Participants

Clinicians well known for their expertise in treating DD were contacted by email and asked to participate in an online survey about interventions utilized in the treatment of DD. Inclusion criteria were having treated patients with DD for at least 9 years, having coauthored the updated ISSTD Guidelines (ISSTD, 2011), or having been highly recommended by one of the Guidelines' coauthors because of expertise and success treating patients with DD. Sixty-six therapists were invited to participate and 38 (57.6%) completed the survey; 12 participants were coauthors of the Guidelines. Data for two therapists were excluded because the therapists had not been treating patients with DD for 9 years. Thus, 36 uncompensated participants completed the survey.

Therapists were from several countries and the majority was psychologists in independent practice in the United States (see Table 1). None of the participants were from Asia, Africa, or South America. Participants reported an average of 25 years (SD = 7.98) of experience treating traumatized patients and over 22 years (SD = 8.39) of experience treating patients with DD across a variety of treatment settings (see Table 2). The majority of the participants reported a psychodynamic theoretical orientation (77.78%) and had published articles or books about trauma and/or dissociation. Some had specialized training in trauma and DD (33%, n = 12; 31%, n = 11, respectively), although the majority had developed their skills by working directly with patients in trauma-focused inpatient and/or outpatient settings (56%, n = 20), consulting with specialists (75%, n = 27), attending workshops and lectures (83%, n = 30), and reading books about DD (86%, n = 31). Five of the clinicians (13.8%) completed the ISSTD's Dissociative Disorders Psychotherapy Training Program courses.

Table 1
*Characteristics of Expert Clinicians (*n = *36)*

Variable	% (*n*)
Discipline	
Psychiatry	38.89 (14)
Psychology	50.00 (18)
Other[a]	11.12 (4)
Gender	
Male	52.78 (19)
Female	47.22 (17)
Country of practice	
United States	63.89 (23)
Canada	5.56 (2)
Europe	11.11 (4)
Australia/New Zealand	19.44 (7)
Treatment settings	
Private practice	83.33 (30)
Clinic/hospital outpatient	33.33 (12)
Inpatient/partial program	19.44 (7)
Forensic	11.11 (4)
Other[b]	5.56 (2)

[a] Other included occupational therapy, nursing, expressive therapy, and an undefined discipline. [b] Other included government-funded programs and university settings.

Procedure

Participants were provided with a link to an online survey, which was adapted from the Treatment Outcome for Patients with Dissociative Disorders study (Brand et al., 2009c). After questions about training and experience, participants completed the Treatment Activities with Dissociative Disorders (TADD; available from coauthor Bethany Brand), a measure of 28 treatment activities based on those discussed in the second edition of the ISSD Guidelines for Treating Dissociative Identity Disorder in Adults (ISSD, 2006). Participants were asked, on a scale of 0 (*never*) to 4 (*very often*), "Please indicate how frequently you believe the following treatment activities should be used with DID or DDNOS patients at each stage of treatment." The survey took approximately 15 minutes to complete and was approved by the institutional review board of Towson University.

The interventions listed in the TADD were divided into rationally derived topic areas (see Table 3). TADD interventions denoted as "potentially risky interventions" were not recommended by the Guidelines; rather, they were devised as a means of determining if therapists were overengaging in techniques that can be detrimental to patients, particularly if used frequently. The intervention "stabilizing from intrusions from alleged perpetrators" was included because of DD patients' distress and destabilization after contact with people who are, or were, abusive (ISSD, 2006; ISSTD, 2011). In line with the ISSD/ISSTD Guidelines and the clinical literature (ISSD, 2006; ISSTD, 2011; Chu, 1998, 2011; Courtois, 1997; Courtois & Ford, 2009; Kluft, 1999), the TADD presents the treatment of DD as occurring in phases. We asked therapists to describe the interventions they recommend using to treat patients with DID or DDNOS at five stages of treatment. The description accompanying Stages 1, 3, and 5 were labeled, respectively, "stabilization and establishing safety," "processing memories of trauma with full emotion (i.e., prolonged exposure, abreactions) and grieving related losses," and "integration and reconnection within self and with others." Stages 2 and 4 did not have descriptive anchors.

Results

We were unable to conduct statistical analyses because of the small sample. Thus, we used qualitative descriptions to convey our findings.

Interventions by Stage

Stages 1 and 2. Early in treatment, clinicians recommended using most of the interventions frequently (see Table 3). In Stage 1, the vast majority of clinicians "very often" used assessment and safety strategies, daily functioning skills, and psychoeducation, as well as cognitive–behavioral therapy (CBT) focused on changing distorted cognitions. One of the most agreed-on interventions in the study was a very high level of the relationally focused intervention of working to establish and repair the therapeutic alliance in Stage 1. The experts agreed that they did not frequently discuss

Table 2
Participant Experience in the Field of Dissociative Disorders

Variable	*N*	Mean (*SD*)	Mode	Range
Number of years treating DD patients	36	22.53 (8.39)	20 ($n = 4$)	9–40
Number of years treating traumatized patients	36	24.94 (7.98)	30 ($n = 7$)	11–41
Number of trauma publications	27[a]	31.04 (50.69)	30 ($n = 3$)	0–225
Number of DID patients treated for more than one year	36	42.69 (70.55)	25 ($n = 3$) 40 ($n = 3$)	3–400
Number of DDNOS patients treated for more than one year	36	29.31 (41.56)	20 ($n = 8$)	1–200
Number of patients currently being treated for DID	36	8.75 (10.12)	3 ($n = 7$)	0–40
Number of patients currently being treated for DDNOS	35[b]	5.57 (5.90)	2 ($n = 8$)	0–15
Number of patients currently being treated for dissociative amnesia	28[b]	1.14 (2.77)	0 ($n = 18$)	0–13
Number of patients currently being treated for dissociative fugue	25[b]	0.13 (0.61)	0 ($n = 23$)	0–3
Number of patients currently being treated for depersonalization disorder	29[b]	0.86 (1.01)	0 ($n = 14$)	0–3
Number of DID patients treated from diagnosis to unification	36[c]	7.76 (7.41)	5 ($n = 7$)	1–30

[a] Not all participants reported trauma publications; therefore, these data reflect the results for those who have published in the field of trauma and dissociation. [b] Not all participants reported that they had worked with individuals with DDNOS, dissociative amnesia, dissociative fugue, and depersonalization. These sample sizes represent those who endorsed currently treating patients with these disorders. [c] Two respondents indicated they had integrated over 185 patients. Due to being outliers, their data were not included in this row.

the therapeutic relationship as a way of helping the client understand past and current relationships until Stages 2 and 3. Clinicians' recommended use of emotion regulation was similar across Stages 1 and 2. No clinicians endorsed frequent trauma focused work early in treatment, although the majority of clinicians supported sometimes using exposure or abreaction techniques and processing delayed recall of trauma.

Stage 3. In the middle stage of treatment of patients with DD, clinicians continued to recommend "very often" using assessment and safety, daily functioning, psychoeducation, relationally focused, emotion regulation, and addressing dissociation interventions. In contrast to Stages 1 and 2, therapists emphasized trauma-focused work, with almost half of clinicians endorsing the use of exposure or abreaction and processing delayed recall of trauma "very often." In addition to the use of trauma-focused interventions, it was during this stage that therapists most highly endorsed the use of CBT techniques, perhaps as distorted, trauma-related cognitions were challenged and reconsidered.

Stages 4 and 5. As opposed to the earlier stages of treatment, there was less uniformity among therapists during the final two stages of treatment; thus, the modes of each intervention ranged from 1 (*rarely*) to 4 (*very often*). Increasing daily functioning skills remained an activity recommended for use "very often," as did relationally focused work and emotion regulation. The relationally focused interventions were recommended at the highest frequency. Support for the use of psychoeducation remained high. Percentages of clinicians recommending activities aimed at addressing dissociation became less frequent, and the emphasis on trauma-focused work decreased.

While many interventions varied in the frequency of recommended use across treatment stages, stabilizing the patient after intrusions from reported perpetrators was consistently recommended across the stages of DD treatment. There was a slight decrease over time, but stabilizing from current-day stressors and crises also appeared to occur fairly consistently across treatment stages. Potentially risky interventions including playing with child self states and using touch were not frequently endorsed by any clinicians in any stage of treatment.

Interventions According to Therapist Experience

Differences in intervention according to years of experience. There were relatively few differences between clinicians who had less experience treating DID ("fewer years" range = 9–20 years, $n = 18$) versus those who had more experience ("more years" range = 21–40 years, $n = 18$). Participants were divided into these two experience categories using a median split. See Table 4 for a listing of the interventions that were endorsed at different frequencies (i.e., differing by two points or more on the 5-point scale) depending on the therapists' years of experience. The group difference between the assessment of medications is unlikely to be due to differential training in psychiatry, because the number of psychiatrists in both the less experienced ($n = 6$) and more experienced ($n = 8$) groups were similar.

Differences in intervention according to number of unifications. The sample was divided using a median split to learn about the differences between those with many successful unifications of patients with DD (high unification group range = 6 to over 300, $n = 15$) versus those with fewer unifications (low unification group range = 0–5, $n = 21$). See Table 5 for a listing of interventions that differed by one or more points on the frequency scale. None of the differences, according to number of unifications, were two or more points, in contrast to the larger differences in interventions found when the therapists were split into low and high number of years of experience.

Discussion

Therapists' Current Practices and Training

Participants in this study were seasoned DD practitioners and included some of the pioneers in the field. Thirty percent of the participants had received training in DD as a student, intern, postdoctoral fellow, or resident. Because therapists were required to have at least nine years of experience treating patients with DD, this finding indicates that, for at least a decade, systematic training has been available to those seeking it. Research is beginning to

Table 3
The Use of Interventions Across Stages of Treatment

Intervention	Stage 1		Stage 2		Stage 3		Stage 4		Stage 5	
	% Endorsing very often	Mode	% Endorsing very often	Mode	% Endorsing very often	Mode	% Endorsing very often	Mode[a]	% Endorsing very often	Mode[a]
Assessment & Safety										
Diagnosing psychiatric illnesses	88.89	4 ($n = 32$)	36.11	4 ($n = 13$)	33.33	4 ($n = 12$)	16.67	2 ($n = 9$)	30.56	4 ($n = 11$)
Assess response to medications	66.67	4 ($n = 24$)	38.89	4 ($n = 14$)	44.44	4 ($n = 16$)	27.78	4 ($n = 10$)	33.33	4 ($n = 12$)
Acceptance of DD diagnosis	75.00	4 ($n = 27$)	47.22	4 ($n = 17$)	52.78	4 ($n = 19$)	30.56	4 ($n = 11$)	30.56	4 ($n = 11$)
Establishing safety	97.22	4 ($n = 35$)	75.00	4 ($n = 27$)	69.44	4 ($n = 25$)	22.22	3 ($n = 13$)	25.00	1 ($n = 10$)
Daily Functioning Skills										
Stabilizing following intrusions from alleged perpetrators	58.33	4 ($n = 21$)	38.89	4 ($n = 14$)	38.89	4 ($n = 14$)	33.33	4 ($n = 12$)	38.89	4 ($n = 14$)
Stabilizing from current day stressors/crises	80.56	4 ($n = 29$)	61.11	4 ($n = 22$)	55.56	4 ($n = 20$)	50.00	4 ($n = 18$)	47.22	4 ($n = 17$)
Psychoeducation										
Teaching/practicing self-care	86.11	4 ($n = 31$)	66.67	4 ($n = 24$)	50.00	4 ($n = 18$)	44.44	4 ($n = 16$)	44.44	4 ($n = 16$)
Educate about disorders and treatment options	91.67	4 ($n = 33$)	63.89	4 ($n = 23$)	55.56	4 ($n = 20$)	30.56	3 ($n = 14$)	36.11	4 ($n = 13$)
CBT focused on cognitions	63.89	4 ($n = 23$)	50.00	4 ($n = 18$)	72.22	4 ($n = 26$)	33.33	4 ($n = 12$)	25.00	2 ($n = 15$)
Relationally Focused Work										
Establish/repair alliance	97.22	4 ($n = 35$)	72.22	4 ($n = 26$)	75.00	4 ($n = 27$)	44.44	4 ($n = 16$)	44.44	4 ($n = 16$)
Processing patient's reactions to therapy	58.33	4 ($n = 21$)	50.00	4 ($n = 18$)	52.78	4 ($n = 19$)	41.67	4 ($n = 15$)	41.67	4 ($n = 15$)
Discussing therapeutic relationship	41.67	4 ($n = 15$)	55.56	4 ($n = 20$)	52.78	4 ($n = 19$)	47.22	4 ($n = 17$)	44.44	4 ($n = 16$)
Teaching/discussing attachment	50.00	4 ($n = 18$)	47.22	4 ($n = 17$)	50.00	4 ($n = 18$)	30.56	2, 4 ($n = 11$)	27.78	3, 4 ($n = 10$)
Developing healthy relationships	83.33	4 ($n = 30$)	75.00	4 ($n = 27$)	55.56	4 ($n = 20$)	47.22	4 ($n = 17$)	55.56	4 ($n = 20$)
Emotion Regulation										
Teaching/practicing containment	80.56	4 ($n = 29$)	66.67	4 ($n = 24$)	75.00	4 ($n = 27$)	11.11	3 ($n = 16$)	11.11	1, 2 ($n = 16$)
Teaching/practicing grounding	94.44	4 ($n = 34$)	61.11	4 ($n = 22$)	63.89	4 ($n = 23$)	30.56	4 ($n = 11$)	19.44	3, 4 ($n = 7$)
Ego strengthening activities	77.78	4 ($n = 28$)	58.33	4 ($n = 21$)	50.00	4 ($n = 18$)	38.89	4 ($n = 14$)	41.67	4 ($n = 15$)
Awareness of emotion	58.33	4 ($n = 21$)	52.78	4 ($n = 19$)	50.00	4 ($n = 18$)	36.11	4 ($n = 13$)	47.22	4 ($n = 17$)
Awareness of body sensation	33.33	3 ($n = 16$)	33.33	3 ($n = 14$)	61.11	4 ($n = 22$)	41.67	4 ($n = 15$)	41.67	4 ($n = 15$)
Affect tolerance and impulse control	81.82	4 ($n = 27$)	72.73	4 ($n = 24$)	69.70	4 ($n = 23$)	45.45	4 ($n = 15$)	36.36	4 ($n = 12$)
Addressing Dissociation										
Processing when and why dissociation occurs	66.67	4 ($n = 24$)	58.33	4 ($n = 21$)	55.56	4 ($n = 20$)	36.11	4 ($n = 13$)	36.11	4 ($n = 13$)
Cooperation with parts	52.78	4 ($n = 19$)	72.22	4 ($n = 26$)	83.33	4 ($n = 30$)	50.00	4 ($n = 18$)	36.11	4 ($n = 13$)
Identify/work with parts	47.22	4 ($n = 17$)	58.33	4 ($n = 21$)	69.44	4 ($n = 25$)	36.11	4 ($n = 13$)	22.22	2 ($n = 10$)
Trauma Focused Work										
Exposure/abreaction to traumatic memories	0.00	0 ($n = 15$)	0.00	2 ($n = 14$)	47.22	4 ($n = 17$)	25.00	3 ($n = 12$)	11.11	2 ($n = 15$)
Processing delayed recall of trauma	0.00	1 ($n = 14$)	0.00	2 ($n = 18$)	44.44	4 ($n = 16$)	19.44	2 ($n = 12$)	11.11	1 ($n = 13$)
Processing trauma with EMDR	0.00	0 ($n = 16$)	0.00	0 ($n = 11$)	16.67	2 ($n = 10$)	13.89	2 ($n = 9$)	2.78	1 ($n = 13$)
Potentially Risky Interventions										
Playing with child personalities	0.00	0 ($n = 29$)	0.00	0 ($n = 26$)	0.00	0 ($n = 28$)	0.00	0 ($n = 28$)	0.00	0 ($n = 31$)
Using physical contact	0.00	0 ($n = 23$)	0.00	0 ($n = 19$)	0.00	0 ($n = 18$)	0.00	0 ($n = 16$)	0.00	0 ($n = 23$)

Note. EMDR = eye movement desensitization and reprocessing.
[a] In cells with two modes, both are listed.

Table 4
Interventions That Differed by Modal Frequency According to Therapists' Years of Treating DD

Intervention	Therapists with 9–20 years of experience (n = 18)[a]					Therapists with 21+ years of experience (n = 18)[a]				
	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5
Assessment & Safety										
Diagnosis	4	4	**2, 4**	2	**1, 4**	4	3, 4	**4**	1, 2	**4**
Assessing medication response	4	3	4	**2**	**1**	4	4	4	**4**	**4**
Establishing safety	4	4	4	2, 3	**1**	4	4	4	3	**4**
Daily Functioning Skills										
Stabilizing after intrusions from alleged perpetrators	4	3	**2**	**2, 4**	4	4	4	**4**	**4**	4
Trauma-Focused Work										
Processing trauma (e.g., exposures or abreactions to traumatic memories	0	**0, 2**	4	2, 3	2	1	**2**	4	3	1
Eye movement desensitization and reprocessing	0	**0**	2	**2**	2	0	**1, 2**	3	**3, 4**	1

[a] The numbers listed are the most commonly recommended frequency for a given intervention (i.e., the modal frequency for the intervention) for that stage. In cells with two modes, both are listed. Modes that differed between groups of therapists by two or more points are in boldface.

emerge from Asia and other non-Western countries about the prevalence and existence of DD (Gingrich, 2009; Van Duijl, Cardeña, & De Jong, 2005; Xiao et al., 2006); however, no experts were found in Asia, South America, or Africa.

While considerable numbers of patients with DID and DDNOS were being treated by study participants, only one therapist reported treating dissociative fugue outside of its occurrence in DID, and few cases of depersonalization disorder were being treated by these highly experienced therapists. The lack of fugue cases supports the planned elimination of dissociative fugue as a free-standing DD from the forthcoming *Diagnostic and Statistical Manual of Mental Disorders–5* (American Psychiatric Association).

Interventions by Stage

In general, these recommendations from DD clinicians are consistent with staged treatment advised by treatment guidelines and expert clinicians (ISSD, 2006; ISSTD, 2011; Courtois, 1997; Courtois & Ford, 2009; Kluft, 1993a; Herman, 1992). Across all stages of treatment, the following interventions were frequently used: diagnosis of psychiatric disorders; psychoeducation; alliance building and repair; processing reactions to therapy; assessing the adequacy of medication; increasing awareness of emotion; developing affect tolerance and impulse control; managing daily functioning and current relationships; and stabilizing patients following stressful life situations and intrusions from reported perpetrators. Given the consistency across therapists and the high frequency of use of these interventions over time and across cultures, we conclude that these interventions make up the core treatment processes and structure used in treating severely dissociative patients. That these core interventions target modulation of affect and impulse control, stabilization from crises, and improving interpersonal skills is consistent with viewing DD viewed as complex trauma-based disorders(ISSTD, 2011; Courtois & Ford, 2009; Herman, 1992; Putnam, 1998). Research indicates that staged treatment addressing these deficits results in better treatment outcome and lower rates of dropout than standard exposure treatment for chronic PTSD patients with histories of childhood trauma (Cloitre et al., 2002, 2010).

Beyond the core interventions, the experts recommended the following interventions early in treatment: grounding (i.e., techniques such as movement or touching an object to control "trancing" or dissociating, passive influence, and switching); contain-

Table 5
Interventions That Differed by One or More Modal Points According to Number of Completed Unifications

Intervention	Therapists with 5 or fewer unifications (n = 21)[a]					Therapists with more than 5 unifications (n = 15)[a]				
	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5
Relationally Focused Work										
Teaching/ discussing attachment	4	4	4	**3**	**2**	4	4	4	**4**	**3**
Addressing Dissociation										
Cooperation with self states	**3**	4	4	4	4	**4**	4	4	4	4
Identify/work with self states	**3**	4	4	4	**3**	**4**	4	4	4	**2**
Trauma-Focused Work										
Processing Trauma (e.g., exposure or abreaction to traumatic memories)	0	2	**4**	**3**	**2**	0	2	**3**	**4**	**1**
Processing delayed recall of trauma	**0**	2	**4**	**3**	**3**	**1**	2	**3**	**2**	**2**

[a] The numbers listed are the most commonly recommended frequency for a given intervention (i.e., the modal frequency for the intervention) for that stage. In cells with two modes, both are listed. Modes that differed between groups of therapists by one or more points are in boldface.

ment (i.e., techniques including self-hypnosis and imagery to specifically control the intrusiveness of traumatic material); ego strengthening (i.e., interventions to promote better overall functioning including self-hypnosis, reaffirming statements, relaxation training); cognitive–behavioral work to change trauma-based cognitions (e.g., techniques to resolve confusing past and present, self-blame for abuse, and delusions of separateness among dissociated self states); and focusing on safety issues (i.e., discussing the antecedents to, and functions of, self-destructive, suicidal, and aggressive behavior toward others, as well as developing safety agreements and crisis management plans).

Like controlled treatment studies of chronic or complex PTSD associated with childhood trauma (Cloitre et al., 2002; 2010), the current data show that DD experts recommend skill-building in the early stages of treatment. Experts in the current study suggest that the skills be expanded for patients with DD to include controlling dissociative and PTSD symptoms, maintaining safety, and replacing trauma-based cognitive distortions. The importance of skill-building in this first stage of treatment likely contributes to the length of treatment for successful resolution of DID. There were four interventions that therapists recommended using with increasing frequency in the middle stages of treatment; three of these treatments are directly related to traumatic material: processing delayed recall of traumatic memories, using exposure or abreaction, and employing eye movement desensitization and reprocessing to process traumatic memories. It is important to recognize that therapists did not recommend frequent use of memory processing interventions in most Stage 3 sessions. Thus, even in the stage characterized by processing trauma, highly experienced DD therapists recommend the continued use of interventions aimed at core, foundational DD work to enable patients to tolerate the challenging trauma-focused work. In general, the clinical literature supports the use of *modified* exposure techniques in these patients, careful titration of affect levels, and taking many sessions to fully process specific memory material so not to overwhelm or flood these polytraumatized patients. Without titration, the patient can be "retraumatized," and may have significant problems with maintenance of safety and stability (Kluft, 1989b; Kluft & Loewenstein, 2007). These data suggest that treatment should not become solely focused on traumatic material, even in the middle "trauma processing" stage of treatment. The fourth intervention recommended for the middle stage of treatment—enhancing awareness of body sensations—may relate to processing traumatic memories. Frequently, dissociated traumatic memories present as inchoate body sensations known as somatoform flashbacks or, colloquially as "body memories" (Rothschild, 2000; van der Kolk, 1994). The increased focus on the patient's bodily sensations during the middle stages of treatment is likely related to patients needing to make sense of physical sensations that are emerging as dissociated traumatic material as well as using "grounding" techniques to decrease dissociation.

Patterns Related to Therapist Experience and Unifications

When looking at treatment interventions across stages of treatment, it appears that there was consistency in the interventions used in Stages 1, 2, and 3 regardless of therapists' experience. There was less consistency in Stages 4 and 5. The consistency of recommendations in the first three stages is likely related to the clear, well-delineated descriptions of these stages in available guidelines (ISSD, 2006; ISSTD, 2011). The guidelines are somewhat less specific about the tasks for the final stages of treatment, during which treatment seems to become more individualized. For example, while every patient with DD needs to learn how to recognize and regulate emotion in order to gradually relinquish avoidance of emotion through dissociation, not every patient needs to address career, existential, or spiritual dilemmas to the same extent. Many of the earlier tasks are likely to continue in the last stages but with a different focus. For example, psychoeducation continues in late-stage treatment but focuses on living as a non-dissociative, unified individual, in contrast to the early treatment psychoeducation about symptoms and their management.

There was also a substantial degree of consistency about psychoeducation and emotion regulation interventions, regardless of the number of years of experience or unifications therapists had helped patients complete. Participants in this study recommend "very often" teaching and using containment, grounding, ego strengthening, awareness of emotion and body sensations, and affect tolerance and impulse control across the five stages of treatment. Furthermore, they consistently recommended a decrease in the frequency of using containment and grounding as treatment progresses, suggesting that patients in the later stages of treatment are less frequently overwhelmed by unintegrated traumatic material and dysregulated dissociative symptoms. The uniformity of recommendations indicates that these core interventions have been found by experts around the world to be clinically useful with a wide variety of patients with DD. These findings could be seen as the beginning of developing best practices for treating severe DD. An important next step would be for researchers to develop manualized treatments that emphasize these psychoeducation and emotion regulation interventions for patients in the early stages of treatment in order to empirically test their effectiveness.

Do the differences in intervention lead to greater numbers of patients unifying? Unfortunately, causal attributions cannot be made with these data. It is possible that the most highly experienced therapists have better outcomes. However, differences in rates of unification as well as in recommended treatment interventions may be related to nonrandom patient characteristics in the therapists' practices. Most of the therapists in the low unification group had fewer years of experience ($M = 18.9$ years). Thus, the findings may be a function of time, with more experienced therapists having had more time to treat patients with DD and, therefore, more opportunities for unification.

The clinical literature describes three groups of patients with DID according to their degree of complexity and treatment responsiveness; they are referred to as high, medium, and low trajectory patients (Kluft, 1994a, 1994b; Loewenstein, 1994). It is likely that differences in the types of patients seen by the experts strongly influence the number of unifications they have helped patients attain. For instance, many of the expert therapists practice in specialized inpatient treatment programs or other settings to which patients are referred because they have repeatedly failed to respond to prior treatments, and/or because the patients may be demoralized, disabled, highly self-destructive, and may have many serious medical comorbidities. Some of these patients may be invested in their dissociative world, have self states with limited willingness to work toward awareness (Kluft, 1994a), or may strongly identify

with their existence as a disabled trauma survivor. Others may have limited social supports or resources for an intensive treatment that could result in fusion or integration. Finally, the failure of most mental health training programs and many countries to provide systematic education about and support for treatment of patients with complex trauma or DD results in many potentially treatable patients spending years of clinical time misdiagnosed with other disorders and being treated with relatively limited response. Even if correctly diagnosed, many patients are unable to find reasonable clinical care and/or do not have the financial resources to fund reasonable clinical care. This results in many patients developing a syndrome of chronic demoralization and "chronicity" that depletes the psychosocial resources necessary for a treatment that could result in unification.

One unexpected finding is the relatively low number of patients with DID treated through unification by this group of expert therapists. While the low trajectory patients, estimated to be one third of patients with DID, have been previously described as too impaired to achieve unification, the high and middle trajectory patients were thought to be capable of responding to long-term, specialized treatment with gradually improving functioning and less internal dividedness, eventually resulting in unification of dissociated self states (Kluft, 1994a; Loewenstein, 1994). The current study suggests a very different picture; that is, that unification as a result of skilled treatment will be less common than expected, even among highly experienced clinicians. Some of the experts who participated in our study worked in settings—such as inpatient acute hospital units and forensic clinics—that limited the extent to which they could work long term with patients. Many of these therapists were likely referred the most treatment-resistant, low trajectory patients; but even still, fewer patients with DID than previously thought were able to, or chose to, achieve unification. Despite the fact that one might expect these experts to have more success helping patients with DID achieve integration than other, less experienced therapists, the data suggest that fewer patients with DID than previously thought were able to, or chose to, achieve unification.

The findings about unification need to be interpreted in light of two methodological issues. First, we did not ask therapists the criteria by which they determined unification. Second, it is common for patients who have achieved unification to later reveal additional hidden dissociated self states or to have self states become dissociated despite having initially been fully unified (e.g., Kluft, 1984). Determining unification is a difficult process, dependent on the patient's honest responses to questions about dissociation and self states, the patient's ability to know what may still be dissociated, and the therapist's ability to detect subtle dissociation.

Whether or not unification takes place or the extent to which it endures, most severely dissociative patients, even those in the lowest functioning group, can improve during specialized therapy that focuses on dissociation (e.g., Brand et al., 2009c; Coons, 1986; Ellason & Ross, 1997; Kluft, 1984; Ross & Dua, 1993). Throughout treatment, most patients become more aware of self states and better able to negotiate compromises regarding internal conflicts, resulting in improved adaptive functioning. Thus, this may be the most realistic goal for the majority of patients with severe dissociation. Future research needs to systematically follow patients with DD over the course of treatment to determine more clearly what percentage achieve unification versus partial unification and what therapist and patient factors contribute to successful unification.

Areas of Debate

When examining the extent to which controversial treatment interventions are utilized in patients with DD, the data are consistent on the importance of talking directly about and with dissociated self states in order to facilitate patients' understanding of and willingness to work collaboratively with their self states. All of the therapists recommended this intervention, and the most experienced ones recommended it from the beginning of treatment at a frequent level.

The experts were also in agreement that providing comfort, such as hand holding, should be avoided in almost all situations involving patients with DD. Touch is likely to have so many negative associations for patients with DD that it can be easily misunderstood and lead to boundary problems and reenactments that undermine therapeutic progress (e.g., ISSTD, 2011). A therapist working with a patient with DD should carefully consider the accuracy of the patient's reality testing and the quality of the therapeutic alliance, as well as discuss the potential meanings of touch, prior to touching the patient.

The data are also consistent on exposure or abreaction. None of the therapists recommended exposure or abreaction in Stage 1; however, almost all recommended it at least at a level of "often" in the middle stage of treatment. While almost all of the clinical literature suggests exposures or abreactions are a necessary part of DID treatment (Kluft, 1993; Putnam, 1989), a single case from Turkey (Şar & Tutkun, 1997) as well as two from the United States (Gold et al., 2001) have reported on patients who attained unification without using exposure or abreaction. Other clinicians, including coauthor Richard Loewenstein, have reported unifications without full abreactions among occasional, rare patients who seem to have developed self states primarily due to attachment disruptions that interfered with the patient receiving comfort and protection from circumscribed early childhood abuse (Kluft, 1984). Typically, these rare patients have substantial ego strength and do not report the severe, sadistic abuse reported by other patients with DD. There also may be cultural factors that influence the clinical features and course of patients with DD. Future research needs to compare treatments that use exposure or abreaction techniques to those that do not to determine the relative effectiveness of each approach across cultural groups.

Training, Treatment, and Research Implications

While a minority of the participating experts were able to find specialized training in DD as part of systematic education in internships, residencies, and postdoctoral fellowships, this kind of training is not widely available. Given the prevalence of complex trauma and related psychological disorders, much more training in conducting carefully paced, staged treatment needs to be made available to mental health professionals.

The current study provides several categories of useful treatment interventions that can provide the basis for a manualized treatment for early stage patients with DD. The field urgently needs randomized controlled studies that use manualized treatment to determine definitively whether treatment is responsible for the

decreased symptoms that have been documented in the currently available yet uncontrolled treatment outcome studies.

Conclusion

Study Limitations

The treatment implications based on this sample of highly experienced DD therapists may not reflect the recommendations all experts would make. Their recommendations may be biased by the clinicians' theoretical backgrounds, the types of patients referred to them, or other influences. Because of the small sample base, we were unable to determine whether the differences in interventions according to the therapists' experience or number of unifications were statistically significant or to explore cross-cultural differences. We were unable to recruit experts from Asia, South America, or Africa. The patterns observed in the data may be influenced by referral patterns and nonrandom patient characteristics, so the extent to which they generalize to other patients and DD experts is unknown. Therapists may have been subject to social desirability in their responses, particularly about the number of patients they have helped achieve unification. These DD experts generally recommended a structured, stage-oriented treatment for patients with DD consisting of three basic phases. In the initial phase, they advocated for emphasizing skill-building in the areas of emotion regulation, impulse control, interpersonal effectiveness, grounding, containment, challenging trauma-based cognitive distortions, and maintaining safety. Additionally they suggested that clinicians identify and work with dissociated self states beginning early in treatment so to foster internal communication and cooperation among disavowed parts of self. In the middle stage, the experts advised the use of occasional modified exposure or abreaction techniques balanced with core, foundational interventions. The last stage of treatment was less clearly delineated and more individualized, although this may be an artifact of limited data about the later stages. The data suggest that unification of self states occurs in only a minority of patients with DID, at least among this sample of clinicians, although this may be related to the types of patients referred to these experts. More DD training for therapists and treatment outcome research is needed; this study provides directions that can be pursued in both areas.

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