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## Guidelines for Treating Dissociative Identity Disorder in Adults (2005)– International Society for Study of Dissociation

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At its meeting in Vancouver, BC, Canada, in May 1994, the Executive Council of International Society for the Study of Dissociation (ISSD) adopted the *Guidelines for Treating Dissociative Identity Disorder (Multiple Personality Disorder) in Adults (1994)*. The *Guidelines* presented a broad outline of what to date was considered to be effective treatment for Dissociative Identity Disorder (DID). However, *Guidelines* like these are never finished and require ongoing revisions. A first revision of the *Guidelines* was proposed by the ISSD's Standards of Practice Committee<sup>1</sup> and was adopted by the ISSD Executive Council in 1997 after substantial comment from the ISSD membership and sev-

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Additional copies of the guidelines (US \$5 for members, \$10 for nonmembers) can be obtained by writing to the ISSD at 60 Revere Dr., Suite 500, Northbrook, IL 60062 USA.

The correct citation for this revision of the *Guidelines* is: International Society for the Study of Dissociation. (2005). [Chu, J.A., Loewenstein, R., Dell, P.F., Barach, P.M., Somer, E., Kluft, R.P., Gelinas, D.J., Van der Hart, O., Dalenberg, C.J., Nijenhuis, E.R.S., Bowman, E.S., Boon, S., Goodwin, J., Jacobson, M., Ross, C.A., Sar, V, Fine, C.G., Frankel, A.S., Coons, P.M., Courtois, C.A., Gold, S.N., & Howell, E.J. Guidelines for treating Dissociative Identity Disorder in adults. *Journal of Trauma & Dissociation*, 6(4), Haworth copy editor, please supply page numbers.

Journal of Trauma & Dissociation, Vol. 6(4) 2005  
Available online at <http://www.haworthpress.com/web/JTD>  
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doi:10.1300/J229v06n04\_05

eral revisions. This current revision was requested and approved by the ISSD Executive Council, and utilized the expertise of a Task Force of expert clinicians and researchers.<sup>2</sup>

These *Guidelines* are not intended to replace clinical judgment. However, they summarize expert consensus concerning safe and effective treatment for DID patients. Where a clear divergence of opinion exists in the field, the *Guidelines* attempt to present the different points of view about the issue. The *Guidelines* strive to be as free as possible of bias toward any theoretical approach to treatment.

These *Guidelines* focus specifically on the treatment of DID. They are a practical guide to the management of patients—primarily adults over the age of 18—and represent a synthesis of current scientific knowledge and rational clinical practice. However, DID is only one of the dissociative disorders. There continues to be a need to explore the phenomenology and treatment of other forms of pathological dissociation (e.g., Depersonalization Disorder, Dissociative Amnesia, etc.) as well as non-pathological forms of dissociation (e.g., the relation of trance states to dissociation). However, principles of treatment of DID may also be applicable to some extent in the treatment of other dissociative disorders.

There are now separate *Guidelines for the Evaluation and Treatment of Dissociative Symptoms in Children and Adolescents* (International Society for the Study of Dissociation [ISSD], 2004), available through the ISSD and published in the *Journal of Trauma & Dissociation*, 5(3), 119-150. The American Psychiatric Association has published *Practice Guidelines for the Treatment of Patients with Acute Stress Disorder (ASD) and Posttraumatic Stress Disorder (PTSD)* (American Psychiatric Association, 2004). Since DID patients almost universally suffer from co-morbid PTSD, the reader may wish to consult those documents in addition to these *Guidelines* in developing treatment plans for dissociative disorder patients.

## INTRODUCTION

Considerable progress has been made in the diagnosis, assessment, and treatment of dissociative disorders during the past decades, as reflected by increased clinical recognition of dissociative conditions, the publication of numerous research and scholarly works on the subject, and the development of specialized diagnostic instruments. Peer re-

viewed publications have appeared in the international literature from clinicians and investigators in the United States, Canada, Puerto Rico, the Netherlands, Norway, Switzerland, Great Britain, Germany, Italy, France, Sweden, Spain, Turkey, Israel, Australia, New Zealand, Japan and other countries. These have included case reports, clinical case series, investigations using standardized diagnostic instruments, open clinical trials, treatment outcome studies, studies of psychophysiology and neurobiology, neuroimaging, and studies of cognition, among others. The *Guidelines* present key findings and generally accepted principles that reflect current scientific knowledge and clinical experience specific to the diagnosis and treatment of Dissociative Identity Disorder (DID; American Psychiatric Association, 2000a). It should be understood that these *Guidelines* supplement, but do not replace generally accepted principles of psychotherapy and psychopharmacology. Undoubtedly, future research will add to our present understanding of treatment of DID and other dissociative disorders.

The *Guidelines* are not intended to dictate the treatment for a specific patient. Treatment should always be individualized. Therapists should always conform to the prevailing standards of care, mental health codes and related local laws, as well as to ethical principles of their professional disciplines. There is a consensus in the dissociative disorders field that treatment for DID is most effective when it adheres to the basic principles of psychotherapy and psychiatric medical management, utilizing specialized techniques as needed.

By themselves, the *Guidelines* are not intended to be construed or to serve as a standard of clinical care. These parameters of practice reflect the state of the art in this field at the present time. They are not designed to include all proper methods of care or to exclude other acceptable treatment interventions. Moreover, adhering to the *Guidelines* will not necessarily result in a successful treatment outcome in every case. Clinicians must use their judgment concerning the appropriateness for a particular patient of a specific method of care in light of the clinical data presented by the patient and options available at the time of treatment.

The *Guidelines* were developed by psychiatrists, psychologists, and other mental health practitioners in active clinical practice, research or other academic endeavors. The *Guidelines* were extensively reviewed by members of ISSD. Contributors and reviewers were asked to base their recommendations on an objective evaluation of available evidence.

### ***EPIDEMIOLOGY, CLINICAL DIAGNOSIS, AND DIAGNOSTIC PROCEDURES***

DID and dissociative disorders are not rare conditions. In studies of the general population, a prevalence rate of DID of one to three percent of the population has been described (Murphy, 1994; Ross, 1991; Waller & Ross, 1997), although some researchers have criticized the methodology of these studies, and have suggested a somewhat lower prevalence. Clinical studies in North America, Europe, and Turkey have found that between one to 20 percent of patients on general inpatient psychiatric units, adolescent inpatient units, and in substance abuse, eating disorders, and obsessive compulsive disorder treatment may meet DSM-IV-TR (American Psychiatric Association, 2000a) diagnostic criteria for DID, particularly when evaluated with structured diagnostic instruments. Many of these patients had not been clinically diagnosed previously with a dissociative disorder (Bliss & Jeppsen, 1985; Goff, Olin, Jenike, Baer, & Buttolph, 1992; Latz, Kramer, & Highes, 1995; McCallum, Lock, Kulla, Rorty, & Wetzel, 1992; Ross, Anderson, Fleisher, & Norton, 1991; Modestin, Ebner, Junghan, & Erni, 1995; Ross et al., 1992; Saxe et al., 1993; Tutkun et al., 1998).

Accurate clinical diagnosis affords early and appropriate treatment for the dissociative disorders. Seven studies of 719 DID patients have shown that they spent five to 11.9 years in the mental health system before they were diagnosed as having DID (Boon & Draijer, 1993a; Coons, Bowman, & Milstein, 1988; Martínez-Taboas, 1991; Middleton & Butler, 1998; Putnam, Guroff, Silberman, Barban, & Post, 1986; Rivera, 1991; Ross, Norton, & Wozney, 1989). While progress has been made in educating the professional community about the prevalence and clinical presentation of dissociative disorders, these seven studies suggest that many cases of DID and related disorders are still being missed, misdiagnosed, and inappropriately treated.

The primary difficulties in diagnosing DID result from lack of education among clinicians about dissociation, dissociative disorders, and the effects of psychological trauma. This leads to limited clinical suspicion about dissociative disorders and misconceptions about their clinical presentation. Most clinicians have been taught that DID is a rare disorder with a florid, dramatic presentation. In fact, DID is a relatively common disorder which presents with subtle symptoms in a patient who may minimize or conceal symptoms. DID patients commonly present in a polysymptomatic fashion with dissociative and PTSD symptoms embedded in a matrix of symptoms such as depression, panic, somatoform

symptoms, eating disorder symptoms, etc. that may lead only to diagnosis of these co-morbid conditions. This results in long and frequently unsuccessful treatment for these other conditions.

Further, almost all practitioners were taught standard diagnostic interviewing and mental status examinations that do not include questions about dissociation, PTSD symptoms, or a history of psychological trauma. Since DID patients rarely directly volunteer information about dissociative symptoms, absent questions about such symptoms, or recognition of them when they present, the clinician cannot diagnose DID. Accordingly, the *sine qua non* for the diagnosis of DID is the use of diagnostic interviews that inquire about dissociation, supplemented when necessary by screening instruments and structured interviews that assess the presence or absence of dissociative symptoms.

### ***Diagnostic Criteria for Dissociative Identity Disorder (DID)***

The *Diagnostic and Statistical Manual, 4th Edition, Text Revision* (DSM-IV-TR; American Psychiatric Association, 2000a) defines the following diagnostic criteria for Dissociative Identity Disorder (300.14):

- A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
- B. At least two of these identities or personality states recurrently take control of the person's behavior.
- C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
- D. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

In recent years, there has been debate about the diagnostic criteria for DID. Some have suggested that a set of polythetic criteria would more accurately portray the typical polysymptomatic presentations of DID patients (Dell, 2001). Others have argued that the current criteria are sufficient (Spiegel, 2001). Still others have suggested that dissociative disorders should be reconceptualized as among "Trauma Spectrum Disorders," emphasizing their intimate association with overwhelming and traumatic circumstances (Davidson & Foa, 1993).

### ***Terminology and Definitions***

Dissociation is defined as “A disruption in the usually integrated functions of consciousness, memory, identity, or perception” (American Psychiatric Association [APA], 2000a, p. 519). Dissociation is an ongoing process in which certain information (such as feelings, memories, and physical sensations) is kept apart from other information with which it would normally be logically associated. Dissociation can be a psychological defense mechanism that also has psychobiological components. Generally, it is thought to originate in “. . . a normal process that is initially used defensively by an individual to handle traumatic experiences [that] evolves over time into a maladaptive or pathological process . . .” (Putnam, 1989, p. 9).

DID patients have distinct identity or personality states, each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self (modified from DSM-IV-TR [APA, 2000a]). Alternate identities are dissociated parts of the mind that the patient experiences as separate from each other. Many terms have been developed to describe the DID patient’s subjective sense of self-states or identities. These include: personality, personality state, self-state, disaggregate self-state, alter, alter personality, alternate identity, part, part of the mind, part of the self, entity, among others. It should be noted that while many of these terms are useful and/or descriptive, some are associated with particular theoretical and conceptual points of view; all are somewhat metaphorical, and some are more useful in certain contexts than others. Some Task Force members advocated for the use of terms such as “dissociated parts of the personality” or “dissociative parts of the personality” to describe the degree of internal separateness and autonomy. The DSM-IV-TR (American Psychiatric Association, 2000a) uses the term “alternate identity” and the *Guidelines* use this term for consistency.

Clinicians should also attend to the unique, personal language with which DID patients characterize their subjective self-states or identities. Patients commonly refer to themselves as having, among others, “parts,” “parts inside,” “aspects,” “facets,” “ways of being,” “voices,” “multiples,” “selves,” “ages of me,” “people,” “persons,” “individuals,” “spirits,” “demons,” “lines,” and “others.” It can be helpful in working with DID patients to use their own unique descriptive terms for their alternate identities. However, some members of the Guidelines Task Force recommend that clinicians avoid using terms such as “people,” “persons” or other terms that might convey or reinforce a belief

that the alternate identities are truly separate individuals. Other Task Force members are of the opinion that judicious use of these latter terms, in and of themselves, would not contribute to reinforcing such beliefs.

### ***Alternate Identities: Definitions and Conceptual Issues***

Alternate identities have been defined in a number of ways. For example, Putnam (1989) describes them as “highly discrete states of consciousness organized around a prevailing affect, sense of self (including body image), with a limited repertoire of behaviors and a set of state dependent memories.” Kluft (1988) states that: “A disaggregate self state (i.e., personality) is the mental address of a relatively stable and enduring particular pattern of selective mobilization of mental contents and functions, which may be behaviorally enacted with noteworthy role-taking and role-playing dimensions and sensitive to intrapsychic, interpersonal, and environmental stimuli. It is organized in and associated with a relatively stable (but order effect dependent) pattern of neuro-psychophysiologic activation, and has crucial psychodynamic contents. It functions both as a recipient, processor, and storage center for perceptions, experiences, and the processing of such in connection with past events and thoughts, and/or present and anticipated ones as well. It has a sense of its own identity and ideation, and a capacity for initiating thought processes and action” (pp. 55).

In short, the alternate identities are intrapsychic entities that have a sense of self, have an emotional repertoire, and can process information. They have both the potential for “being-in-the world” behavioral enactments as well as subjective symbolic and metaphorical characteristics. They have aspects of both structure and process.

It is outside the scope of these *Guidelines* to provide a comprehensive discussion of current theories concerning the development of the alternate identities in DID (see Loewenstein & Putnam, 2004, and Putnam, 1997 for a more complete discussion). Briefly, however, many believe that alternate identities result from the inability of many traumatized children to develop a unified sense of self that is maintained across various behavioral states, particularly if the traumas occur before the age of five. DID develops during the course of childhood and rarely, if ever, derives from adult-onset trauma (unless it is superimposed on pre-existing childhood trauma). Traumatic experiences, particularly severe, repetitive trauma, produce extreme states of experiences in the child. Simultaneously, development of discrete, personified “behavioral states”

in the child are thought to encapsulate intolerable traumatic memories and affects to mitigate their effects on overall development. Also, disturbed caretaker-child attachments and parenting further disrupt the child's ability to integrate experiences that occur in different contexts (e.g., with family, in traumatic situations, with friends, in school). Dissociation of traumatic experiences in this way may preserve relationships with caretakers and allow more normal maturation in other developmental areas such as intellectual, interpersonal, and artistic endeavors. Secondary structuring of these discrete behavioral states occurs over time through a variety of developmental and symbolic mechanisms resulting in the characteristics of the specific alternate identities. Once this process begins, it may generalize to help the patient manage and cope with a variety of life events and experiences. Further, alternate identities may diverge considerably in number, complexity, and sense of separateness as the child proceeds through latency, adolescence, and adulthood (Kluft, 1984; Putnam, 1997).

Another etiological model posits four factors that are required for DID to develop: (1) the capacity for dissociation, (2) experiences that overwhelm the non-dissociative coping of the child, (3) secondary structuring of the DID alternate identities with individualized characteristics such as names, ages, genders, and (4) lack of soothing and restorative experiences that leave the child to find ways of comforting him/herself after overwhelming experiences (Kluft, 1984). In particular, factor 3 phenomena may be very diverse and may differ significantly from patient to patient. For example, parameters that may lead to very elaborated alternate identity systems include multiple traumas, high levels of creativity and intelligence, and extreme withdrawal from the world with intense involvement in fantasy experiences, among others. Accordingly, most experienced therapists pay relatively limited attention to the overt presentational characteristics of the different alternate identities. They focus instead on the cognitive, affective, and psychodynamic information embodied by the alternate identity as well as that of the alternate identities as a "system" of representation, symbolization, and meaning in the mind.

The theory of "Structural Dissociation," another etiological model, is based on the ideas of Janet and attempts to create a unified theory of dissociation that includes DID. This theory suggests that in dissociation there is a basic failure of integration of systems of ideas and functions of the personality. Following trauma, the personality divides into an "apparently normal part of the personality" (ANP) dedicated to daily functioning and an "emotional part of the personality" (EP) dedicated to

defense. Defense in this context is related to psychobiological functions related to survival in response to life threat such as fight/flight, not to the psychodynamic notion of defense. It is hypothesized that chronic trauma and/or neglect leads to additional secondary structural dissociation of EPs. In this model, DID is produced by a tertiary level of structural dissociation among both ANPs and EPs related to long-standing trauma, neglect, and attachment pathology during early development (Nijenhuis & Van der Hart, 1999; Van der Hart, Nijenhuis, Steele, & Brown, 2004).

In short, these developmental models posit that DID does not arise from a previously mature, unified mind or “core personality” that becomes “shattered” or fractured. Rather, DID results from a failure of normal developmental integration caused by overwhelming experiences and disturbed caretaker-child interactions during critical early developmental periods leading to the development and elaboration of discrete, personified behavioral states. This view may help clinicians understand how patients may vary considerably in the number, type, and characteristics of the alternate identities. Further, it helps explain how patients could experience themselves as having very numerous alternate identities and/or seemingly bizarre alternate identities such as animals, deities, or mythical beings.

### ***Diagnostic Interviewing***

A careful clinical interview and a thoughtful differential diagnosis can usually lead to the correct diagnosis in persons who have DID (Coons, 1984). The patient should be asked about episodes of amnesia, fugue, depersonalization, derealization, identity confusion, and identity alteration (Steinberg, 1995), age regressions, autohypnotic experiences, hearing voices (Putnam, 1991a), passive-influence symptoms such as “made” thoughts, emotions, or behaviors (Dell, 2001; Kluft, 1987a), and somatoform symptoms such as bodily sensations related to past trauma (Nijenhuis, 1999). Loewenstein (1991a) has described an office mental status examination that inquires about many of the symptoms of DID, including evidence of alternate identities, amnesia, autohypnotic phenomena, PTSD, somatoform symptoms, and affective symptoms.

Clinicians should keep in mind that some persons with DID do not realize (or do not acknowledge to themselves) that their internal experience is different from that of others. In keeping with the view that dissociation is a defense against uncomfortable realities, alternate identities

and other dissociative symptoms are commonly denied and disavowed by persons with DID.

The diagnosis of DID is nearly universally associated with an antecedent history of significant traumatization—most often first occurring in childhood (Putnam et al., 1986). Virtually every systematic study that has examined the trauma history of DID patients has found that DID patients have a higher rate of early childhood trauma than any other clinical group. Accordingly, the diagnostic process should include an effort to outline the patient's trauma history. Clinicians should use careful clinical judgment about how much detail of traumatic experiences to pursue during initial interviews, especially when those experiences seem to be poorly or incompletely remembered. A premature trauma anamnesis may evoke a florid decompensation (i.e., severe posttraumatic and dissociative symptoms). Due to their dissociative amnesia, DID patients often provide a fragmented history during initial treatment; a more complete personal history typically emerges over time. Because most DID patients also have Posttraumatic Stress Disorder (PTSD), the diagnostic process should assess whether symptoms of PTSD are present. Assessment for PTSD may provide another avenue into the patient's trauma history.

### ***Measures of Dissociation***

There are three classes of instruments that assess dissociation: clinician-administered structured interviews, clinician-administered measures, and self-report instruments.

#### *Clinician-Administered Structured Interviews*

There are two structured interviews for the dissociative disorders: the Structured Clinical Interview for DSM-IV Dissociative Disorders-Revised (Steinberg, 1994a, 1994b, 1995), and the Dissociative Disorder Interview Schedule (Ross, 1997; Ross, Heber, Norton, Anderson, & Barchet, 1989).

The *Structured Clinical Interview for DSM-IV Dissociative Disorders-Revised* (SCID-D-R) is a 277-item interview that assesses five symptoms of dissociation: amnesia, depersonalization, derealization, identity confusion, and identity alteration. Most items have follow-up questions that request a description of the experience, specific examples, and an estimate of the experience's frequency and impact on social functioning and work performance. The SCID-D-R diagnoses the five

DSM-IV dissociative disorders; it also yields a score for each of the five dissociative symptoms and a total score. These scores are based on frequency and intensity of symptoms. The SCID-D-R takes 45 to 180 minutes or more to administer if subjects endorse many positive responses to interview questions and are allowed to elaborate on their answers extensively. The interviewer, whether a clinician or a trained technician, must have considerable familiarity with dissociative symptoms. The SCID-D-R has good-to-excellent reliability and discriminant validity. Total SCID-D-R scores have been shown to have a correlation of .78 with the Dissociative Experiences Scale (Boon & Draijer, 1993b) and .78 to .93 with the MID (Dell, 2004; Gast et al., 2003; Somer & Dell, 2005).

The *Dissociative Disorder Interview Schedule* (DDIS) is a 132-item structured interview with a yes/no format that assesses the symptoms of the five DSM-IV dissociative disorders, somatization disorder, borderline personality disorder, and major depressive disorder. The DDIS also assesses substance abuse, Schneiderian first-rank symptoms, trance, childhood abuse, secondary features of Dissociative Identity Disorder, and supernatural/paranormal experiences. The instrument usually takes 30 to 60 minutes to administer. The DDIS makes categorical diagnoses and yields an index of the number of items that were endorsed in each section of the interview. The DDIS does not assess frequency or severity of symptoms. The DDIS had an overall interrater reliability of .68, an overall kappa of .96 for clinician-DDIS agreement on the diagnosis of DID, and a sensitivity of .95 for the diagnosis of DID (Ross, 1997). False-positive diagnoses of DID occurred in less than 1% of cases (Ross, 1997). The DDIS' secondary features of DID and Schneiderian first-rank symptoms correlated with the DES at .78 and .67, respectively (Ross, 1997). Effective use of the DDIS requires less training than does the SCID-D-R.

#### *Clinician Administered Measures*

There is one clinician-administered inventory that measures dissociative states, the Clinician Administered Dissociative States Scale (CADSS) (Bremner et al., 1998). It has 27 items with 19 subject-rated items and 8 observer-scored items, all rated on a 0-4 scale. It has three factors that assess symptoms of amnesia, depersonalization and derealization. The CADSS has an interrater reliability with an intraclass correlation coefficient of .99 for the subject-rated scale, .92 for the total score, but only .34 for the observer rated items. Cronbach's alpha was

.92 for the scale as a whole, but somewhat lower for the individual symptom subscales. Correlation was significant with the Dissociative Experiences Scale (DES;  $r = .48$ ,  $df = 49$ ,  $p < .001$ ), and with the SCID-D ( $r = .42$ ,  $df = 40$ ,  $p = .005$ ). The CADSS scores were significantly different in PTSD patients with high dissociation compared to PTSD patients with low dissociation, non-PTSD combat veterans, schizophrenics, patients with affective disorders, and healthy controls. CADSS scores increased significantly with exposure to traumatic memories in a subgroup of PTSD participants. The CADSS is viewed as a reliable and valid measure of present-state dissociative symptomatology and readily allows for repeated measures. It has been used primarily in research on psychophysiology and psychopharmacology of PTSD.

### *Self-Report Instruments*

There are six self-report measures of dissociation that have been used with some frequency. Five of the instruments (i.e., the Dissociative Experiences Scale [DES], the Questionnaire of Experiences of Dissociation [QED], the Dissociation Questionnaire [DIS-Q], Somatoform Dissociation Questionnaire [SDQ] and the Multiscale Dissociation Inventory [MDI]) are brief screening inventories. The Multidimensional Inventory of Dissociation (MID) is a multiscale diagnostic instrument.

The *Dissociative Experiences Scale* (DES; Bernstein & Putnam, 1986) is the first and most successful of the self-report measures of dissociation. It has been translated into many languages from its original English version. As of 1997, the DES had been used in over 250 published studies (Carlson, 1997). The DES is a 28-item self-report instrument. Items are rated on a continuous scale (original version) or on an 11-point Likert scale (revised version) that ranges from 0 ("never") to 100 ("always"). DES items primarily tap absorption, imaginative involvement, depersonalization, derealization, and amnesia. The DES has excellent internal consistency: Cronbach alphas of .95 (Frischholz, et al., 1990) and .96 (Boon & Draijer, 1993b), and split-half reliabilities of .83 (Bernstein & Putnam, 1986) and .93 (Pitblado & Sanders, 1991). The DES has a four-to-eight week temporal stability of .84 (Bernstein & Putnam, 1986) and a four-week temporal stability of .96 (Frischholz, et al., 1990). The DES correlated .78 with the SCID-D-R, .85 with the SDQ-20, and .90 with the MID (Dell, 2004). Construct validity of the DES was supported by a steady progression of mean DES scores (from low to very high) across the following groups: nonclinical population, patients with a trauma history, patients with PTSD, patients with Dis-

sociative Disorder Not Otherwise Specified (DDNOS), and patients with DID (Carlson & Putnam, 1993). Using a cutoff score of 30, DES scores predicted a diagnosis of DID with a sensitivity of .74 and a specificity of .80 (Carlson, Putnam, Ross, Torem, Coons, Dill, Loevenstein & Braun, 1993). Similarly, Draijer and Boon (1993b) used a cutoff score of 25 to predict the diagnosis of DID with a sensitivity of .93 and a specificity of .86. A shorter version of the DES, the DES-Taxon (DES-T), utilizes eight questions from the DES that are most closely identified with a taxon (class) of individuals who demonstrate "pathological dissociation" (Waller, Putnam, & Carlson, 1996).

The *Questionnaire of Experiences of Dissociation* (QED; Riley, 1988) is a 26-item, true/false self-report instrument. Its items were drawn from the literature about hysteria, multiple personality, non-DID dissociative patients, and temporal lobe epilepsy. The QED was shown to have a Cronbach alpha coefficient of .77 (Riley, 1988). The QED has discriminated groups of nonclinical individuals and alcoholics from groups of somatization disorder, PTSD, and DID patients (Dunn, Ryan, Paolo & Miller, 1993; Riley, 1988). A QED study of college students found six factors: depersonalization, process amnesia, dissociated body behavior, fantasy/daydreams, trance, and imaginary companions (Ray, June, Turaj & Lundy, 1992). Although there is a modest research literature on the QED, the instrument does not appear to be frequently used by clinicians.

The *Dissociation Questionnaire* (DIS-Q; Vanderlinden, Van Dyck, Vandereycken, Vertommen, & Verkes, 1993; Vanderlinden, 1993) is a 63-item, five-point Likert format, self-report instrument. The initial item-pool ( $N = 95$ ) from which the DIS-Q was developed was comprised of the DES, Perceptual Alteration Scale (PAS; Sanders, 1986), QED, and additional items that were derived from dissociative patients. Data from four samples yielded a 63-item DIS-Q, with a stable four-factor solution that explained 77% of the variance: (1) identity confusion and fragmentation, (2) loss of control, (3) amnesia, and (4) absorption. The total DIS-Q had a Cronbach alpha coefficient of .96; the subscales had alpha values of .94, .93, .88, and .67, respectively. The total DIS-Q had a three-to-four-week temporal stability of .94; subscales had stabilities of .92, .92, .93, and .75. The DIS-Q discriminated among diagnostic groups: nonclinical individuals, general psychiatric patients, DDNOS patients, and DID patients. The DIS-Q correlated .85 with the DES (Vanderlinden et al., 1993; Vanderlinden, 1993). Developed in The Netherlands, the DIS-Q is more commonly used by European than North American clinicians and researchers.

The *Somatoform Dissociation Questionnaire-20* (SDQ-20) is a 20-item self-report instrument using a five-point Likert scale (Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden, 1996). Based on the clinical/descriptive work of Janet (1889), the SDQ-20 is explicitly conceptualized as a measure of *somatoform dissociation*. The SDQ-20 items address tunnel vision, auditory distancing, getting stiff, psychogenic blindness, difficulty urinating, insensitivity to pain, psychogenic paralysis, pseudoseizures, and so on. The SDQ-20 was shown to have a Cronbach alpha coefficient of .95 and correlated .76 with the DIS-Q and .85 with the DES (Nijenhuis et al., 1996, 1999). Its construct validity was shown to be supported by its solid correlation with reported trauma (Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden, 1998). SDQ-20 scores discriminated among diagnostic groups even when controlling for general psychopathology (Nijenhuis, Van Dyck, Spinhoven, Van der Hart, Chatrou, Vanderlinden, & Moene, 1999). A shorter version of the SDQ-20, the SDQ-5, is comprised of five items from the SDQ-20 (Nijenhuis, 1999). The SDQ-5 was developed as a screening instrument for dissociative disorders and correlates well with findings of the longer inventory.

The *Multidimensional Inventory of Dissociation* (MID) is a 218-item self-report, multiscale measure of pathological dissociation that makes diagnoses and yields a comprehensive dissociative profile (Dell, 2004). The MID has 23 dissociation scales that vary in length from three to 12 items. The 23 scales achieved good-to-excellent Cronbach alpha values in a large clinical sample (range = .84 to .96; median alpha value = .91) and good-to-excellent temporal stabilities in a small clinical sample over a four-to eight-week test-retest interval (range = .82 to .97; median temporal stability coefficient = .92). The mean MID score was shown to have a four-to eight-week temporal stability coefficient of .97. The MID's convergent validity was demonstrated by the instrument's high correlations with five other measures of dissociation: DES ( $r = .90$ ), DIS-Q ( $r = .83$ ), SCID-D-R ( $r = .78-.92$ ), QED ( $r = .75$ ), and SDQ-20 ( $r = .75$ ). A factor analysis of the MID's items indicated that the MID has 12 first-order factors and one second-order factor: dissociation. The MID had a positive predictive power of .93, a negative predictive power of .84, and an overall predictive power of .89 for major dissociative disorder (i.e., DID or DDNOS-1). The MID is the only measure of dissociation that has validity scales: Defensiveness, Rare Symptoms, Attention-Seeking Behavior, Factitious Behavior, and Neurotic Suffering.

The *Multiscale Dissociation Inventory* (MDI; Briere, 2002) is a 30-item multiscale measure of dissociation with a 5-point Likert format. The MDI is fully standardized, allowing *t* score comparisons to a normative group of trauma-exposed men and women. It yields six subscales—Disengagement, Depersonalization, Derealization, Emotional Constriction/Numbing, Memory Disturbance, and Identity Dissociation—and a total dissociation scale. The scales have good to excellent coefficient alphas, and retain their strong psychometric properties in clinical and nonclinical populations (Briere, Weathers, & Runtz, 2005). The scales show their expected relationships to trauma history and to other known dissociation scales, including the DES (Briere, 2002; Dietrich, 2003). A cutoff score of 15 on the Identity Dissociation Scale yields high specificity (92%) and sensitivity (93%) for identifying individuals with Dissociative Identity Disorder. The MDI takes approximately 15 minutes to complete, and has been written for a sixth grade reading level.

### ***Other Psychological Tests***

Some measures that are frequently used in psychological testing (e.g., Rorschach, MMPI-2, WAIS-R, MCMI-III) can provide understanding of the patient's personality structure and may suggest DID (Armstrong, 1991). In combination with more specific diagnostic testing (e.g., SCID-D-R, DES, etc.), standardized psychological tests may aid the clinician in differential diagnosis and prognosis, the identification of co-morbid disorders, and the evaluation of treatment options. It should be noted, however, that commonly used psychological tests were *not* designed to detect dissociative disorders, and may lead to misdiagnosis when the psychologist (1) is not familiar with the typical responses of dissociative patients on these tests, (2) does not administer additional dissociation-specific tests (such as structured clinical interviews), and (3) does not inquire specifically about dissociative symptoms during the clinical or testing interview.

### ***False Positive Diagnoses of DID***

There has been a heated debate in the professional literature concerning the so-called “iatrogenesis” of DID. Expert opinion in the dissociative disorders field has argued strongly against the notion that DID can be produced iatrogenically (cf. Gleaves, 1996). No study in any clinical or research population has yet demonstrated that the full clinical

syndrome of DID can be produced in this fashion. On the other hand, false positive diagnoses of DID may arise from a variety of circumstances.

Clinicians should be alert to the possible false positive diagnosis of DID. Dissociative symptoms are central in other dissociative disorders, and may be present in PTSD as well as other disorders, such as somatization disorder. It should not be assumed that symptoms such as amnesia or even identity “fragmentation” automatically signal the presence of DID. The identity problems that occur in personality disordered patients may occasionally be misdiagnosed as a symptom of DID by clinicians who are unfamiliar with the clinical features of DID. Mood changes in bipolar patients, especially bipolar patients with co-morbid PTSD, have also been confused with clinical DID. Some psychotic patients with delusions of being inhabited by other people may also be misdiagnosed as DID. Of course, it should be noted that some DID patients have co-morbid bipolar or psychotic disorders. In these cases, a careful diagnostic evaluation, including diagnostic interviews and psychological testing, may be essential for an adequate differential diagnosis.

Patients who already have some dissociative features may be particularly at risk for the misdiagnosis of DID. When such patients are subjected to premature, intense exploration of trauma memories without adequate symptom stabilization, they may subjectively have a sense of personality fragmentation that can be misdiagnosed as DID. Naïve clinicians may also confuse the patient’s investment in a metaphorical “inner child” or similar phenomena with clinical DID. Further, clinicians who are poorly trained in hypnosis, and use this modality in treatment, may confuse hypnotic phenomena such as the production of “ego states” with clinical DID (Watkins & Watkins, 1997).

As with any psychiatric condition, a presentation of DID may be factitious or malingered. Clinicians should be alert to atypical presentations of apparent DID, especially in situations where there is strong motivation to simulate an illness (e.g., pending legal charges; Coons, 1991; Coons & Milstein, 1994; Draijer & Boon, 1999; Kluft, 1987c; Thomas, 2001). Research studies have shown that the SCID-D can be useful in differentiating “imitative” DID patients from those who actually meet DID diagnostic criteria. Instead, many of the imitative patients meet criteria for DSM-IV cluster B personality disorders and show a significantly different profile on the SCID-D (see also Boon & Draijer 1993c, Draijer & Boon, 1999). In addition to the clinical interview, comprehensive evaluation of possible factitious and/or malin-

gered DID may include (a) measures of dissociation (e.g., DES, MID, SDQ-20, SCID-D, DDIS), (b) standardized measures of PTSD, (c) measures of malingering (e.g., Structured Interview of Reported Symptoms [SIRS]; Rogers Bagby, & Dickens, 1992), although recent studies have suggested that some DID subjects may be misdiagnosed as feigning on the SIRS, (d) standard psychological tests (e.g., Millon Clinical Multiaxial Inventory [MCMI-II; Millon, 1997] or the Rorschach), (e) a review of all available clinical documentation, and (f) use of collateral sources of information. In forensic settings, some or all of these assessments are likely to be required to supplement the clinical interview.

### ***GOALS OF TREATMENT***

The DID patient is a single person who experiences himself/herself as having separate self-states or alternate identities, each of which has relative psychological autonomy from one another. These subjective identities may take executive control of the patient's body and behavior, and/or influence the patient's experience and behavior. It is important for clinicians to keep in mind that despite the DID patient's subjective experience, the patient is not a collection of separate people sharing the same body. The DID patient should be seen as a whole adult person, with the alternate identities sharing responsibility for life as it is now. All the alternate identities together make up the identity or personality of the human being with DID. In the clinical setting, clinicians working with DID patients generally ought to hold the whole person to be responsible for the behavior of any or all of the alternate identities, even in the presence of amnesia for the behavior, or lack of a sense of control or agency over the behavior.

#### ***Integrated Functioning as the Goal of Treatment***

It is the consensus of expert opinion that wherever possible, treatment should move the patient toward better integrated functioning (see below). Although the therapist may, at times, address alternate identities as if they were separate, a fundamental tenet of the therapeutic work with DID is to bring about an increased degree of communication and coordination among them. The therapist should keep in mind that the "patient" is the entire spectrum of alternate identities, not just the "host" (defined as the alternate identity that has the most presence in the outside world at a given time), the alternate identity that bears the official

name of the person, or any group of identities. Thus, it is counter-therapeutic to treat any alternate identity as if it were more “real” or more important than any other. It is also counter-therapeutic to suggest that the patient create additional alternate identities, to name alternate identities when they have no names (although the patient may choose names if he/she wishes), or to suggest that alternate identities function in a more elaborated and autonomous way than they already are functioning.

On the other hand, it is counterproductive to tell patients to ignore or “get rid” of alternate identities (although it is acceptable to provide strategies for the patient to resist the influence of destructive or self-destructive alternate identities, or to help control chaotic emergence of certain alternate identities at inappropriate circumstances or times). In addition, the therapist should not “play favorites” among the alternate identities or exclude apparently unlikable or disruptive identities from the therapy (although such steps may be necessary for a limited period of time at some stages in the treatment of some patients to provide for the safety and stability of the patient or the safety of others). The therapist should help foster the idea that all alternate identities represent adaptive attempts to cope or to master problems that the DID patient has faced. Accordingly, the alternate identities can be helped to find more adaptive ways to solve problems rather than using solutions that are dysfunctional, unsafe, or problematic.

Most experts in the dissociative disorders field agree that the most stable treatment outcome is fusion-complete integration, merger, and loss of separateness-of all identity states (e.g., Kluft, 1993a). However, a considerable number of DID patients will not be able to achieve full fusion and/or do not see fusion as desirable, even after undergoing considerable treatment. Accordingly, a more realistic long-term outcome may be a cooperative arrangement, sometimes termed “resolution”—that is, optimally integrated and coordinated functioning among alternate identities that allows optimal vocational, interpersonal, intrapsychic, and emotional functioning. Patients who achieve this kind of resolution frequently are more vulnerable than those who gain stable fusion to later decompensate into florid DID and/or PTSD when sufficiently stressed. Many factors can contribute to patients achieving this kind of resolution rather than fusion. These factors can include avoidance of unresolved, extremely painful life issues, lack of financial resources for treatment, co-morbid medical disorders, advanced age, significant unremitting DSM Axis I and/or Axis II co-morbidities, and/or significant narcissistic investment in the alternate identities and/or DID itself, among others (see below).

Terms such as “integration” and “fusion” are sometimes used in a confusing way. *Integration* refers to the work on all forms of dissociated mental processes throughout treatment. Kluft (1993a, p. 109) defines integration as, “[An] ongoing process of undoing all aspects of dissociative dividedness that begins long before there is any reduction in the number or distinctness of the identities, persists through their fusion, and continues at a deeper level even after the identities have blended into one. It denotes an ongoing process in the tradition of psychoanalytic perspectives on structural change” *Fusion* refers to a point in time when two or more alternate identities experience themselves as joining together with a complete loss of subjective separateness. *Final fusion* refers to the point in time when the patient shifts his/her sense of self from that of having multiple selves to that of a unified subjective self. This implies fusion of all alternate identities and the persistence of a sense of subjective unity. Kluft (1984) defined “stable fusion” as occurring after 27 months (two years after an initial three months) without evidence of alternate identities. Even after final fusion, additional work on “integration” of the patient’s dissociated ways of thinking and experiencing may continue. For instance, the therapist and patient might need to work on integrating an ability previously held by one alternate identity across all roles in which it would now be appropriate, or learn what the patient’s new pain threshold is, or how to integrate all the dissociated ages into one chronological age, and to re-gauge appropriate and healthy exercise or exertion levels for the patient’s age. Traumatic and stressful material also may need to be reworked from this new unified perspective.

### ***Treatment Outcome, Treatment Trajectories and Cost Effectiveness for DID***

Studies of treatment outcome for DID and of cost efficacy for DID treatment have shown that DID patients can have a very successful treatment outcome. Single case descriptions of successful treatments for DID date back more than a century. Outcome data for groups of patients treated by a single clinician have demonstrated that many DID patients can achieve and sustain substantial improvement including complete final fusion and integration (Kluft, 1984, 1986a). Systematic outcome studies also have shown a positive outcome for DID when using a model including direct work with alternate identities and trauma material to help achieve greater integration for the DID patient. The first such study followed up 20 DID patients an average of three years after

intake (Coons, 1986). The majority of patients were in treatment with therapists unfamiliar with DID, but supervised by experienced clinicians. Nonetheless, two-thirds of the clinicians reported moderate to great improvement in their patients.

In the Netherlands, a chart review study of 101 dissociative disorder patients in outpatient treatment for an average of six years found that clinical improvement was related to the intensity of the treatment with more comprehensive therapies having better outcomes (Groenendijk & Van der Hart, 1995). The largest and most systematic treatment outcome study reevaluated 54 DID inpatients two years after discharge to outpatient treatment (Ellason & Ross, 1997). As a group, there were significant overall decreases in psychopathology including number of Axis I and Axis II disorders, decreased DES scores, decreased depression on the Beck and Hamilton scales, and decreased dissociative symptoms on all of the DDIS subscales. Patients who achieved final fusion according to rigorous criteria were the most improved.

Two studies of outcomes and cost-efficacy of DID treatment have concordant findings suggesting that outcome depends on patients' clinical characteristics (Loewenstein, 1994; Putnam & Loewenstein, 2000). The more treatment responsive group of DID patients showed significant remission of symptoms within three to five years of beginning appropriate treatment. A second group with more alternate identities and more personality disorder features showed good outcome but required hospitalizations in addition to outpatient treatment. A third group, characterized by the longest period of treatment before DID diagnosis, largest number of alternate identities, and most personality disorder problems had a much longer, more costly, and more difficult course. Overall, however, treatment approaches specifically targeting DID showed reductions in overall psychiatric treatment cost after the first year compared with prior treatment for these patients.

These preliminary studies have notable limitations including the diverse and non-standardized nature of the therapy and lack of comparison groups. Nonetheless, in aggregate, they indicate that many DID patients improve with treatments focused on their dissociative symptoms and that overall treatment costs may be saved in the long-term by using the phased trauma treatment model for these patients (see below).

These studies also point to a major issue in treatment and treatment planning: the heterogeneous nature of the DID population. The literature identifies several subgroups of DID patients (cf. Kluft, 1994). At one extreme are relatively high functioning and highly motivated patients with relatively few co-morbidities and reasonable social supports

who have a relatively rapid and straightforward treatment course. At the other extreme are those who function at the level of disabled, chronically and persistently ill psychiatric patients. They may have multiple co-morbidities, such as severe substance abuse, eating disorders, organic mental disorders, mood disorders, and/or multiple medical problems. Another severely impaired subgroup may be involved in violent or criminal subgroups and/or may be abusive to their own children or violent towards others. A third group is intermediate between these extremes with varying levels of co-morbidity, psychosocial dysfunction, and interpersonal pathology. Accordingly, treatment planning for DID patients should take account of the motivation and personal resources of the patient to engage in an intensive, demanding psychotherapy focused on major life change.

### ***PHASE ORIENTED TREATMENT APPROACH***

Over the past two decades, the consensus of experts is that complex trauma-related disorders-including DID-are most appropriately treated with a phase or stage oriented approach. The most common structure for this is a treatment consisting of three phases or stages:

1. safety, stabilization and symptom reduction,
2. working directly and in depth with traumatic memories, and
3. identity integration and rehabilitation.

(cf. Brown, Schefflin, & Hammond, 1998; Chu, 1998; Courtois, 1999; Herman, 1992a; Kluft, 1993a; Steele, Van der Hart, & Nijenhuis, 2001, 2004; Van der Hart, Van der Kolk, & Boon, 1998). The writings of Kluft (1993a) and Steele, Van der Hart and Nijenhuis (2005), among others, address many of the specific issues in phase oriented DID treatment and other dissociative disorders. Phase oriented treatment of dissociative disorders is not a new idea. Pierre Janet advocated a similar phase oriented treatment for dissociative disorders beginning in the late 19th century (cf. Brown, Schefflin, & Hammond, 1998; Van der Hart, Brown, & Van der Kolk, 1989).

Complex PTSD (Herman, 1992b, 1993; Van der Kolk, Roth, Pelcovitz, & Mandel, 1993) is a construct that fits many DID patients (Courtois, 2004). These patients usually have had repeated traumas typically beginning in childhood and spanning several developmental periods. In

addition to PTSD symptoms, they have major difficulties with affect regulation, dissociation, and body image, the latter often manifesting itself as eating disorders, self-destructive attacks on the body, and somatization. They may have substantial relational pathologies including major problems with trust and enmeshment in violent or abusive relationships. They often view the world as dangerous and traumatizing, and see themselves as shameful, damaged, and responsible for their own traumatization. These patients commonly have significant problems with self-destructiveness and are often refractory to standard treatments (Herman, 1993; Van der Kolk et al., 1996). Accordingly, treatment for complex PTSD is a long-term, multi-modal, relatively eclectic psychotherapy designed to address the multitude of clinical difficulties with which these patients struggle.

A detailed description of phase oriented treatment for DID is beyond the scope of these *Guidelines* (consult references in the previous paragraphs). However, it is common for DID patients to initially present to treatment with suicidal, self-harming, and/or self-destructive behaviors that may lead to a continual and/or repetitive series of crises. These are often related to serious psychosocial stressors that have undermined the patient's stability. They may have co-morbid conditions including PTSD, substance use disorders, eating disorders, somatoform disorders, anxiety and mood disorders (primarily in the depression spectrum), personality disorders (often a mixed personality disorder with avoidant, obsessive, borderline, and/or narcissistic traits), and, less commonly, organic mental disorders, and/or psychotic disorders.

The phases of treatment are to some extent a heuristic construction. The phases describe the dominant orientation of the therapeutic work during a particular stage to assist the DID patient develop greater overall life adaptation, safety and stability while, when indicated, working on traumatic material. For instance, in the stabilization phase, treatment may focus at times on traumatic experiences, but in a more distanced and cognitive way to help the patient more effectively separate past events from contemporary experiences. In the middle phase of treatment, stabilization and symptom management is often necessary to prevent patients from becoming overwhelmed by the nature of the work on trauma and to help stabilize them if they do. A focus on rehabilitation and better overall life adaptation is essential throughout any form of mental health treatment and should occur in each phase of treatment.

### ***The Phase of Establishing Safety Stabilization and Symptom Reduction***

In the initial stages of treatment, emphasis should be placed on establishing a therapeutic alliance and educating patients about their difficulties and about the process of treatment. Maintaining a sound treatment frame in the context of a therapeutic holding environment is critical to establishing a stable therapy that potentially results in a successful outcome. As with other patients with complex PTSD, initial work with DID patients must address any major self-destructive behaviors and other issues that may potentially jeopardize patients' physical or psychological safety.

#### ***Suicide Risk***

Research studies of DID patients suggest that a history of suicide attempts and self-injurious behavior is found in a very high percentage of DID patients. No studies have been done to compare suicide risk between DID and other patient groups. However, since the overwhelming majority of DID patients meet DSM-IV-TR diagnostic criteria for current or past PTSD, data on suicide in PTSD are relevant to suicide risk in DID. The National Comorbidity Study (Kessler, 2000) found that a diagnosis of PTSD is associated with a six-fold increase in the likelihood of an initial suicide attempt, an odds ratio higher than that for any other anxiety disorder and about half that for mood disorders. Further, individuals with PTSD have an approximately equal odds ratio for making a suicide plan or impulsive suicide attempt compared with those with Major Depression. Of course, many DID patients also meet diagnostic DSM-IV-TR criteria for Major Depressive Disorder, which may increase the odds that DID patients will make suicide attempts.

Recent studies have also shown that childhood maltreatment in and of itself is associated with an increased risk of suicidal behavior (Arnow, 2004). In these studies, suicidal risk was increased in a dose dependent manner by multiple abuse events and by multiple forms of abuse: physical, sexual, emotional abuse and neglect.

Studies have also found that childhood sexual abuse is strongly associated with a history of self-injury, eating disorders, and other forms of parasuicidal behavior (Van der Kolk, Perry, & Herman, 1991). Higher rates of childhood sexual abuse and other forms of maltreatment also increase risk of suicide attempts substantially, with rates increasing with more forms of abuse experienced (Arnow, 2004). The high rates of se-

vere, repetitive childhood sexual abuse and other forms of maltreatment in the histories of DID patients, strongly indicate that self-injurious and self-damaging behavior will be common as well in this population.

These data and other studies suggest that suicidal and/or self-destructive behaviors may be exceptionally common among DID patients (Putnam et al., 1986; Ross & Norton, 1989a). While studies have not addressed the prevalence of completed suicide in DID patients, many Guidelines Task Force members reported knowing of cases of DID patients who have ultimately committed suicide. Accordingly, clinicians treating DID must be aware and take seriously the potential for suicide and/or self-destructiveness in this patient population.

### *Clinical Management of Safety Issues*

DID patients usually give a history of being abused or having their safety disregarded throughout their early lives. They tend to reenact these paradigms in their lives, venting their aggression, shame, fear, horror and other overwhelming affects onto themselves through self-destructive behaviors. Accordingly, one major cornerstone of the treatment of the DID patient is to help the patient achieve safety from behaviors that may make them dangerous to themselves, dangerous to others (especially to their minor children), and/or vulnerable to exploitation or violence by others. Many DID patients will exhibit these sorts of problems when they present for treatment or may reveal that they are occurring as treatment progresses. Most commonly, these problems include suicidal and/or parasuicidal behaviors, alcohol and/or substance abuse, enmeshment in violent or exploitative relationships, eating disorder symptoms, violent or aggressive behavior toward others, lack of food, clothing or shelter, and high-risk behaviors that may subject them to danger. The latter can include fugues or wandering in dangerous neighborhoods or environments, driving recklessly, engaging in unsafe sexual practices, and/or failure to attend to medical problems, among others. Safety issues may recur during treatment and need to be addressed vigorously and thoroughly.

Without successful resolution of the myriad safety problems that the DID patient brings to therapy, little will be accomplished overall in the treatment. The clinician should keep a very high index of suspicion for covert unsafe behaviors and address them and address them vigorously, being sure to bring their management into the forefront of treatment. A careful history often shows that the DID patient's unsafe behaviors may have gone on for years. These behaviors often can best be understood as

self-regulatory, even self-soothing, adaptive strategies that are logically related to the patient's history of traumatic experiences and attempts to cope with these. Accordingly, they are usually best worked with as adaptations to be shaped in a different direction, rather than "bad" behaviors to be eliminated. At the same time, the therapeutic alliance and the sense of a "holding environment" for the DID patient may be facilitated if the therapist strongly takes a stand for "non-abusive values" to self or others (Loewenstein, 1993).

Safety issues should be addressed in a comprehensive and direct manner. Other treatment issues may need to be put on hold until safety is established. Interventions should include: (1) education about the necessity for safety for the treatment to be successful; (2) identifying alternate identities who act unsafely and/or control unsafe behaviors; (3) development of agreements with the latter and with all alternate identities to help the patient delay acting on unsafe impulses and/or to use alternative strategies for management of problems (see below); (4) cognitive therapy, cognitive-behavioral therapy, and/or dialectical behavior therapy to help the patient address the cognitive distortions and affect dysregulation that frequently underlie unsafe behaviors, and to develop alternative behavioral repertoires to remain safe; (5) use of symptom management strategies such as grounding mechanisms, crisis planning, self-hypnosis and/or medications (see below) to provide alternatives to unsafe behaviors; (6) development of specific treatment plans to manage eating disorder and/or substance use problems that may include referral to specialized treatment programs; (7) involvement of appropriate agencies if the clinician has a reasonable suspicion that the patient is abusive to children or to vulnerable adults or is in danger of acting violently towards another person (following the laws of the jurisdiction in which the clinician practices); (8) helping the patient with appropriate resources for self-protection from domestic violence (following the laws of the jurisdiction in which the clinician practices); and (9) insisting that the patient seek treatment at a more restrictive level of care, including hospitalization, to prevent the patient from harming self or others.

Commonly, as part of the management of the DID patient, the clinician will develop "safety contracts" or "safety agreements" with the patient's alternate identity system to provide a structure for the patient to cease unsafe behaviors such as suicide attempts or self-mutilation. From both a clinical and medico-legal perspective, these agreements are not a substitute for the clinician's judgment about the patient's safety. They must be interpreted in the total context of the patient's clinical sit-

uation and should be reviewed on a regular basis with the patient. The clinician should always insist on more restrictive treatment alternatives if, in the clinician's clinical judgment, the patient is unsafe, despite the patient's insistence on the validity of the "contract."

Safety agreements may be best conceptualized as delaying or temporizing strategies, much as a substance abusing patient might use the AA structure as an alternative to drinking. In general, the clinician obtains assent from all alternate identities that "I will not hurt myself or kill myself, or anyone else external or internally, accidentally or on purpose at any time" (Braun, 1986, p. 12) or something similarly comprehensive. However, clinicians should recognize that no language is free of loopholes, and they should insist that patients comply with the spirit of the agreement. In addition, clinicians should not bear the burden of making a contract with each alternate identity. Instead, the patient should be helped to develop strategies (e.g., using ideomotor responses) to make sure that all alternate identities acknowledge that they are bound by the contract.

Other behaviors may be added into the agreement when necessary such as use of alcohol or drugs, driving recklessly, etc. These agreements are only really effective if the patient has a "safety plan" as an alternative. The safety plan may include a hierarchy of alternative behaviors including: contacting friends, leaving the setting where the patient feels unsafe, using symptom management strategies such as self-hypnosis, grounding and containment techniques, using medications as needed, and, finally, calling the therapist and waiting for a return call and/or going to the emergency department if the patient feels imminently unable to maintain safety.

Patients may more readily participate in time-limited safety agreements, especially early in treatment, as they may be reluctant to give up long-standing self-regulatory behaviors forever. Experienced clinicians generally try to negotiate agreements for several weeks or months, and will not renew these agreements more frequently than session to session (except during crises when they may be renewed during a phone contact to avoid immediate hospitalization). The need for safety agreement renewal more frequently than session to session suggests that the treatment needs to be modified, often by finding a more restrictive setting for the patient such as partial or inpatient hospitalization.

Some patients may experience these agreements as more concrete if they are written down and signed by some or all of the alternate identities. However, the clinician should not have any greater confidence in the reliability in these agreements if they are written and signed. The

fundamental issue is the patient's honest commitment to the agreement and taking personal responsibility for their safety, which may include asking for assistance instead of acting unsafely when overwhelmed. Working on the issue of honesty concerning the safety agreement also may focus on important issues in developing the therapeutic alliance (see below).

Use of safety agreements may help patients to eventually realize that they have greater control over safety issues than previously realized, to help them understand their ambivalence concerning personal safety, and to more effectively mobilize their efforts to control acting unsafely. Frequently, discussion of cessation of unsafe behaviors brings a wealth of crucial material into the therapy concerning the alternate identity system, the patient's history, transference issue (especially traumatic transference themes), and dominant ideas and beliefs that shape the patient's behavior.

### ***Stabilization and Symptom Reduction***

Most models of phase oriented treatment begin with an initial period of symptom stabilization. The focus in this phase of treatment is the management and control of symptoms rather than exploration of traumatic memories. For example, if the patient has a spontaneous flashback or episode of intrusive recall of trauma during treatment, the therapist should help the patient modulate the intensity of the experience and not encourage detailed discussion of the material. In this phase the clinician would assist the patient with the development of personal and environmental safety, modulation of psychophysiological arousal levels, improved affect tolerance and impulse control, control of post-traumatic and dissociative symptomatology, diagnosis and stabilization of co-morbid disorders, better functioning in daily life, and improved capacity for engaging in mutually supportive relationships.

A variety of treatment interventions and strategies may be needed to assist the patient in stabilizing. These include psychoeducation about trauma-related difficulties; teaching the patient skills in "grounding" from dissociative and posttraumatic symptoms; teaching the patient skills for "containment" of dissociative, posttraumatic, and affective eruptions; helping the patient through cognitive-behavioral techniques to recognize problematic thought patterns and beliefs; and helping the patient with better adaptation to current life stresses and interpersonal problems. Psychopharmacological interventions such as medications for mood, anxiety, posttraumatic, sleep, and thought disorders may be a

helpful adjunct to treatment (see section on psychopharmacology, below).

Chronically traumatized individuals, including DID patients, may benefit from periodic “ego-strengthening” interventions such as skill building, soothing images, reaffirming statements, and calming imagery such as “safe places.” When patients spontaneously experience intrusive traumatic imagery, they often benefit from learning strategies that help them delay, contain or control the level of intrusiveness of the traumatic material into their daily functioning. Specific early stabilizing interventions in DID are designed to help with spontaneous and uncontrolled dysfunctional switching of alternate identities, passive influence, amnesia, somatoform symptoms, and similar experiences that are highly disruptive and may be linked to intrusive PTSD symptoms.

Typical interventions include psychoeducation concerning the disorder, techniques to improve internal communication and co-consciousness among alternate identities, and strategies for them to have safe ways of communicating as well as containing their symptoms. Issues of accountability are usually discussed here, including how the patient as an individual is held accountable for the conduct of all alternate identities, in the external world, in therapy, and within the internal system. The strategies designed to improve internal communication may include techniques to encourage negotiation between the alternate identities, acknowledgement of the importance of all alternate identities, and commitments by all alternate identities for safety from self-harmful and/or suicidal behaviors (see above). In some cases the stabilization plan must include rehabilitation or crisis centers, specialized substance abuse or eating disorder programs, social services involvement such as child protection agencies, and residential, partial hospital and/or inpatient treatment.

As described in a prior section, DID patients have a broad range of ego-strength, commitment to treatment, social supports, life stresses, economic resources, and other factors that may make them more or less able to undertake a demanding, change-oriented treatment. Accordingly, many patients may continue in Phase 1 treatment for long periods of time—sometimes even for their entire treatment course. These patients may make considerable improvements in safety and overall functioning, but may not be able to participate in an extensive, emotionally intense, detailed exegesis of their trauma history. The focus of treatment for chronically low-functioning patients should remain on stabilization, crisis management and symptom reduction, rather than on the details of traumatic memories and fusion of alternate identities. Several factors

have been described that may influence a decision towards maintaining such a focus including severe attachment problems, minimal ego strength and coping capacity, ongoing enmeshment with perpetrators, severe DSM-IV-TR Axis II pathology, significant medical problems, and ongoing substance abuse and dependency (cf. Boon, 1997, Kluft, 1997). In general, patients should only move into Phase 2 work if they are adequately stabilized in the initial phase, and provide adequate informed consent (see below) for entry into the next phase.

### *Working with Alternate Identities*

As part of learning about the nature of their disorder, DID patients must begin to understand, accept and access the alternate identities that play an active role in their current life. Clinicians must accept that successful treatment of DID almost always requires interacting and communicating with the alternate identities in some way. Early in the treatment, therapists and patients must establish safe and controlled ways of working with the alternate identities that will eventually lead to co-consciousness and greater integration. In order to work with alternate identities, they must be accessed directly or indirectly (see below). A complete discussion of this is beyond the scope of these *Guidelines*; see Putnam, 1989, Ross, 1997, Kluft, 2001, and Kluft and Fine, 1993 for more extensive discussions of treatment of DID.

Some alternate identities may insist that they do not inhabit “the body” of the host identity. In this form of “delusional separateness,” they may insist that suicide or self injury has no effect on themselves, only on other identities. Accordingly, severe safety problems can result from this issue. It is important to challenge this extreme form of dissociative denial directly. However, in some cases, it may take many sessions to erode delusional separateness, even with the alternate identities acknowledging the contradiction of finding themselves in the body that they deny inhabiting.

Alternate identities can be accessed directly, e.g., “I need to talk to the one(s) who went to Atlantic City last night and had unsafe sex.” On the other hand, experienced clinicians usually develop a repertoire of skills to access alters more indirectly. For example, the therapist may suggest that the alternate identities engage in inner conversations with one another, may use non-verbal responding such as ideomotor signals in response to questions (Hammond, 1990), or may insist that “everybody listen” when important matters are being discussed. Often the clinician can “talk through” or “talk over” the alternate identity presenting

in the therapy session to communicate with other alternate identities relevant to the current clinical issues. The patient can be asked to “listen inwardly” to hear what the other alternate identities have to say. The latter techniques are helpful since they may allow rapid discussion of material among alters and may attenuate the disruptive effects of frequent switching that can occur when many different identities try to communicate with the therapist. Implicitly, these techniques break down dissociative barriers by encouraging sharing of thoughts, feelings, and perspectives that are subjectively sequestered within alternate identities. Hypnotic induction may facilitate the emergence of alternate identities (see section on hypnotic techniques) especially during safety crises, but, under ordinary circumstances, hypnosis is not necessary to allow alternate identities to emerge in the treatment-firm and persistent encouragement alone usually succeeds.

It is often helpful to generate an ongoing “map” or “roster” of the patient’s current view of the alternate identity system. This can help in understanding the subjective relationship among alternate identities as well as to indicate where hidden identities may exist that influence or control symptoms or safety issues. Some clinicians recurrently schedule a kind of “roll call,” calling the names of each known alternate identity and getting their assent that they are “present” and “listening” (Kluft, 1993a). In “mapping” a patient’s system, clinicians should *not* try to identify or elicit identities solely for the sake of mapping. It can be counter-therapeutic and potentially destabilizing to ask patients to reveal parts of themselves before they are psychologically prepared to do so. In general, alternate identities should be elicited as they appear naturalistically or if they have relevance to current clinical issues. On the other hand, in situations involving significant safety problems, repeated acting out by the patient, and/or at times of therapeutic impasse, it can be important to directly elicit alternate identities, previously known or not, that are experienced as causing these difficulties.

Many systems have been developed to attempt to make a typology of alternate identities. Discussion of this is beyond the scope of these *Guidelines*. All alternate identities should be conceptualized as attempts to solve life problems and as adaptations to disturbances in the patient’s early development and subsequent life. Accordingly, experienced clinicians working with DID commonly actively seek to access and safely engage alternate identities who embody intense mistrust, negative affects, or urges to harm the person’s body, and may be experienced as malevolent, rageful, violent, and/or internally abusive. With proper treatment, these alternate identities can be transformed and become the

source of important strengths and resiliency during treatment (Watkins & Watkins, 1988).

### *Trust and the Therapeutic Alliance*

Patients with a history of interpersonal trauma in childhood often have major difficulties with trust. This frequently manifests itself towards their therapists and can play out in a variety of complex transference manifestations (Brown, Schefflin, & Hammond, 1998; Davies & Frawley, 1997; Pearlman & Saakvitne, 1995). DID patients frequently report extensive childhood histories of traumatic experiences, usually involving maltreatment and/or neglect by family members, caretakers and others in positions of authority or trust. Accordingly, clinicians should never underestimate the difficulties these patients may experience in establishing a therapeutic alliance. In addition, treatment may begin to erode dissociative barriers and defenses leading to greater intrusion of traumatic memories. This may engender additional fears of loss of control due to increased awareness of extreme affects and disturbing cognitions. Feeling vulnerable, patients may manifest more difficulty with trust, fearing that they will be abused or manipulated as they were in childhood. Such “traumatic transference” reactivity may be intense among various alternate identities either overtly or covertly (e.g., the host appears to trust the therapist, while other identities feel vulnerable and sabotage the therapy). Finally, patients with a history of child abuse-especially incest-may be at particular risk of sexual exploitation by authority figures, including mental health professionals (Kluft, 1990). DID patients with a history of therapist abuse usually require an even longer time to develop a sense of safety in treatment, let alone, trust.

The clinician should attend to issues of the therapeutic alliance from the beginning of treatment. The clinician should be actively aware of the potential difficulties that building a therapeutic relationships can engender for the DID patient. It is helpful for the clinician to structure sessions to include education about the nature of DID and trauma treatment, the intense discomfort that can be engendered during treatment, and to anticipate and make explicit traumatic transference issues, particularly negative transferences. The clinician’s judicious use of containment and grounding techniques in sessions to avert crises also can help begin to build a therapeutic alliance with the DID patient. Patients may alternate from pressures to “open everything up to get out all the memories” to intense phobic avoidance of trauma issues. The clinician can foster a realistic therapeutic alliance by structuring the treatment to bal-

ance both of these pressures and to find a pragmatic balance between attenuation of trauma material and working more in depth on trauma material. One clinical study suggests that DID patients who are able to improve their therapeutic alliance in a real way may have a better and more rapid positive outcome than DID patients who are not able to do so (Kluft, 1994).

Effective therapy for DID usually requires a therapist who is engaged and who actively structures the treatment by anticipating difficulties and by having a clear plan to help the patient through the stages of treatment. A gradual fostering of a real therapeutic alliance with the DID patient will often occur as the clinician helps the patient pace the therapeutic work, learn skills for mastering symptoms and crises, separate the traumatic past from the present, and change PTSD and DID based cognitive distortions. The therapist's active insistence on safety and recovery usually is a contrast for the patient with persons from the past who remained passive or unconcerned about the DID patients safety and well-being.

### ***The Phase of Focused Work on Traumatic Memories***

In this phase of treatment, the focus turns to working with the DID patient's memories of traumatic experiences. It is generally accepted among experienced clinicians that effective work in this phase involves remembering, tolerating, and integrating overwhelming past events. Optimally in this stage, work on traumatic memories can be carefully planned out and scheduled: which memories will be the focus, at what level of intensity, which alters will participate, how to maintain safety during the work, and procedures to contain material if the work becomes too intense. Patients benefit when therapists help them use planning, information, exploration, and titration strategies (cf. Fine, 1991; Kluft, 2001) to develop a sense of control over the emergence of traumatic material. Specific interventions for DID patients involve working with alternate identities that experience themselves as holding the traumatic memories. These interventions help broaden the patient's range of emotions and affects across alternate identities, and assist the patient as a whole with tolerating the affects associated with the trauma such as shame, horror, terror, rage, helplessness, confusion, anger and grief.

The patient and therapist may elect to work with memories spontaneously if they emerge in therapy, assuming that there is adequate time in session, and that the patient can work on memory material without significant life disruptions. Accordingly, as the various elements of a

traumatic memory emerge, they are explored, rather than being re-dissociated or rapidly contained. Over time, and often with repeated iterations, the material in these memories is transformed from traumatic memory to what is generally termed narrative memory (cf. Brown, Schefflin, & Hammond, 1998 for a comprehensive review of trauma and memory in treatment). In addition to abreaction-the intensive discharge of emotions and tensions related to the trauma, the mechanism of change is one of repeatedly re-accessing and re-associating the fragmented and dissociated elements of traumatic memories (Van der Hart & Brown, 1992).

Active work on traumatic memories ultimately aims to bring together most dissociated aspects of traumatic experience: the affects associated with the trauma, the physiological and somatic representations of the experience, the sequence of events that occurred, to the extent that they can be remembered or reconstructed, with adult cognitive awareness and understanding of the role of self and others in the events (Braun, 1988; Brown, Schefflin, & Hammond, 1998; Chu, 1998).

As the patient re-experiences the events, attempts can be made to “detoxify” them by placing them in a more understandable context, and by finding alternative meanings for them. The patient’s unrealistic views of him/herself in the context of trauma (“It’s all my fault,” “I asked for it,” “I wanted it,” “I should have stopped it,” “I made it happen,” etc.) can be systematically challenged using the patient’s adult observing ego to understand what really occurred. Also, during this stage, the detailed recall of the past commonly leads to work on resolution of ambivalence and conflict concerning old or current relationships with family members and significant others and the latter’s remembered roles in traumatic experiences. In addition, during this stage, DID patients may grapple with their fear and/or ambivalence about change and recovery (Chu, 1998).

The process of Phase 2 work allows the patient to gain a sense of control over the experiences and their reactions to them, and to build a better understanding of his/her personal history and sense of self. In addition, DID patients become able to recall the traumatic experiences across alternate identities, especially those who were amnesic or without emotional response to them. Some authors have used the term “synthesis” for this process (Van der Hart, Steele, Boon, & Brown, 1993). Synthesis can be described as a controlled therapeutic process designed to assist alternate identities that experience themselves as “holding” traumatic memories to share these with other alternates who experience

themselves as being unaware of this material or do not regard it as part of their autobiographical memory.

However, even with careful therapeutic planning, destabilization can occur during this stage of treatment. This may require a return to focus on Phase 1 issues such as stabilization, internal communication, containment, and symptom management, as well as work on resistance and reluctance among alternate identities to continue trauma work. In addition trauma-based cognitive distortions and/or transference reactivity also may interfere with work on memories and will need to be systematically addressed. In some cases, destabilization may involve safety problems that require more restrictive levels of care such as partial hospital or inpatient treatment.

In this phase of treatment, work on traumatic material may need to occur repeatedly at many different levels of affective intensity to help the patient more fully integrate the totality of the recalled traumatic experiences. As this occurs, the alternate identities may experience themselves as less and less separate and distinct. Spontaneous and/or facilitated fusions among alternate identities may occur as well as this process unfolds. Facilitated fusions often involve "fusion rituals." These therapeutic ceremonies usually involve imagery or hypnosis that ". . . are perceived by some . . . patients as crucial rites of passage from the subjective sense of dividedness to the subjective sense of unity . . ." (Kluft, 1986, quoted in Kluft, 1993a, p. 119). The patient's experience is that alternate identities join together with an image of joining together or becoming unified ". . . [These rituals] merely formalize the subjective experience of the work that therapy has already accomplished . . ." (Kluft, 1993a, p. 120).

Fusion rituals are often misunderstood. Many clinicians attempt to press for fusion before it is appropriate to do so. Fusion rituals are useful when previous psychotherapeutic work has caused a separateness to no longer serve a meaningful function for the patient's intrapsychic and environmental adaptation and when the patient is no longer narcissistically invested in maintaining the particular separateness. Clinicians should *not* attempt to press for fusion before the patient is clinically ready for this. Premature attempts at fusion may cause significant distress for the DID patient or, alternatively, a superficial compliance with the alternate identities attempting to please the therapist by seeming to disappear. Premature fusion attempts can also occur when the therapist and patient collude to avoid particularly difficult therapy material. On the other hand, ongoing, dispassionate education of the DID patient

about the manifold issues that the question of unification brings up may be helpful during any stage of DID treatment.

### ***The Phase of Integration and Rehabilitation***

In the third phase of DID treatment, patients make additional gains in internal coordination and integration, and usually begin to achieve a more solid and stable sense of who they are and how they relate to others and to the outside world. In this phase, DID patients may continue to fuse alternate identities and improve their functioning in a more and more unified manner. They may also need to revisit the trauma history from a more “unified” perspective. As patients become less fragmented, they usually develop a greater sense of calm, resilience, and internal peace. They may make more coherent sense of their past history and deal more effectively with current problems. The patient shifts focus from the traumatic past and towards living better in the present. Work on loss, grief, and mourning may be profound in this stage as the patient grapples with the realistic perception of the many losses that the traumatic past has engendered. On the other hand, the patient may begin to have less focus on the past traumas, directing his/her energy to living better in the present. With a greater level of integration, the patient may be more able to sort out traumatic “memories” and decide that some of these may be more related to subjective symbolism concerning the past, or to dissociative experiences that seemed “real” at the time but did not occur in objective reality.

Many of the tasks of late phase treatment of DID are similar to the those of non-traumatized patients who function well, but are experiencing emotional, social, or vocational problems. However, the unifying DID patient may need specific coaching about dealing with everyday life problems in a non-dissociative manner. Similarly, the patient may also need help in tolerating everyday stresses, petty emotions and disappointments as a routine part of human existence.

## ***TREATMENT MODALITIES***

### ***Framework for Outpatient Treatment***

The primary treatment modality for DID is usually individual outpatient psychotherapy. Frequency of sessions and duration of treatment may depend on a number of variables including the patient’s character-

istics, the abilities and preferences of the clinician, and external factors such as insurance reimbursement and the availability of skilled therapists. As described in the preceding sections, there is a broad spectrum of DID patients with respect to motivation for treatment, resources for treatment, and co-morbidities that may affect the course of treatment. As with other patients with complex posttraumatic disorders, treatment for DID patients generally is long-term, usually requiring years, not weeks or months of treatment.

Frequency of sessions provided may vary depending on a variety of factors including the goals of the treatment and the patient's functional status and stability. The minimum frequency of sessions for most DID patients with a therapist of average skill and experience is once or twice a week, with many experts in the field recommending twice a week. Long-term supportive Phase 1 treatments usually occur once or twice per week depending on the patient's ability to manage symptoms and maintain themselves at an outpatient level of care. Task Force members differ about frequency of sessions for change oriented treatments involving intensive Phase 2 and Phase 3 therapy work. Some opine that many patients will need to be seen at least two times per week and often more frequently during these phases to provide sufficient intensity for the trauma work and to keep a focus on everyday events in the patient's life. Others believe that once to twice weekly therapy may be sufficient to accomplish the work of these phases in selected patients.

Some contributors to these *Guidelines* believe there is a potential danger for dysfunctional dependence that can occur in some patients with more intensive therapy, especially in patients prone to regression. Other contributors suggest that the type of treatment, not its frequency, is the critical variable in the development of a treatment impasse due to regression. For example, some highly unstable, chronic patients can be helped to not regress by the stabilizing effect of a highly structured and supportive treatment that occurs several times per week over many years.

In certain circumstances, a greater frequency of sessions (up to three or more per week) can be scheduled on a time-limited basis to aid the patient in maintaining the highest possible level of adaptive behavior and/or (as an alternative to hospitalization) in containing self-destructive and/or severely dysfunctional behavior. For patients newly discharged from inpatient treatment, a period of sessions at a greater frequency may sometimes be necessary to help the patient make the adjustment from the high frequency of sessions and/or greater level of interpersonal support provided in many inpatient programs. Very fre-

quent outpatient sessions should be generally limited to brief periods for re-stabilization, and regression should be minimized by emphasizing the need for the patient to be appropriately independent and to use the most mature coping skills possible.

While the usual 45-50 minute session remains the norm for most therapists, some therapists have found extended sessions useful. DID patients have sometimes benefited from two 75-90 minute sessions or one extended session and one 45-50 minute session per week. Specific clinical situations have led to the practice of occasionally extending sessions beyond their usual length, e.g., for preplanned trauma memory processing. In all clinical situations, therapists need to attempt to help patients to reorient themselves to external reality and cease processing of traumatic memories well before the scheduled end of therapy sessions, although they can only influence, but never control, the patient's ability to reorient to the present. Repeated difficulties with grounding the patient in current reality at the end of sessions necessitates that the therapist make this issue the focus at the beginning of a subsequent session to help understand the causative factors and to suggest interventions (e.g., letting the patient know some minutes before the end of the session to initiate the process of re-orientation to leaving therapy).

There is a divergence of opinion concerning very lengthy sessions (e.g., sessions longer than 90 minutes), with some experienced clinicians doubting if they are ever required, and others finding them useful for specific purposes. If used, they should be scheduled, structured, and have a specific focus such as completion of processing of traumatic memories and imagery, or administration of a diagnostic battery. They may also be indicated when logistics force the patient to come to the therapist infrequently, but to work intensely while there.

Medication management sessions for the DID patient often require 25-30 minutes or, occasionally, a 45-50 minute session. This is necessary to both discuss medication management and to handle the often complex psychological responses of the DID patient to taking medication. The DID patient's traumatic transference, posttraumatic cognitive distortions, and DID trance logic may all combine to require more in-depth explanations of the risks and benefits of medications than for other patients. DID patients are often both medication phobic and medication seeking, the latter often to avoid painful psychotherapeutic issues.

Initial medication evaluation sessions may require one or more 45-50 minute sessions to take an adequate history and to educate the patient and initiate a medication trial. Some psychiatrists will schedule a single

initial 75-90 minute session to accomplish this purpose. Subsequent sessions should be handled with the same frequency as for non-DID patients. More frequent visits may be needed when medications are being initiated or significantly adjusted, especially if the patient is unstable. Once stabilized on medications, the patient usually can be seen once per month, or even less often for stable patients on long-term medication regimens. As discussed below, it is vital for the medication prescriber and the primary psychotherapist to have clearly defined roles and boundaries to assure that there is only one primary psychotherapist for the patient.

#### *Duration of Treatment*

The duration of treatment depends on the patient's presenting functional ability, ego strengths, and any past treatment and its impact. Some early reports on treatment outcome showed that over two to three years of intensive outpatient psychotherapy, many patients could reach a relatively stable condition in which they did not experience a sense of internal separateness (Kluft, 1984). However, the treatment needs of DID patients vary enormously, and many patients require three to five years following the diagnosis of DID as a minimum length of treatment, with many more complex patients often requiring lengthier outpatient psychotherapy, sometimes with inpatient stays during crises. More severe personality pathology (especially obsessive-compulsive, borderline, narcissistic, and passive-aggressive types) is associated with longer treatment. Some therapists who are experienced in treating DID patients with severe comorbid Axis II disorders have suggested that incremental improvement may continue for as long as two decades of treatment or more in this population.

#### *Types of Treatment for DID*

The most commonly cited treatment orientation is individual psychodynamically oriented psychotherapy, often eclectically incorporating other techniques (Putnam & Loewenstein, 1993). For example, cognitive behavioral therapy techniques can be modified to help patients explore and change dysfunctional trauma-based belief systems or to manage stressful experiences or impulsive behavior (e.g., stress inoculation training, dialectical behavioral therapy [DBT]). However, standard cognitive therapy protocols for depression and anxiety usually require modification when used in the treatment of DID. Many thera-

pists employ hypnosis as an adjunctive modality in the treatment of DID (Putnam & Loewenstein, 1993; see below). The most common uses of hypnosis are for calming, soothing, containment, and ego strengthening. In addition to individual psychotherapy, patients may benefit from specialized interventions such as family or expressive therapy, educational programs such as bibliotherapy, and other treatments. Some patients require specialized substance abuse or eating disorder treatment.

Because DID patients often have difficulties with self-harming behaviors and impulse control, Dialectic Behavioral Therapy (DBT; Linehan, 1993) is now often incorporated in modified form or added as adjunctive group therapy. Some authors have published articles advocating the use of Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 2001) as an adjunctive treatment modality in dissociative disorders. However, this modality of treatment may have considerable risks for the DID patient (e.g., flooding with too much traumatic material) and only should be used in the context of an overall comprehensive treatment plan that includes interventions to ensure stabilization and specific work with the alternate identity system (see below).

Behavior modification techniques may be useful when taught to the patient as self-control strategies for symptom management. For example, work on PTSD triggers may involve systematic desensitization strategies. As in any psychotherapy, learning theory is useful in understanding how some elements of psychotherapeutic practice are helpful to patients. For example, exploration and processing of traumatic material can be conceptualized as a form of exposure therapy that permits traumatic memories to be transformed into narrative memories. Experienced therapists pay attention to rewarding healthy behaviors with attention and praise. Expressing mild disappointment in response to maladaptive behaviors may be helpful to some patients, leading to a discussion of the factors related to those behaviors. However, it is unhelpful at best, and counterproductive in many cases, to make use of behavior modification techniques to punish the expression of dissociation itself, e.g., to ignore or attempt to extinguish the expression of the alternate identities. Further, the therapist should generally avoid the use of aversive conditioning or extinction procedures since these may strongly evoke many types of abuse experiences commonly reported by DID patients.

Many specific techniques and interventions have been developed to facilitate DID treatment. These include imagery and hypnotic tech-

niques, approaches to transference and countertransference, cognitive techniques, etc. Further, much of the literature on therapy for complex PTSD may be helpful as well in this regard. A detailed discussion of these interventions and techniques is beyond the scope of these *Guidelines*. There are numerous excellent sources in the literature that detail aspects of the treatment of complex PTSD (cf. Briere, 1989; Chu, 1988, 1998; Courtois, 1999; Gold, 2000; Herman, 1992a; Ross, 2000, among others), and for the treatment of DID (cf. Fraser, 2003; Kluft, 1993a, 1993b, 1999; Kluft & Fine, 1993; Putnam, 1989; Rivera, 1996; Ross, 1997; Steele et al., 2005; Van der Hart et al., 1998; Watkins & Watkins, 1988, among others).

Treatment for DID is optimally provided by an individual psychotherapist. However, additional clinicians may be helpful in comprising a treatment team. Depending on individual circumstances, treatment teams may include a variety of professional disciplines including psychopharmacologists, case managers, family therapists, expressive therapists, and medical professionals. It is vital that members of the treatment team co-ordinate their treatment of the DID patient and that there is clarity about who is the clinician responsible for overall treatment management and decision-making. It is problematic when the DID patient has two or more individuals providing simultaneous intensive psychotherapy (e.g., seeing the medicating psychiatrist one hour per week and seeing the psychologist psychotherapist two hours per week for intensive therapy). Because of the DID patient's divided mental processes and amnesia, it is easy for the patient to develop relationships in which one set of alternate identities interacts with one clinician and another set with another clinician, even without confusion of treatment team roles. This can thwart the goals of more integrated functioning, and tends to externalize the patient's conflicts amongst different treatment team members.

### ***Inpatient Treatment***

The treatment structure for DID should be based on the principle that therapy optimally occurs on an outpatient basis, including processing traumatic material when necessary. This notion should be conveyed to the patient as part of the informed consent process. However, inpatient treatment may be necessary at times when patients are at risk for harming themselves or others, and/or when their posttraumatic or dissociative symptomatology is overwhelming or out of control. Inpatient treatment should occur in the context of a goal-oriented strategy de-

signed to restore patients to a stable level of function to resume outpatient treatment expeditiously. Efforts should be made to identify the factors that have destabilized or threaten to destabilize the DID patient, such as family conflicts, significant losses, etc., and to determine what must be done to ameliorate these. Emphasis should be placed on building strengths and skills to cope with the destabilizing factors.

Hospitalization may at times provide an opportunity for diagnostic clarification. In addition to elucidating trauma-related disorders, an inpatient evaluation can screen for the presence of other co-morbid condition that require immediate treatment, e.g., a major depressive episode that manifests with both depression and increased PTSD symptoms.

With current constraints imposed by third party payers, most hospitalizations are brief and only for the purpose of stabilization. However, in some cases, the structure and safety of a hospital setting make possible therapeutic work that would be impossible or prohibitively destabilizing in an outpatient setting. Inpatient treatment in programs that are conducive to treating trauma patients can include planned and judicious processing of traumatic material, and work with aggressive and self-destructive alternate identities and their behaviors, assuming that there are resources to support a more prolonged hospitalization.

Specialized inpatient units dedicated to the treatment of trauma and/or dissociative disorders may be particularly effective in helping patients develop the skills they need to become more safe and stabilized as outpatients. These programs provide a setting where patients can receive specialized diagnostic assessments, intensive individual psychotherapy, psychopharmacological interventions, and work on symptom management and skill-building that are not possible in usual general hospital psychiatric programs. To be sure, patients' participation in such programs may be limited by third party payers, due to the longer length of stay usually found in such programs. However, in some cases, insurance companies have referred refractory patients to specialized programs with the hope that costs may be reduced in the long-term by specialized interventions.

Decompensation or failure to improve during a hospitalization may occur in several circumstances. A small minority of DID patients, including massively decompensated and dysfunctional individuals, and those destabilized by severe present-day trauma, may require prolonged inpatient treatment in order to be restabilized. Treatment-related factors that may impede clinical improvement include unfocused inpatient treatment, or, conversely, inpatient treatment overly focused on trauma, e.g., with global and unrealistic goals, such as "getting out all of the

memories,” or with an extensive focus on past traumatic material to the exclusion of contemporary issues and development of symptom management skills.

In inpatient treatment, seclusion and physical or chemical restraints may be indicated for the DID patient who is acting out violently and has not responded to verbal or pharmacological interventions. However, these restrictive measures often can be avoided by careful planning in advance for symptom management and containment strategies to help in crises. These can include accessing helper alternate identities, using imagery to find a “safe place” for overwhelmed or self-destructive alternate identities, and imagery to “dial down” or otherwise attenuate strong affects. As needed medications for anxiety and/or agitation such as benzodiazepines or neuroleptics also may be helpful in reducing agitation or providing sleep to abort a crisis (see below).

The use of “voluntary” physical restraints to control a violent alternate identity while working through trauma is no longer considered an appropriate intervention.

### ***Partial Hospital or Residential Treatment***

Many partial hospital programs (PHPs) are focused on management of the psychotic or bipolar patient and may not meet the needs of the DID patient. However, despite this, the DID patient may be able to gain some assistance from PHP programs as a step-down from inpatient treatment. Programs that allow an individualized focus for the trauma survivor and that are cognizant of trauma related issues may be most helpful for this purpose.

Specialized partial hospital or residential treatment for DID patients and others with severe trauma can be very helpful as either a step-down from inpatient care, or as a more intensive outpatient modality to prevent inpatient hospitalization and/or to provide intensive skills training. In general, these specialized programs use multiple daily groups to educate about trauma related disorders, to teach symptom management skills, and to provide training in relationships and other life skills. DBT or other more formal, structured techniques for symptom management may be incorporated into these programs. Unfortunately, few of these programs exist so that patients may need to travel to a distant location to receive these services, and many insurance plans will not reimburse a residential component of the treatment that would allow the patient to attend a PHP far from home.

### **Group Therapy**

Group psychotherapy is not a viable *primary* treatment modality for DID. Also, DID patients generally do poorly in generic therapy groups made up of individuals with heterogeneous diagnoses and clinical problems. However, certain types of time-limited groups for selected patients with DID or complex PTSD, can be valuable adjuncts to individual psychotherapy. These types of groups can help educate patients about trauma and dissociation, assist in the development of specific skill sets, and help the patients understand that they are not alone in coping with dissociative symptoms and traumatic memories. In general, task-oriented, educational, and skill building groups that teach coping strategies, social skills, and symptom management techniques have proved to be most helpful. In general, these task-oriented groups should be time limited, highly structured, and clearly focused.

Some clinicians have found that many DID patients have difficulty tolerating the strong affects elicited by traditional process-oriented psychotherapy groups or those that encourage discussion, even in a limited way, of participants' traumatic experiences. Some open-ended therapy groups have resulted in symptom exacerbations and/or dysfunctional relationships among group members. However, other clinicians have reported carefully selected DID patients may benefit from longer-term, homogenous, more process-oriented groups for DID and complex PTSD patients. These groups tend to focus more on improvement of interpersonal functioning, coping with the demands of individual treatment, support during life crises, and use of the group to buttress development of affect tolerance, insight, and awareness of posttraumatic reactivity and cognitive distortions. Successful groups of this type require an explicit, firm, comprehensively articulated treatment frame with unambiguous expectations and rigorous boundaries for the participants' actions inside and outside group (e.g., limitations on detailed discussion of trauma memories in group, no socializing outside group among group members, etc.).

Some patients may make good use of 12-step groups such as AA, NA, or Al-Anon when addressing substance abuse problems. However, the therapist should caution the patient about situations that may arise in these groups that may lead to exacerbation of posttraumatic or dissociative symptoms. This may occur due to graphic discussions of trauma or violence by group participants, and/or the possibility of meeting exploitative or abusive individuals who attend these groups and to whom the DID patient may be vulnerable.

It is the consensus of DID experts that 12-step “incest survivor” groups or non-professional “self-help” groups for DID patients have resulted in extremely poor outcomes for DID patients, especially for those in the first two phases of treatment. These groups commonly result in clinical deterioration due to the unregulated discussion of trauma material, poor boundaries between group members, and the disturbed or exploitative behavior of some group members. Many experienced clinicians will refuse to continue to treat DID patients who insist on involving themselves in these types of groups.

Marathon groups of any type (i.e., longer than two hours) may prove destabilizing for some DID patients and are not recommended.

### ***Pharmacotherapy***

Psychotropic medication is not a primary treatment for dissociative processes, and specific recommendations for pharmacotherapy of most dissociative symptoms await systematic research. However, most therapists treating DID report that their patients have received medication as one element of their treatment (Putnam & Loewenstein, 1993). Clinical and research reports support the use of various medications to treat co-morbid disorders such as PTSD (particularly hyperarousal and intrusive symptoms) and coexisting affective disorders, among others (Loewenstein, 1991b). Physicians and nurse specialists who prescribe medication should make patients aware, as part of the informed consent process for psychopharmacology, that medication protocols for DID are mostly empirical in nature and designed to target specific symptoms.

Alternate identities within the DID patient may report different responses to the same medication. This may be due largely to the different levels of activation in different identities and/or to their subjective experience of separateness, rather than actual, differential biological effects of the medications on the different alternate identities. In general, medications are more effective if the targeted symptoms are reported across “the whole human being,” rather than in only one or a few identities.

Medications in DID are usually best conceptualized as “shock absorbers,” rather than as curative interventions. Partial responses are the rule with DID patients as well as in similar complex PTSD patients with multiple co-morbidities and dysphoria and despair based on multiple adverse life experiences. The goal is to find the best medication or medications at a given time that most effectively moderate the patient’s symptoms. Not uncommonly, the DID patient will report that medications work for a while, and then stop doing so. Sometimes, these medi-

cations will work again if the patient is given them at a later time. Because of the potential for partial responses to many different medications, prescribers should be alert to the potentially negative effects of polypharmacy.

Nearly all classes of psychotropic medications have been used empirically with DID patients. Most often, *antidepressant medications* are used to treat depressive symptoms and/or PTSD symptoms. PTSD and Major Depressive Disorder are common outcomes of trauma. Accordingly, they are the most frequent co-morbidities diagnosed in DID patients. Currently, the most commonly used medications for these indications are the selective serotonin re-uptake inhibitor (SSRI) antidepressants. Several of these (e.g., paroxetine [Paxil], sertraline [Zoloft]) have been found, in well-designed clinical trials, to be efficacious for patients with relatively uncomplicated PTSD. Fluoxetine (Prozac) has been reported to be helpful in treating mood and PTSD symptoms in patients with complex PTSD. Other SSRIs (e.g., citalopram [Celexa], escitalopram [Lexapro]), and non-SSRI antidepressants (e.g., venlafaxine [Effexor], bupropion [Wellbutrin]) have been found to be empirically effective in moderating depressive symptoms, PTSD symptoms, panic symptoms, and irritability in many DID patients. Antidepressants with anti-obsessive efficacy such as clomipramine (Anafranil) and fluvoxamine (Luvox) may be particularly helpful for the subgroup of DID patients with significant obsessive-compulsive symptomatology. Also, older antidepressant groups such as the monoamine oxidase inhibitors (MAOIs) and the tricyclic antidepressants (TCAs) are effective in some DID patients, but have largely been replaced by the SSRIs due to the SSRIs' more favorable side effects profile and safety.

*Anxiolytics* may be used primarily on a short-term basis to treat anxiety, but the clinician must keep in mind that the commonly used benzodiazepine medications (BZDs; lorazepam [Ativan], clonazepam [Klonopin], diazepam [Valium], chlordiazepoxide [Librium] and others) have addictive potential and that some patients with DID are vulnerable to substance abuse. Patients with PTSD may be tolerant to seemingly quite high doses of BZDs. This is thought to be due to the severe chronic hyperarousal and putative alterations in benzodiazepine receptor binding in these patients. Some DID patients can successfully be maintained on a stable long-term BZD regimen. Others may require increased dosages to overcome tolerance to the beneficial effects of the medications. However, clinicians should be aware that increasingly higher dose regimens carry the potential of diminishing benefits and higher adverse effects. Usually, in these cases, the BZDs will eventually

have to be discontinued, by a careful taper to prevent a BZD discontinuation syndrome.

Other *sedating medications* (e.g., trazodone [Desyrel], diphenhydramine [Benadryl], mirtazapine [Remeron], low dose tricyclic antidepressants, etc.) have been used for anxiety and especially for insomnia in this population. Unfortunately, DID patients commonly suffer from a complex sleep disorder including PTSD nightmares and flashbacks, sleep problems related to affective disorders, triggered fear reactions at night due to recall of reported nocturnal abuse, and the activities of the alternate identities (some of whom are nocturnal). Accordingly, sleep problems in DID are usually best addressed in the overall framework of the treatment using symptom management strategies for fearful alternate identities, negotiating sleep for the nocturnal identities, and cognitive behavioral strategies to decrease PTSD reactivity at night, along with judicious use of medications. In general, barbiturates, chloral hydrate, and similar medications should be avoided in DID patients due to their addictive qualities and lethal potential in overdose.

*Neuroleptic* or *antipsychotic medications*, particularly the newer atypical agents (e.g., risperidone [Risperdal], quetiapine [Seroquel], olanzapine [Zyprexa], ziprasidone [Geodon]), have been used to treat successfully the overactivation, thought disorganization, intrusive PTSD symptoms as well as the chronic anxiety, insomnia and irritability experienced by many DID patients. Although antipsychotic medications have also been used to treat the inner auditory hallucinatory experiences in DID, usually these “hallucinations” are unaffected by even high dose neuroleptics. In a few cases, they may be decreased or somewhat quieted; but they do not disappear. In rare cases individuals with DID have true comorbid psychotic symptoms that are responsive to antipsychotic medication (for example, the patient can distinguish the “inside voices” of the alternate identities that are medication non-responsive from the “outside” psychotic voices that do respond to neuroleptics).

Neuroleptics have many side effects, most prominently significant weight gain has been reported in several of the newer agents (e.g., olanzapine [Zyprexa]). Weight gain is often very problematic for DID patients and can cause glucose intolerance and other significant metabolic side effects. Accordingly, careful monitoring by the psychiatrist, often including metabolic testing, is mandatory if the patient is receiving these medicines. Some extremely ill DID patients have responded well to clozapine (Clozaril) for severe PTSD symptoms and chronic thought disturbance. The latter manifests itself with refractory, often bizarre or severely concrete, cognitive distortions. Other atypical

symptoms, more characteristic of chronically psychotic patients, like mistrust bordering on true paranoia, may be found in these patients as well. The patient on clozapine must be able to obtain weekly blood tests to monitor the blood count for agranulocytosis (disappearance of the body's white blood cells).

*Mood stabilizers* are medications that specifically target mood swings in bipolar patients. Many mood stabilizers are anticonvulsants that have also been used in open label studies in PTSD. Because many DID patients suffer from rapid mood swings, psychiatrists frequently diagnose them with rapid-cycling bipolar disorder or Type II bipolar disorder. However, a careful history usually shows that the mood swings are actually due to PTSD intrusions and/or the switching of alternate identities or interference by alternate identities. There is no evidence that bipolar disorder is more common among DID patients than in the general population. Accordingly, only a small minority of DID patients derive benefit for mood swings from these medications. However, some patients describe a moderation in PTSD symptoms, anxiety and mood instability on anticonvulsant mood stabilizers such as valproate (Depakote), lamotrigine (Lamictal), carbamazepine (Tegretol), oxcarbazepine (Trileptal), gabapentin (Neurontin), or topiramate (Topomax). To be sure, DID patients with true intercurrent bipolar disorder often will receive benefit from appropriate mood stabilizing medications.

*Other medications* used to treat DID patients include naltrexone, an opiate antagonist that may have some efficacy in decreasing the pressure for self-mutilation or other self-destructive and self stimulatory behaviors, especially if the patient reports a "high" from self harm. Some patients have responded to centrally active beta blockers such as propranolol (Inderal) for PTSD hyperarousal and panic. Clonidine (Catapres), a centrally acting alpha agonist whose primary indication is as an antihypertensive medication, has been used to treat PTSD and may be effective for hyperarousal and intrusive PTSD symptoms including nightmares in some DID patients. Prazosin (Minipress), another antihypertensive medication, has been reported to be helpful for PTSD nightmares in a study of combat veterans.

Hospitalized DID patients experiencing acute anxiety, agitation, intrusive PTSD symptoms, chaotic switching and/or urges to harm themselves or others may respond to "prn" (as needed) oral or intramuscular benzodiazepines (primarily lorazepam) and/or oral or intramuscular neuroleptics. Either typical or atypical neuroleptics may be given for this indication. Typical neuroleptics used for acute agitation in inpatient DID patients include haloperidol (Haldol), fluphenazine (Prolixin), and

others. Intramuscular ziprasidone (Geodon) and sublingual olanzapine (Zyprexa) may also be useful for this indication. Administration of ziprasidone should not be commenced without a screening electrocardiogram (ECG) to rule out a prolonged QT interval that may predispose to lethal arrhythmias that can occur when ziprasidone is administered. Droperidol (Inapsine) is also useful for acute agitation in hospitalized DID patients. However, it can only be given with cardiac monitoring due to reports of fatal arrhythmias with its administration. Thus, it is usually impractical to use droperidol routinely any longer in most inpatient settings.

Unfortunately, systematic research on medications for DID does not exist and most studies of pharmacotherapy for PTSD have not been performed on female survivors of repeated childhood maltreatment and adversity. Until that time, the pharmacological treatment for DID will remain almost entirely empirical and based on clinical experience.

### ***Medical and Somatoform Co-Morbidity in DID***

Recent studies suggest high rates of a variety of medical problems in individuals who report adverse childhood experiences such as maltreatment and parental mental illness, substance abuse, suicide, and similar problems (cf. Felitti et al., 1998, Schnurr & Green, 2003). In these studies there was a “graded relationship” between adverse childhood experiences and adult diseases including cancer, ischemic heart disease, chronic lung disease, liver disease, and fractures. Multiple exposures to adverse life events in childhood predicted multiple health risk factors in adulthood.

In addition, these, and other studies, have shown higher rates of high-risk sexual behaviors, adolescent pregnancy, sexually transmitted diseases, obesity (including morbid obesity), earlier smoking, pelvic inflammatory disease, alcohol and drug abuse, and abnormal PAP smears in association with childhood maltreatment. Further, childhood maltreatment may be associated with a variety of direct medical consequences of physically traumatic abuse such as orthopedic problems, head trauma, seizure disorders, sexually transmitted diseases, and urogenital and rectal pathology, among others. Neglect may lead to problems with growth and development, hearing and vision problems, failure to obtain immunizations and vaccinations, dental problems, and other difficulties (Salmon & Calderbank, 1996; Springs & Friedrich, 1992).

Further, a history of childhood sexual abuse is commonly associated with several medical disorders including gastro-esophageal reflux dis-

ease (GERD), irritable bowel syndrome (IBS), chronic pelvic pain, headache and other chronic pain syndromes, fibromyalgia, and morbid obesity (Scarcini, McDonald-Haile, Bradley, & Richter, 1994; Walker, Katon, Neraas, Jemelka, & Massoth, 1992; Walker, Katon, Roy-Byrne, Jemelka, & Russo, 1993).

Although these medical and related problems have not been systematically studied in DID, Guidelines Task Force Members have commonly encountered these conditions in DID patients.

### *Somatization and Somatoform Disorders*

Somatoform disorders and dissociative disorders have been historically linked through the concept of hysteria. Until the DSM-III, somatoform and dissociative conditions were conceptualized as having similar underlying processes or mechanisms. The DSM-III made a heuristic decision to place somatoform and dissociative disorders in separate categories. The ICD-9, however, has continued to conceptualize these disorders as sharing an underlying relationship. Recent research has found high rates of somatization and somatoform disorders in DID patients and high rates of childhood maltreatment, particularly sexual abuse, in patients with somatization disorder (Briquet's Syndrome), somatoform pain disorder, hypochondriasis, and conversion disorder, particularly pseudoseizures (Barsky, Wool, Barnett, & Cleary, 1994; Bowman & Markand, 1996; Goodwin & Attias, 1999; Loewenstein, 1990; Loewenstein & Goodwin, 1999; McCauley et al., 1997; Morrison, 1989; Sar, Akyuz, Kundakci, Kiziltan, & Dogan, 2004; Saxe et al., 1994).

In addition, recent research has described in detail the symptoms of somatoform dissociation (Nijenhuis, 1999). A well-validated psychometric measure, the Somatoform Dissociation Questionnaire (SDQ), has been developed and used in a variety of research studies (see above). One study of 148 DID patients found an average of 15.72 somatic symptoms per patient (Loewenstein, 2002). Common somatoform symptoms in DID patients include abdominal pain, pelvic pain, joint pain, face and head pain, lump in the throat, back pain, pseudo-seizures, and pseudo-asthma, among others.

### *Psychophysiological Differences Among Alternate Identities*

There is a long history of reports of psychophysiological differences between the alternate identities in DID. Case reports include markedly different handwritings, variable visual acuity, medications responses,

allergies, plasma glucose levels in diabetic patients, heart rate, blood pressure readings, differential EEG patterns, neural network patterns on functional magnetic resonance imagery (fMRI), and differences in brain activation and regional blood flow using single positron emission computed tomography (SPECT), among others (Loewenstein & Putnam, 2004, Putnam, 1984, 1991b; Sar, Unal, Kiziltan, Kundakci, & Ozturk, 2001). Systematic studies using small groups of DID patients and controls who simulate different personality states have found significant differences in DID subjects compared to controls. These include significantly greater variation in visual evoked potential patterns, 16-lead EEG, galvanic skin response, muscle tension, laterality, immune function, fMRI activation, and visual acuity and related ophthalmological variables. In general, these studies have found relatively subtle, but salient, differences between DID patients and controls. Overall, DID patients, as a group, show greater *variability* on psychophysiological variables compared to controls, rather than the kinds of reproducible differences found between different individuals.

The implications of these findings for treatment of DID have not been systematically explored, although clinicians have reported changes and greater stability in glucose control in DID patients achieving final fusion. (Kluft, 1986a) They do suggest, however, that DID patients may offer important insights into brain, mind, body relationships that should form the basis for important future systematic research.

### *Treatment Considerations*

Clinicians treating DID may be faced with both sides of the medical/somatization problem. DID patients may seek out medical care for some of their problems, but ignore many other serious medical issues. On the one hand, DID patients may utilize health resources at a higher rate than the general population, yet other patients may be phobic of seeking any medical care at all. Somatoform elaboration may be superimposed on medical illness. DID patients may have an uncanny ability to produce realistic conversion symptoms that mimic serious medical problems including seizures, severe headaches, neurological problems, breathing difficulties, etc. Occasionally, family practice or internal medicine physicians may ask mental health professionals for consultation because a DID patient presents with extensive somatization, or problems such as widely fluctuating blood pressure or glucose intolerance, apparently related to switching among alters with different physiological profiles.

DID patients may be preoccupied with somatoform pain syndromes and take high doses of narcotic analgesics with limited response. On the other hand, other DID patients may be able to dissociate pain for long periods of time, thus delaying seeking medical care until severe complications have occurred, even metastatic cancer that might have been prevented if medical care had been sought earlier.

These *Guidelines* cannot explicate all the complex issues that need to be addressed in evaluating and treating the somatic problems of the DID patient (see Goodwin and Attias, 1999). In brief, the treating clinician must educate the patient about reasonable health care and be an advocate for the patient to seek out appropriate medical care. The treating psychiatrist often has a role in the interface with the medical care community to help the patient get needed services but to help rein in the pressure for more and more tests or interventions when there is no clear-cut major new problem.

Education about somatoform symptoms in a supportive and respectful way, emphasizing the impact of trauma on the perception of the body, may help the patient more readily accept the idea of somatization, rather than eliciting the response, "You say it's all in my mind!" This can help reduce unnecessary health care utilization and encourage appropriate utilization. The treating clinician and the patient must both respect the ambiguity of the mind/body situation in attempting to evaluate bodily symptoms.

Education about medical care, work on cognitive distortions, and PTSD related to medical care may be helpful in the patient being able to tolerate necessary medical procedures and to follow medical recommendations. The therapist also may need to educate medical personnel about dissociation and help them anticipate any difficulties that might occur during the procedure or treatment. Careful preparation is especially important for any intervention that is intrusive, especially interventions involving anesthesia and/or surgery. The therapist may need to work with alternate identities who deny "the body," or who state they live in a different body, or that their body is a different chronological age, etc., in order to help the patient accept appropriate care. Assistance to alternate identities' severe somatoform flashbacks ("body memories") can reduce inappropriate treatment for somatoform symptoms.

### ***Hypnosis as a Facilitator of Psychotherapy***

Hypnosis has been used to assist the treatment of DID since the early 19th century (Ellenberger, 1970). There is a wide literature concerning

the use of hypnosis and DID (cf. Kluft, 1982, 1989; Ross & Norton, 1989b). Hypnosis is a facilitator of treatment, not a treatment in and of itself. Clinicians should always be adequately trained in any adjunctive modalities-especially hypnosis-that they are using in the treatment of a particular patient. Further, clinicians using hypnosis in the treatment of trauma and dissociation should receive specialized training in using hypnotic interventions with this patient population. In addition, clinicians should be aware of current controversies concerning the use of hypnosis in trauma treatment, memory recall during trauma treatment, and in the etiology of DID (Brown, Schefflin, & Hammond, 1998).

It has been shown repeatedly in both clinical studies and studies using standardized measures that DID patients consistently show the highest hypnotizability when compared with all other clinical groups (schizophrenics, bulimics, borderline personality disorder patients, PTSD patients, and others) as well as normal controls (Frischholz, Lipman, Braun, & Sachs, 1992). Accordingly, many hypnotic techniques have been developed to assist with DID treatment. DID experts generally agree that hypnotic techniques can be useful both in session and between sessions if patients are taught autohypnosis.

Since, as a group, DID patients are highly hypnotizable, many techniques developed for use with hypnosis can be used without the formal induction of trance utilizing patients' autohypnotic abilities. Hypnotic techniques can be used for ego-strengthening, symptom exploration and relief, anxiety relief, accessing alternate identities and restoring adult identities when immature or dysfunctional identities are in control at a session's end, containment of flashbacks, containment and control of both spontaneous and facilitated expressions of strong feelings and abreactions, stabilizing the patient or particular identities between sessions, exploration and relief of painful somatic expressions of traumatic materials, restabilizing and restoring mastery, cognitive rehearsal and skill building, facilitating communication within the alternate identity system, and in fusion rituals.

In the hospital, staff can be trained to assist with an agitated, overwhelmed, self-destructive, and/or violent DID patient by means of "temporizing techniques" such as imagery for calming, grounding, and/or containment of symptoms. However, staff members should not use formal hypnosis per se unless credentialed to do so by the hospital (Kluft, 1992). When these techniques are employed, the patient is generally informed beforehand and the intervention becomes part of the nursing treatment plan.

There is a range of opinions concerning the role of hypnosis in the ongoing psychotherapy of DID. Some clinicians discourage its use because they prefer alternative techniques, and others are concerned that the use of hypnosis may encourage the patient to report material consistent with perceived suggestions that may not be consistent with historical reality. Some experts point to the long history of the success of DID treatments that have employed interventions facilitated with hypnosis. They maintain that some form of hypnosis inevitably takes place in therapeutic work with this highly hypnotizable group of patients.

There is little controversy about the use of hypnosis for supportive and ego strengthening interventions, resolving crisis, stabilization, and promoting integration. Hypnosis may also be used to provide a relaxed state and to better facilitate modulation and titration of affect while working on already recalled traumatic memories in Phase 2 therapy (e.g., placing traumatic images on a mental “screen” to see them at more of a distance, etc.). The impact of using these techniques on memory material itself has not been studied and it is unclear to what extent, if any, these hypnotic techniques influence the patient’s recall (Brown, Schefflin, & Hammond, 1998).

Some consider the use of hypnosis to access alternate identities controversial (e.g., requesting identities to make themselves available, promoting inner dialogues, the use of Fraser’s [2003] “Dissociative Table” and allied techniques). More controversy surrounds the use of hypnotically facilitated techniques to explore areas of amnesia, or to further explore fragmentary images or recollections. Some authorities who support hypnosis for these indications point to the recovery of material that has been confirmed at a later date or to the therapeutic progress often achieved irrespective of the veracity of what is found. Others believe that use of these methods carries the risk that hypnotically facilitated memory processing will increase the patient’s chances of mislabeling fantasy as real memory. They believe that these are strong disincentives to this use of hypnotic exploration.

In addition to being highly hypnotizable, some DID patients may be highly “fantasy-prone” (Lynn, Rhue, & Green, 1988), although preliminary studies suggest that most DID patients are only moderately fantasy prone (Williams, Loewenstein, & Gleaves, 2004). Nonetheless, there is concern that some DID patients are vulnerable to confuse fantasy and authentic memory whether or not hypnosis is induced. Thus, therapists who do use hypnosis in an exploratory manner should minimize the use of leading questions and avoid hints and pressures that may, in some cases, alter the details of what is recalled in hypnosis. Hypnosis may

also leave patients with an unwarranted level of confidence in what has been recalled in hypnotic states. However, there is evidence that specific informed consent concerning this latter issue may result in the patient not showing this undue confidence in memories newly retrieved under hypnotic conditions (see Cardeña et al., 2000). Brown, Schefflin & Hammond (1998) provide an extensive discussion of indications, contraindications and the potential risks and benefits of increasingly intrusive methods, ranging from free recall to hypnotically facilitated interventions, for overcoming amnesia in traumatized patients.

As with any other specialized technique, the therapeutic use of hypnosis should be conducted with appropriate informed consent provided to the patient concerning its possible benefits, risks, limitations, and current controversies concerning hypnosis and delayed recall of trauma as well as for the use of hypnosis for the diagnosis and treatment of DID and other trauma disorders. Informed consent should include possible limitations on the permissibility of testimony in legal settings concerning recollections obtained under hypnosis based on the statutes and judicial rulings of the jurisdiction in which the therapist practices (American Society of Clinical Hypnosis, 1994).

### ***Eye Movement Desensitization and Reprocessing (EMDR)***

Controversy exists concerning the application of EMDR to the treatment of DID. There is empirical support for EMDR as an efficacious treatment for single-event PTSD, but there are little data on the efficacy of EMDR for complex PTSD and dissociative disorders. Both proponents and critics of EMDR agree that additional research is needed to resolve questions about EMDR's mechanism of action (Chemtob, Tolin, Van der Kolk, & Pitman, 2000). Based on research studies, some Task Force members have suggested that the beneficial effects of EMDR may come from the more careful attention to treatment structure, cognitive-behavioral interventions, and phase oriented planning for work on trauma as part of EMDR protocols, not the eye movements and related techniques.

Major clinical problems have occurred when EMDR has been used without modification with DID patients, or when DID has emerged unexpectedly during EMDR treatment. These have included florid decompensation with self-destructive behavior, marked increases in intrusive PTSD symptoms, and emotional flooding, sometimes resulting in hospitalization.

Some Task Force members are more supportive of EMDR. They note that there are clinical reports that modified EMDR can be helpful as a limited adjunctive technique in the treatment of DID (Fine & Berkowitz, 2001; Lazrove & Fine, 1996; Paulsen, 1995; Shapiro, 1995, 2001; Twombly, 2000). Gelinas (2003) has written the most comprehensive review suggesting an integrated approach combining modified EMDR with phase oriented trauma treatment in complex PTSD. Gelinas notes that combining EMDR with the treatment of DID requires a solid understanding of phase oriented trauma treatment as well as a good understanding of DID treatment and work with alternate identities. EMDR proponents also insist that practitioners treating DID patients must take both parts of the EMDR training course, and obtain subsequent consultation regarding its use in complex PTSD and DID until they are experienced in utilizing EMDR with these populations.

The use of modified EMDR in a phase-oriented trauma treatment for DID implies an understanding of how to structure the treatment to protect the patient's overall stability while doing specific work on particular traumata, an approach described by Fine (1991, 1993) who was chair of an ISSD work group on the use of EMDR for DID.

In addition, practitioners wishing to use EMDR with DID should be well acquainted with current controversies about its use, and give appropriate education and informed consent to patients concerning potential risks and benefits of this modality of treatment.

### ***Expressive and Rehabilitation Adjunctive Treatments***

Expressive and rehabilitation therapies may be very helpful to DID patients, as they are often uniquely responsive to nonverbal approaches. Modalities such as art therapy, music therapy, movement therapy, psychodrama, occupational therapy, recreational therapy, and horticultural therapy provide the patient with an alternative expressive format through which they may safely communicate underlying thoughts and feelings. The nonverbal process and products (artwork, musical expression, movement sequence etc.) can serve as a visual record of the experiences of the internal system of alternate identities, and may be examined at any point in treatment. They can provide vital information about past traumatic experiences, current triggers and stressors, safety issues, and coping strategies. At times, this information can be provided nonverbally at a point in treatment long before it can be verbally accessed. In addition, verbal discussion of the nonverbal work can facilitate a variety of treatment goals. In conjunction with verbal associations, non-

verbal psychotherapy approaches bridge the gap between the patient's inner and outer worlds.

Nonverbal therapeutic techniques may improve concentration, reality based thinking, internal organization, problem solving skills, and use of grounding and containment techniques. Additional goals may include improving internal communication and cooperation amongst alternate identities, fostering insight, sublimating rage, working through traumatic experiences, and assisting with fusion and integration. Expressive therapies can be used to facilitate goals of all three phases of trauma treatment. Many psychotherapists find the productions of nonverbal modalities (such as patients' drawings and journals) useful as part of ongoing psychotherapy.

Through the provision of structured, reality based activities and interactive experiences, the patient's level of functioning can be assessed, including the ability to execute tasks in a consistent and age appropriate manner. Occupational therapy assessments may help acquire data about how daily living is impaired by symptoms. Personal hygiene, meal preparation, money management, work, school, leisure/unstructured time, and social life all may be affected adversely by DID and PTSD.

Individual art therapy may be helpful for inpatients and outpatients at various points in treatment. Studies of art therapy in DID have led to the development of the Diagnostic Drawing Series (DDS), a standardized art assessment method that can be helpful in the differential diagnosis of DID (Cohen, Mills, & Kijak, 1994).

The lack of availability and cost of adjunctive therapies may make it difficult to provide many of these treatments outside of a hospital setting. However, art, movement, and occupational therapy in a group format have been conducted successfully in outpatient settings and may be a cost-effective alternative to individual expressive therapy.

Expressive/Rehabilitation therapists are typically licensed masters or doctoral level clinicians, and are board certified in their respective fields. Although clinicians occasionally may ask DID patients to create artwork as part of therapy assignments, the formal use of expressive/rehabilitation therapies must only be practiced by clinicians with appropriate training and certification.

The primary clinician of the DID patient has primary responsibility for the treatment and should work closely with all adjunctive therapists to assure coordination of care. Open releases of information should be maintained in order to allow ongoing communication and coordination on an as-needed basis.

### ***Electroconvulsive Therapy***

ECT has not been shown to be an effective or appropriate treatment for dissociative disorders, but it may be important in relieving an associated refractory depression. Only one case series involving ECT with dissociative disorder patients has been reported (Bowman & Coons, 1992). Three patients with Dissociative Disorder, NOS and severe treatment-resistant depression were successfully treated with ECT with marked improvement in depressive symptoms and minimal side effects. Dissociative symptoms as measured by the DES were not changed. The patients in this study were more able to use psychotherapy for their dissociative disorder after ECT.

On the other hand, many DID patients have had ECT before the diagnosis of DID while being unsuccessfully treated for apparent refractory mood disorders, and before the posttraumatic nature of the mood problems was recognized. In these cases, the ECT was almost always reported to be unhelpful, often resulting in memory loss and other disturbing side effects without clinical benefit. A small, severely ill subgroup of DID patients actually will seek out ECT because of its propensity to wipe out memories for a period of time.

However, a sub-group of DID patients in appropriately structured treatment for DID, with a distinct, persistent worsening of mood symptoms accompanied by significant psychomotor retardation and other vegetative symptoms different from the patient's usual baseline, may respond to ECT after other antidepressant strategies have failed.

Patients should be carefully prepared prior to ECT as should be done in the case of any interventions requiring anesthesia and/or surgery. Specific informed consent for ECT should be obtained by the treating psychiatrist.

### ***Pharmacologically-Facilitated Interviews***

Before the development of clinical and psychometric assessment tools, hypnotic and/or pharmacologically-facilitated interviews-most commonly using amobarbital (Amytal)-were used to aid in diagnosis of DID. Due to the current academic and forensic controversies surrounding dissociative disorders and trauma memory, it is prudent to reserve these interventions for emergency situations when other methods of assessment have failed, e.g., in a hospitalized patient who is engaging in high risk behavior in dissociated states, but who has been refractory to other methods of inquiry, including hypnosis. These interventions should

optimally be conducted by a clinician experienced in their use and in the differential diagnosis of dissociative disorders. Clear informed consent should be obtained for use of these interventions for the diagnosis of DID and recall of traumatic experiences.

Occasionally, pharmacologically facilitated interviews have been used to assist DID patients in accessing to alternate identities or to allow emergence of traumatic material that otherwise cannot be recalled. No systematic modern data exists on the fallibility or accuracy of what is recalled in such interviews, although amobarbital was widely used in World War II to facilitate recall of traumatic memories in soldiers with combat-related amnesia. Studies from the 1940s and 1950s showed that patients can dissemble and confabulate while under the influence of amobarbital and similar agents (Henderson & Moore, 1944; Redlich, Ravitz, & Dession, 1951). Given the current controversies, the clinician should give a similar informed consent regarding the nature of memory to the patient contemplating a drug-facilitated interview for amnesia symptoms as is given to the patient considering hypnosis. The clinician should emphasize that these drugs are not a “truth serum,” and that whatever apparently new information emerges under the drug condition should be regarded no differently with respect to accuracy than any other material that emerges in the course of treatment.

Side effects of amobarbital and similar drugs can include respiratory depression, sedation, hypotension, incoordination, and allergic reactions. Accordingly, these procedures should only be done in a medical facility where monitoring and resuscitation equipment is available. Due to the many complexities and problems associated with these procedures, they are currently rarely performed in the diagnosis and treatment of DID.

### ***Psychosurgery***

There is no evidence to support the use of psychosurgery in the treatment of DID.

## ***SPECIAL TREATMENT ISSUES***

### ***Informed Consent***

Clinicians should be aware of the general issues of informed consent for psychological and psychiatric treatment and for DID treatment in

particular. Therapists should obtain informed consent in a manner consistent with prevailing standards of care (Brown et al., 1997; Courtois, 1999; Gutheil & Applebaum, 2000), and should consider specific additional informed consent procedures for adjunctive treatment modalities such as hypnosis or EMDR.

Further, clinicians should educate themselves about the specific issues that have become of heightened concern due to recent controversies around trauma treatment. In particular, these relate to several areas: the traumatic versus “sociocognitive” etiology of DID, the debate over the existence of delayed recall for traumatic experiences, the possibility that therapy can produce confabulated “memories” of events that have not occurred, and regression in treatment. Even properly conducted treatment of DID can cause temporary regressions while patients are adjusting to recollections of trauma and the accompanying emotions. Experienced therapists attempt to limit the duration and severity of these temporary regressions and inform patients of this possibility before addressing recollected trauma. Clinicians should acquaint themselves with the issues and controversies about these matters and give a balanced view of them to patients initiating treatment for DID. There is some evidence that this sort of informed consent and education of patients can help patients evaluate memories that emerge during treatment (Cardeña et al., 2000). Each state, province, or nation has its own definitions and criteria for the adequacy of informed consent, and clinicians must inform themselves about the conditions in their locality.

### ***Boundary Issues in the Psychotherapy of DID***

Victims of child abuse or neglect—such as persons with DID—have often grown up in situations where personal boundaries were not established and were invaded. In the therapy of such persons, there is a significant potential for reenactments of boundary violations. Accordingly, therapists must be very prudent, cautious, and thoughtful about the issue of boundaries. The therapist must foster a therapeutic relationship with clear boundaries. The therapist is responsible for clearly defining such a therapeutic relationship. Transference and countertransference responses with trauma patients, especially those with DID, are complex and must be meticulously managed. In general, sudden or impulsive changes in boundaries or treatment frame should be avoided in DID treatment. Consultation can often be helpful in managing clinical dilemmas concerning boundaries. A fuller discussion of these issues can be found elsewhere (see Dalenberg, 2000; Davies & Frawley, 1994;

Loewenstein, 1993; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994).

Boundary issues arise throughout treatment of DID, with negotiation and discussion of these issues occurring as needed. Requests from DID patients to extend or alter the boundaries in therapy are very common. Therapists need to carefully evaluate such requests before making any changes to the usual and customary boundaries of treatment. Most experts agree that the patient needs a clear statement near the beginning of treatment concerning therapeutic boundaries. This statement may not always be understood immediately by the patient, may take several sessions to convey, and frequently may require repetition at various points in the therapy. The discussion concerning therapeutic boundaries might include some or all of the following issues: length and time of sessions, fee and payment arrangements, the use of health insurance, confidentiality and its limits, therapist availability between sessions, procedure if hospitalization is necessary, patient charts and who has access to them, the use (or nonuse) of physical contact with the therapist, involvement of the patient's family or significant others in the treatment, discussion of the therapist's expectations concerning management by the patient of self-destructive behavior, legal ramifications of the use of hypnosis as part of the treatment (i.e., persons who have been hypnotized may be deemed to have an entirely contaminated memory and unable to testify on their own behalf), among others. A fuller discussion of these issues can be found elsewhere (Chu, 1998; Courtois, 1999).

The subsequent sections describe specific areas related to the boundaries of treatment of the DID patient. Although some of the discussion of therapist practices may seem bizarre or absurd, experienced clinicians have found many cases where the kinds of boundary problems described in the subsequent sections have occurred. The DID patient may experience an intense pressure for certain changes in the boundaries or treatment frame, and repeatedly request them from the therapist or indirectly pressure the therapist to make these changes. Experienced clinicians often use these situations as opportunities to explore important clinical material without altering the treatment structure. These may include unconscious urges to reenact earlier boundary violations with significant others, conflicts among alternate identities wishing to "test" the therapist, and a cognitive mind set that everyone is untrustworthy about boundaries in some way, so it is best to "get it over with" quickly (i.e., the betrayal of the patient by the therapist), among others. However, clinicians new to DID treatment may find themselves changing the bound-

aries in a misguided attempt to repair the woes of the DID patient that seem difficult to help with more usual therapeutic approaches.

Treatment should ordinarily take place in the therapist's office. It is not appropriate for a patient to stay in the therapist's home or for members of the therapist's family to have ongoing relationships with the patient. Treatment usually occurs face to face instead of on the analytic couch, though the latter is also acceptable in selected patients for therapists with psychoanalytic training. Treatment should ordinarily take place at predictable times, with a predetermined session length under most circumstances. Clinicians should generally strive to end each session at the planned time. Therapists need to follow relevant legal and ethical codes with respect to gifts exchanged between therapists and patients, dual relationships, and informed consent for treatment. Further, clinicians should rigorously follow relevant legal and ethical guidelines concerning disclosure of fees, payment arrangements, barter, and collections procedures.

A personal relationship of any kind with the DID patient some time after the conclusion of treatment is not recommended, even if this is allowed by the ethical codes of the professional organization of which the therapist is a member and not prohibited by local laws.

### *Crisis Management*

Because many DID patients are prone to crises at certain points in treatment, patients need a clear statement about the therapists' or other clinicians' (such as crisis intervention workers) availability in emergencies. Generally, offering regular, unlimited telephone contact is not helpful and may even be regressive. However, providing limited availability to the patient on a predefined basis at times may be essential. Except under unusual or emergency circumstances, calls from the therapist that are not either in response to a patient request or preplanned interventions are not recommended. The payment policy for telephone contact should be discussed with the patient in advance wherever possible. Although extra sessions are sometimes needed, when the patient frequently requests or requires the scheduling of extra sessions because of crises, the therapist needs to evaluate the structure of treatment to assess the patient's stability and whether the patient perceives the scheduled frequency of sessions to be adequate for his/her needs. DID patients frequently have the belief that they must show the therapist in actions how distressed and overwhelmed they are, lest the therapist not believe or understand them. This can lead to a state of almost continual crisis until

this issue is better clarified. At other times the patient may be unconsciously seeking to avoid taking responsibility for symptom management or life changes. In other DID patients, more classical dependent transference needs are being expressed. Repeated crises may also reflect the patient's inability at a given time to function outside a more restrictive level of care such as an inpatient, residential or partial hospital setting. As in most predicaments in DID treatment, the therapist should discuss the issues in depth with the patient, using the framework of the patient's alternate identity system in order to carefully assess the situation and make appropriate treatment decisions.

Some patients will paradoxically attempt to avoid treatment during crises, or avoid obviously needed emergency contact with the clinician, usually on a posttraumatic or traumatic transference basis (e.g., refusing to make an emergency call when acutely preoccupied with a sudden increase in suicidal ideation after a major loss). At these, and at other times when the patient is acutely dangerous to self or others and refusing appropriate increased levels of care, emergency interventions involving the police, the patient's family, or others may be necessary to involuntarily hospitalize the patient, following local laws. In addition, the clinician should psychotherapeutically address the patient's difficulties in seeking appropriate help at times of crisis and at other times.

### *Physical Contact with the Patient*

Physical contact with a patient is generally not recommended as a treatment "technique." Therapists generally need to explore the meanings of a patient's requests for hugs or hand holding, for example, rather than reflexively fulfilling these requests. "Reparenting" techniques such as sustained holding, simulated breast feeding or bottle feeding, etc. are clinically inappropriate and unduly regressive behaviors that have no role in the psychotherapy of DID. Some therapists feel that limited physical contact may be appropriate when a patient is feeling highly distressed or is overwhelmed, such as when the patient is intensely re-living a very disturbing traumatic experience as part of Phase 2 therapy. If previously and specifically discussed with the patient—that is, by full exploration with the whole alternate identity system—limited physical contact, such as briefly holding the patient's hand or resting a hand on the patient's arm, may help the patient stay connected to present-day reality. However, other therapists feel that such contact should be avoided because patients may misinterpret its intent or meaning based on intense posttraumatic reactivity.

Some patients may seek out massage therapy or other types of “body work”; the risks and timing of such treatments should be carefully discussed with the patient and the adjunctive therapist. Some DID patients have found these interventions helpful, generally when the massage therapist is knowledgeable about trauma issues and careful about personal boundaries. Others have experienced severe intrusive PTSD symptoms, switching, and disorientation when being touched during massage or physical therapy. Because of this, before the patient undertakes massage or related therapies, full discussion of the risks and benefits should be undertaken considering the impact on the entire alternate identity system. The primary therapist may need to coordinate directly with the massage therapist to assure that the proposed treatment is appropriate and safe for the DID patient.

Sexual contact with a current patient is never appropriate or ethical. Laws and ethical standards of the various healthcare disciplines regulate such contact with a past patient. Because DID patients have a relatively high vulnerability to exploitation and because of the intensity of the therapeutic interactions in DID treatment, any sexual contact by a therapist with his or her former DID patient is exploitive and inappropriate.

### ***Validity of Patients’ Memories of Child Abuse***

Frequently, DID patients describe a history of abuse, often including sexual abuse, beginning in childhood. Many DID patients enter therapy having continuous memory for some abusive experiences in childhood. In addition, most also recover memories of additional previously unrecalled abusive events and/or additional details of partially recalled memories, with recovery of material occurring both inside and outside of therapy sessions. Frequently, delayed recall of trauma precedes or precipitates the patient’s entry into psychotherapy (Chu, Frey, Ganzel, & Matthews, 1999). Delayed memories can often be corroborated and are no more likely to be confabulated than memories always recalled (Dalenberg, 1996; Kluft, 1995, 1997; Lewis, Yeager, Swica, Pincus, & Lewis, 1997). Discussion of this material and its relationship to present beliefs and behaviors is a central aspect of the treatment of DID.

A number of professional societies have issued statements concerning recovered memories of abuse (American Psychiatric Association, 1993, 2000b; Australian Psychological Association, 1994; British Psychological Society, 1995). These statements all concluded that it is possible for accurate memories of abuse to have been forgotten for a long

time, only to be remembered much later in life. They also indicate that it is possible that some people may construct pseudomemories of abuse and that therapists cannot know the extent to which someone's memories are accurate in the absence of external corroboration, notwithstanding how difficult it may be to obtain any type of corroboration for a specific traumatic memory from childhood. DID patients' recall of child abuse experiences, as well as their recall of other experiences, may at times mix recollections of actual events with fantasy, confabulated details, or condensations of several events. Comprehensive discussion about the controversy around these issues can be found elsewhere (Brown, Schefflin, & Hammond, 1998; Courtois, 1999; Dallam, 2002; Freyd, 1996; Pope, 1996).

Therapy does not benefit either from clinicians automatically telling patients that their memories must be false or that they are accurate and must be believed. The therapist is not an investigator, and should not become involved in attempting to prove or disprove the patient's trauma history. A respectful neutral stance on the therapist's part, combined with great care to avoid suggestive and leading interview techniques, along with ongoing discussion about the nature of memory seems to allow patients the greatest freedom to evaluate the veracity of their own memories.

Although therapists are not responsible for determining the veracity of patients' memories, it may be therapeutic, at times, to communicate their professional opinion (Van der Hart & Nijenhuis, 1999). For example, if a patient has developed a well-considered belief that his or her memories are authentic, the therapist can support this belief if it appears credible and consistent with the patient's history and clinical presentation. Conversely, if the therapist has developed a well-considered and strong belief that the patient's memories are false, it may be important to voice this stance, and to provide education to the patient, e.g., concerning the vagaries of memory and recall, the presence of delusional thinking, etc. Discussion of therapists' beliefs should take into consideration the phase of therapy and the rapport with the patient. The therapists' beliefs should not be shared with patients in a manner or at a time that forecloses discussion, and does not respect the patient's potentially differing belief.

In general, DID patients often are conflicted and unsure about their memories, with different alternate identities taking different points of view. Accordingly, it is most helpful for the therapist to help the alternate identities explore these conflicts and differing viewpoints rather than side with any one of them. The therapist can help educate the pa-

tient about the nature of autobiographical memory (e.g., that it is generally considered reconstructive, not photographic), and about factors that can confuse memory and how these might impact a given memory report. The therapist should foster a therapeutic atmosphere that enjoins premature closure about the memory material, assuring that it can always be reviewed again at a later time, for example, after a number of fusions have changed the patient's level of dissociative symptoms and orientation to reality.

### ***“Ritual” Abuse***

There is divergence of opinion in the field concerning the origins of patients' reports of seemingly bizarre abuse experiences such as involvement in organized occultist “ritual” abuse and covert government sponsored mind control experiments. Some clinicians believe that patients' reports of such occurrences can be rooted in extremely sadistic events of organized abuse experienced by these patients in childhood and/or later in life. They believe that such abuse experiences may be part of a larger pattern of organized crime that sometimes includes child pornography, child and adult prostitution, and trafficking in women and drugs. These clinicians have sometimes observed that some of these patients are still enmeshed in such networks at the beginning of therapy, and the alternate identities that present for treatment may have total amnesia for the fact that the abuse is still continuing. Although these clinicians accept the possibility that these reports can be accurate, they also acknowledge that some accounts may contain inaccuracies, and that other accounts may be entirely rooted in fantasy.

Other clinicians believe that patients' experiences of extremely sadistic events in childhood can be misremembered as “ritual” abuse and covert government sponsored mind control experiments. They believe that the actual events are distorted or amplified by the patient's age and traumatized state at the time of the abuse, and sometimes by deliberate attempts by perpetrators of abuse to deceive, intimidate or overwhelm their victims.

Yet other clinicians believe that alternate explanations—such as contagion, unconscious defensive elaborations, false memory, delusion, or deliberate confabulation—may suffice to explain these patients' reports. Therapists who automatically regard all such reports invariably as historically true or historically false in the therapy setting may diminish the likelihood of timely progress toward the patient's clarification of the historical accuracy of such memories. As patients become more inte-

grated and less dissociative, they may become more able to clarify for themselves the relative accuracy of their memories. See Fraser (1997), for a balanced series of presentations on the issue of ritual abuse.

### ***OTHER ISSUES***

#### ***Publications and Interactions with the Media***

The media and the public have a long fascination with DID, going back to the 19th century. Also, when doing a story, media reporters commonly want an individual to be the focus of the “human interest” aspect of the story. Thus, clinicians working with DID may find themselves targeted by the media asking to do a story on DID, usually with the request that the clinician provide a patient to be the story’s focus.

In all interactions with the media concerning DID, the therapist’s primary responsibility remains the welfare of his/her patients. Thus, the therapist must maintain the highest ethical and legal standards of confidentiality with respect to clinical material.

Appearances by patients in public settings with or without their therapists, especially when patients are encouraged to demonstrate DID phenomena such as switching, may consciously or unconsciously exploit the patient and can interfere with ongoing therapy. Therefore, it is generally not appropriate for a therapist actively to encourage patients to “go public” with their condition or history. Patients who ignore this advice rarely have a positive experience and often wind up feeling violated and traumatized.

#### ***Patients’ Spiritual and Philosophical Issues***

Like other victims of trauma by human agency, DID patients may struggle with questions of moral responsibility, the meaning of their pain, the duality of good and evil, the need for justice, and basic trust in the benevolence of the universe. When patients bring these issues into treatment, ethical standards for the various professional disciplines specify the need to conduct treatment without imposing one’s own values on patients, e.g., that “forgiveness” of perpetrators is mandated by God, that an appropriate treatment outcome will result in the patient believing or disbelieving in God, etc. Indeed, when carefully explored, there may be a range of spiritual and religious beliefs among DID alternate identities. Exploration of these spiritual and existential issues can

be very fruitful in DID therapy and may result in a deepening of the therapeutic work. Education and coordination between therapist and clergy can be helpful in ensuring that patients' religious and spiritual needs are addressed.

Although patients may experience certain alternate identities as demons and as not-self, DID experts regard these entities as additional alternate identities, not supernatural beings. Accordingly, therapists should approach with extreme caution the wish of the DID patients or their concerned others for an exorcism ritual. Names of alternate identities such as "Devil," "Satan," or "Lucifer" may likely reflect the patients' concrete culture-bound stereotyping of their self aspects using religious terminology. The name given to an alternate identity can express many different subjective, symbolic, and/or interactive meanings and purposes, such as power and sense of personal badness. It also may reflect specific spiritual and/or religious abuse such as abuse by clergy and/or being told in the course of abuse that the patient "is filled with the devil," etc. The name given to an alternate identity should not be taken as *prima facie* evidence that there is a demonic presence in the person.

Indeed, exorcism rituals have not been shown to be an effective treatment for DID, have not been shown to be effective for "removing" alternate identities, and have been found to have deleterious effects in two samples of DID patients that experienced exorcisms outside of psychotherapy. Some Guidelines Task Force members have noted that, in rare cases, exorcism rituals may provide a way for some patients to rearrange images of their identity systems in a culturally syntonetic manner (Bowman, 1993; Fraser, 1993; Rosik, 2004). Other Task Force members do not believe that exorcism is ever an appropriate intervention for DID patients.

### ***DID Patients as Parents***

DID patients have been shown to have a wide range of competence as parents—from exemplary to abusive (Kluft, 1987b). However, because many DID patients may have difficulty in parenting and a minority admit to being abusive toward their children, and also because DID may involve a heritable biological predisposition to dissociate, some experts have recommended that the children of all DID patients be assessed by a therapist familiar with dissociative disorders and indicators of child abuse. Other family interventions, such as couple's therapy and family therapy sessions including the patient's children may be indicated. However, caution should be exercised in what information is shared

with minor children concerning the patient's DID diagnosis, depending on the age of the children, and their cognitive and emotional development.

Clinicians should have an index of suspicion that the DID parent may be abusive and that this may occur in dissociative states. However, when a DID patient is dysfunctional in parenting, the dysfunction is often not abuse, but the result of the symptoms of DID (e.g., amnesia) and the life problems associated with this disorder (e.g., depression, fear of being assertive). This dysfunction can include neglect of the children, allowing the children to be exposed to reportedly abusive members of the DID patient's family of origin, exposure to the abusive significant others of the patient, witnessing the patient being subjected to domestic violence, allowing the children to witness the patient switching among alternate identities, committing acts of self-harm in front of the children, etc.

The therapist should actively assess these issues and assist the DID patient with appropriate parenting behavior. The patient may need extensive education and assistance in learning how to behave as an appropriate parent. Work on safety of the patient's children should be an absolute priority in the adult patient's treatment. This may include specific work with alternate identities who deny that they are the parent of the patient's children and/or refuse to acknowledge the needs of the children in a variety of ways. In addition, patients should be strongly enjoined to behave as an adult with their children, to not switch openly in front of children, and to not regress into child identity states with the children in the belief that this is a better way to behave with children. DID patients may have particular difficulties with specific developmental phases in their children or with particular child temperaments. This may relate to specific traumatic events or specific developmental disturbances experienced by the DID parent. Due to the many life difficulties in which the DID patient's children may be enmeshed, referral to and formal treatment of the children by a specialist in child psychiatry and/or child psychotherapy may be indicated no matter what diagnoses the children receive.

## CONCLUSIONS

These *Guidelines* present current accepted principles that reflect current scientific knowledge and the clinical experience of the past 25 years related to the diagnosis and treatment of Dissociative Identity Dis-

order. However, the *Guidelines* are not intended as the final word, as the field of dissociation is still in development. The field is in need of additional systematic research-including treatment outcomes research-in addition to the collection of more case material. Given that ongoing research on the diagnosis and treatment of dissociative disorders, and other related conditions such as Posttraumatic Stress Disorder (PTSD), will undoubtedly lead to further developments in the field, clinicians are advised to consult the published literature to keep up with important new information.

## NOTES

1. Members of the Standards of Practice Committee were Peter M. Barach, PhD (chair), Elizabeth S. Bowman, MD, Catherine G. Fine, PhD, George Ganaway, MD, Jean Goodwin, MD, Sally Hill, PhD, Richard P. Kluft, MD, Richard J. Loewenstein, MD, Rosalinda O'Neill, MA, Jean Olson, MSN, Joanne Parks, MD, Gary Peterson, MD, and Moshe Torem, MD.

2. Members of the Guidelines Revision Task Force included James A. Chu, MD (Chair), Richard Loewenstein, MD, Paul F. Dell, PhD, Peter M. Barach, PhD, Eli Somer, PhD, Richard P. Kluft, MD, Denise J. Gelinis, PhD, Onno van der Hart, PhD, Constance J. Dalenberg, PhD, Ellert R.S. Nijenhuis, PhD, Elizabeth S. Bowman, MD, Suzette Boon, PhD, Jean Goodwin, MD, Mindy Jacobson, ATR, Colin A. Ross, MD, Vedat Sar, MD, Catherine G. Fine, PhD, A. Steven Frankel, PhD, Philip M. Coons, MD, Christine A. Courtois, PhD, Steven N. Gold, PhD, and Elizabeth Howell, PhD.

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