Dispelling Myths About Dissociative Identity Disorder Treatment: An Empirically Based Approach

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Objective: Some claim that treatment for dissociative identity disorder (DID) is harmful. Others maintain that the available data support the view that psychotherapy is helpful.

Method: We review the empirical support for both arguments.

Results: Current evidence supports the conclusion that phasic treatment consistent with expert consensus guidelines is associated with improvements in a wide range of DID patients' symptoms and functioning, decreased rates of hospitalization, and reduced costs of treatment. Research indicates that poor outcome is associated with treatment that does not specifically involve direct engagement with DID self-states to repair identity fragmentation and to decrease dissociative amnesia.

Conclusions: The evidence demonstrates that carefully staged trauma-focused psychotherapy for DID results in improvement, whereas dissociative symptoms persist when not specifically targeted in treatment. The claims that DID treatment is harmful are based on anecdotal cases, opinion pieces, reports of damage that are not substantiated in the scientific literature, misrepresentations of the data, and misunderstandings about DID treatment and the phenomenology of DID. Given the severe symptomatology and disability associated with DID, iatrogenic harm is far more likely to come from depriving DID patients of treatment that is consistent with expert consensus, treatment guidelines, and current research.

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There has been increased awareness of the potential for psychotherapy to do harm (Dimidjian & Hollon, 2010; Shimokawa, Lambert, Smart, 2010). Dimidjian and Hollon (2010) assert that researchers have "ignored indirect harm" (p. 23) caused when erroneous statements are made that certain treatments are harmful, when they are not. They warn, "A beneficial treatment that is falsely assumed to be inert or worse can result in opportunities lost" (p. 23). These inaccurate conclusions lead to patients being deprived of effective treatment, spending months or years needlessly suffering from significant symptoms, functioning poorly, and subjected to "therapy" that is not beneficial compared to the treatment erroneously described as harmful. Years of patients' lives and professionals' time are wasted, along with unnecessary loss of crucial health care dollars.

Detection of "harm" may be complicated, as treatments can have both beneficial and harmful effects (Dimidjian & Hollon, 2010). Dimidjian and Hollon (2010) recommend measuring a wide variety of outcomes and specifically assessing for deterioration. A recent review found that worsening of symptoms occurs among 5% to 10% of adults receiving psychotherapy in university treatment centers, employee assistance programs, clinics, and community mental health centers (Whipple & Lambert, 2011). Individuals who have experienced complex trauma, (i.e., repeated interpersonal trauma, often beginning in early development, and occurring throughout the lifespan) may be particularly vulnerable to deterioration if treatment is not adapted to their myriad symptoms and difficulties. These include dissociation, affect dysregulation, mood disorders, problems with identity, somatization, and posttraumatic stress disorder (PTSD) symptoms, as well as substance abuse, self-harm, and interpersonal difficulties, among others (e.g., Cloitre, Courtois, et al., 2012). For example, despite exposure therapy being considered a first-line treatment for PTSD in randomized controlled trails (RCTs)[1] complex trauma survivors treated with exposure therapy showed trend level worsening of a physiological marker of emotion regulation (respiratory sinus arrythmia) and anxiety-related attentional bias (D'Andrea & Pole, 2012). D'Andrea and Pole suggest that participants' high level of dissociation and comorbidity contributed to their poor response to this treatment. However, the patients showed improvement with psychodynamic therapy or stress inoculation therapy. The former helps with relational issues that are common in survivors of interpersonal trauma, while the latter improves coping skills. Both of these are important in treating complex trauma (Cloitre, Courtois, et al., 2012; Kezelman & Stavropoulos, 2012).

We examine the evidence for and against the claim that treatment of dissociative identity disorder (DID) is harmful. Critics of the trauma model (TM) of dissociation have repeatedly made this claim (e.g., Gee, Allen & Powell, 2003; Lilienfeld, 2007; Lilienfeld & Lambert, 2007; Lynn, Lilienfeld, Merckelbach, Giesbrech, & van der Kloet, 2012; McHugh, 1992, 2013; Powell & Gee, 1999). Most individuals with DID report trauma exposure consistent with the construct of complex trauma, and are reported to have the many types of difficulties consistent with this (e.g., Brand, Classen, McNary, & Zaveri, 2009; Foote, Smolin, Kaplan, Legatt, & Lipschitz, 2006). Thus, it is logical that DID individuals will not respond to, and may even have adverse outcomes to, treatments that do not specifically address their complex symptoms (e.g., standard exposure therapy for posttraumatic disorders; Foa, Keane, Friedman, & Cohen, 2009). The current standard of care for DID treatment is described in the International Society for the Study of Trauma & Dissociation's (ISSTD) Treatment Guidelines for Dissociative

1. RCTs are studies in which patients are randomly assigned to either two or more treatments or an untreated "control" group.

Identity Disorder in Adults (ISSTD, 2011). These Guidelines recommend a tri-phasic, multi-modal, trauma-focused psychotherapy. In Stage 1, the clinical work prioritizes safety issues and symptom stabilization, including symptoms of dissociation, depression, suicidal and self-destructive behavior, and PTSD. In this model, failure to focus on stabilization, and/or premature focus on detailed exegesis of traumatic memories, almost invariably leads to overwhelming emotions, exacerbation of PTSD and dissociative symptoms, and, usually, decompensation of the patient, with increasing difficulties with safety, overwhelming symptoms, and deterioration in day-to-day functioning.

In this model, DID patients are first taught affect and impulse regulation skills as well as skills for communication and cooperation among dissociated self-states.[2] It is only after safety is established, symptoms are stabilized, and adequate coordination and cooperation among self-states occurs that, in Stage 2, trauma may be processed in more detail, working through trauma-based feelings, thoughts, and impulses. However, even in Phase 2 there must be ongoing, careful attention to pacing, maintaining the patient's safety, stability, and grounding in present reality.[3] Exposure is done only in modified form, emphasizing careful and incremental processing of memories (ISSTD, 2011; Kluft, 2013), and is not used session after session, as is done in standard exposure therapy (Foa et al., 2009; ISSTD, 2011). In the third stage, current and future life issues such as engaging in healthy relationships and meaningful activities become the dominant focus. Many patients achieve partial or complete integration among self-states (e.g., Kluft, 1984, 1986, 1988b).[4] This staged treatment model is similar to the standard of care advocated for complex trauma by the International Society for Traumatic Stress's *Expert Consensus Treatment Guidelines for Complex PTSD in Adults* and in Australia's *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* (Cloitre, Courtois, et al., 2012; Kezelman & Stavropoulos, 2012).

EXPERT TREATMENT GUIDELINES AND EVIDENCE ABOUT DID TREATMENT

We review the studies for DID treatment, including case studies, case series, cost-efficacy studies, prospective inpatient studies, and outpatient studies. We identified DID treatment articles by searching peer-reviewed journal articles published in English since 1989 identified on PsychINFO and PubMed databases by crossing the term "treatment" with "dissociative" (yielded 96 articles) and "multiple personality disorder" (yielded 64 articles). We also searched the references in key articles, including Brand, Classen, McNary, & Zaveri (2009), Lilienfeld (2007), and Powell & Howell (1998).

Beginning at least as early as the 16th century, the psychological and medical literature began to describe individuals with multiple personality states, including studies by Alfred Binet, the author of the first formal test of intelligence, Benjamin Rush, Pierre Janet, William James, Sigmund Freud, and Morton Prince, the founder of the *Journal of Abnormal Psychology*, among others (Carl-

2. Many terms exist in the literature for DID self-states, including identities, personality states (DSM-5), dissociative parts of the personality (van der Hart, Nijenjhuis, & Steele, 2006), alters, "parts," and so forth. See the ISSTD guidelines (2011) for a discussion. We choose to use the term *self-states* (Kluft 1988a) as we believe it is the most descriptive and theoretically neutral term currently available.

3. Also, some DID patients never adequately establish the stability or have the wish to engage in Stage 2 work. Many of these patients remain in long-term stabilizing treatment. Even here, patients may achieve considerable gains in stability and cost less to the health care system (Loewenstein, 1994).

4. Discussion of "integration" and "fusion" in DID is a complex topic, and readers are referred to Kluft (1986, 1988a) and to the ISSTD Guidelines (2011) for a full discussion.

son, 1981; Ellenberger, 1970; Loewenstein, 1993; Van der Hart & Dorahy, 2009). For more than 20 years, the professional organization dedicated to supporting education, research, and training about dissociative disorders, the International Society for the Study of Trauma & Dissociation (ISSTD), has worked to train therapists in the best practices for treating DID. Informed by over 60 years of clinical and research literature, beginning in 1994, the ISSTD published expert consensus treatment guidelines for DID in adults with revisions in 1997, 2005 and 2011 incorporating the most recent research (ISSTD, 2011).[5] A recent survey of 36 international DID treatment experts asked them, based on a list of interventions, to identify and rate which ones they found most effective at each stage of DID treatment (Brand, Myrick, et al., 2012). The most commonly recommended strategies were consistent with the treatment described in the ISSTD Treatment Guidelines. This supports the notion that there is a core set of interventions that are consistently effective in treating DID patients, even cross-culturally (Spiegel et al., 2011). Just as in the Guidelines, experts recommended that the initial phase of treatment prioritize skill building in emotion awareness and regulation, impulse control, interpersonal effectiveness, grounding (i.e., techniques for decreasing dissociation and increasing awareness of current reality), and containment of intrusive material. The importance of improving emotion awareness and regulation is supported by neurobiological research which shows that high dissociation involves difficulty modulating affect due to excessive limbic inhibition (e.g., Brand, Lanius, Vermetten, Loewenstein, & Spiegel, 2012; Lanius et al., 2010). In addition, the experts emphasized an early focus on safety: improving control over dangerousness to self and/or others and other high-risk behaviors. The experts advised addressing trauma-based cognitive distortions as well as identifying and working with dissociated self-states. While they recommended the use of significantly modified exposure/abreaction techniques for Stage 2 patients, they emphasized that trauma-focused work should occur alongside interventions such as grounding, managing emotions and impulses, and containing traumatic material, as well as others that help maintain the patient's safety. The consistency of the recommendations among the experts and ISSTD Treatment Guidelines indicates that a clear standard of care is emerging for the treatment of DID.

Clinical cases and case series in peer-reviewed journals document the beneficial response to DID treatment for patients from the United States, Canada, Europe, Asia, Africa, and the Caribbean (e.g., Coons, 1986; Draijer and Van Zon, 2013; Hove, Langfeldt, Boe, Haslerud, & Stoerseth, 1997; Kluft, 1984, 1986, 1988b; Martinez-Taboas & Rodrigues-Cay, 1997; Şar, Ozturk, & Kundakci, 2002; Şar & Tutkun, 1997; Van der Hart & Boon, 1997). These studies' systematic data show that DID treatment consistent with the expert guidelines is associated with decreased dissociation, depression, anxiety, posttraumatic stress, general psychiatric distress, and self-destructiveness, among others (Brand, Classon, McNary, & Zaveri, 2009). In addition, cost-efficacy studies of DID treatment have shown a robust decrease in costs over years of follow-up, once phasic DID treatment was initiated, even in the most chronically ill DID patients (Fraser & Raine, 1992; Lloyd, 2011; Loewenstein, 1994; Ross & Dua, 1993).

In a rigorously designed case study, Kellett (2005) described the 24-session cognitive analytic treatment of a DID patient using a single case "AB" experimental design (i.e., multiple daily self-report measures completed for 35 days prior to treatment, followed by 175 days of treatment and 168 days of

5. The ISSTD has also issued Guidelines for the Evaluation and Treatment of Dissociative Symptoms in Children and Adolescents, under its former name, International Society for the Study of Dissociation (2004).

follow-up). The careful documentation of the patient's severe yet stable symptoms before treatment, followed by improvement after targeted interventions, permitted Kellett to conclude that the patient's depression and dissociation decreased only after specific interventions were applied. This study strongly suggests that the improvements were caused by the treatment, rather than the passage of time or other non-treatment variables.

A review of treatment outcome for four dissociative disorders (DD; dissociative amnesia, depersonalization disorder, DID, dissociative disorder not otherwise specified [DDNOS]) found a variety of pre/post studies, including individual cases, case series, and inpatient studies, that used consecutive admissions (Brand, Classon, McNary, & Zaveri, 2009). The authors concluded that the prospective inpatient outcome studies that specifically identified and focused on DID demonstrated a significant reduction in a broad range of comorbid symptoms in response to hospitalization, with some further improvement at follow-up of as long as two years (e.g., Ellason & Ross, 1996, 1997, 2004).

Patients showed reduction in the number of psychiatric disorders, including depression, dissociation, somatic symptoms, substance abuse, and borderline features, and they required less psychiatric medication (e.g., Ellason & Ross, 1997). This review found evidence of consistent improvement associated with treatment; see Table 1 for the DID/DDNOS studies and their effect sizes (ES). However, due to the correlational nature of all but one study, improvement could not be unambiguously linked to treatment. No empirical study available for the Brand and colleagues' review, or published subsequently, found that patients were harmed by treatment. A meta-analysis of the eight studies that included necessary data found moderate to large within-subject, pre-post standardized Hedge's *g* ES across seven categories of symptoms (mean = 0.71, range 0.36–1.82), indicating that DID treatment is associated with moderate improvement in a variety of outcomes (see Table 2; Brand, Classon, McNary, & Zaveri, 2009). Brand conducted a comparative meta-analysis of six treatment studies of individual therapy for adults in which at least 25% of the sample reported childhood abuse; the overall within group, pre-post ES was comparable to those in the DD studies (mean = 0.82, 95% CI [0.21, 1.86]; see Table 2).

One area of agreement between the critics (e.g., Powell & Howell, 1989) and DID treatment proponents (e.g., Brand, Classon, McNary, & Zaveri, 2009) is that DD treatment outcome research had methodological weaknesses, including a reliance on severely ill inpatients, who may improve due to regression to the mean, not just in response to treatment. Recent research with improved methodology consistently finds that DID treatment is beneficial. For example, a Norwegian study of consecutive admissions to a specialized inpatient trauma program provided stabilization treatment consisting of group and individual therapy based on Herman's (1997) model for complex trauma survivors. The authors found that DID symptoms do not substantially improve if dissociated self-states and amnesia are not directly addressed in treatment (Jepsen, Langeland, Sexton & Heir, 2014). This study had notable methodological strengths. None of the 23 patients diagnosed by structured interview with a "complex dissociative disorder" (CDD)—either DID or DDNOS[6]—had previously been assessed or treated for a DD, and the program did not target dissociative symptoms such as amnesia or self-states. Thus, the study provides an opportunity to assess outcome among DID

6. DID and most DDNOS patients experience many similar symptoms and require similar treatment so are considered together in this review (ISSTD, 2011).

TABLE 1. Studies Providing Treatment to Dissociative Identity Disorder and DDNOS Patients Used in Brand, Classon, McNary, and Zaveri (2009) Meta-analysis

Authors	Date	Sample description and *N*	Treatment	Primary Findings	Effect Sizes
Choe & Kluft	1995	*N* = 21 DID females	Daily individual therapy and specialized group therapy (approx. 12/week) on inpatient dissociative disorders unit. Average length of stay = 23 days.	Improved: DES Total Score and symptoms of absorption and depersonalization/derealization; Worsened: amnesia scores	Pre- to post- treatment: DES = -1.23
Ellason & Ross	1996, 1997, 2004	*N* = 135 DID patients at baseline, *N* = 35–54 at 2-year follow-up	Inpatient trauma program. No information on average length of stay.	At 2-year follow-up 22% patients were integrated. Both integrated and unintegrated patients showed significant improvement on a wide range of MCMI-II subscales. Across all patients there was significant improvement on number of Axis I and II disorders, dissociation, depression, all subscales of DDIS, global severity index and all subscales on the SCL-90-R, and reduced medication use. Integrated patients showed significantly more improvement across measures compared to unintegrated.	Pre- 2-year follow-up: Number of diagnoses: SCID I = -1.73, SCID II = -.58, DES = -.99, BDI = -0.81, GSI (all pts.) = .85, GSI (integrated pts.) = -2.99
Ross & Ellason	2001	*N* = 50 trauma inpatients. Clinical diagnoses at discharge were 37 DID, 4 DDNOS, and 9 Major Depressive Disorder with psychotic features.	Inpatient trauma unit; went on to partial program (if so, completed measures at discharge from partial). Average length of inpatient stay = 19.5 days. Average length of stay at partial = 11.0.	Significant reduction in general distress, hopelessness, depression, suicidal ideation but no change in dissociation.	Pre- to post- treatment: DES = -.13, GSI = -.92, BDI-II = -1.23, BSS = -.60, BHS = -.90
Ross & Haley	2004	*N* = 46 of 60 consecutive admissions to trauma unit (52% with DID)	Inpatient trauma unit; average length of stay = 18.2 days. CBT and experiential therapies. 30 hours of group and 2 hours of individual treatment.	Significant decreases in depression, suicidal ideation, hopelessness, dissociation, and general distress at discharge. Changes maintained at 3-month FU and many continued to improve.	Pre- to post- treatment: DES = -.29, GSI = -.80, BDI-II = -1.48, BSS = -.89, BHS = -1.17
Gantt & Tinnin	2007	*N* = 72 trauma survivors (13 DID, 37 DDNOS, 22 PTSD)	Outpatient intensive program with combination of art therapy, hypnosis, and "video therapy." No information on average length of stay.	Based on clinician assessment of DD patients (DID and DDNOS combined): Recovered - 16/50 (32%), Improved - 27/50 (54%), Unchanged - 6/50 (12%), Worse - 2/50 (4%). Outcomes assessed using last available assessment point. Significant improvement on all objective measures.	Pre- to post- treatment: DES = -.66, SCL-45 = -.91, IES = -1.35
Ross & Burns	2007	*N* = 111 patients. 90% of patients on this unit have a DD but diagnoses not provided for this sample	Inpatient treatment on trauma unit; average length of stay = 10.3 days.	Significant decrease in depression. Length of stay not correlated with discharge BDI score or change in BDI score.	Pre- to post- treatment: BDI = -1.82

Note. Adapted from Brand, Classon, McNary, and Zaveri (2009) and used by permission. BAI = Beck Anxiety Inventory; BDI = Beck Depression Inventory; BHS = Beck Hopelessness Scale; BSS = Beck Scale for Suicidal Ideation; DES = Dissociative Experiences Scale; DDIS = Dissociative Disorders Interview Schedule; DDNOS = Dissociative Disorder Not Otherwise Specified; FU = follow-up; GSI = Global Severity Index of the SCL-90-R; IES = Impact of Event Scale MCMI-II = Millon Clinical Multiaxial Inventory II; Pts. = patients; SCID-I = Structured Clinical Interview for DSM-IV; SCID-II = Structured Clinical Interview for DSM-IV version 2; SCL-90-R = Symptom Checklist-90-Revised; SCL-45 = Symptom Checklist-45.

TABLE 2. Comparison of Effect Sizes for DD Studies and Individual Treatment Studies for Childhood Trauma

Outcome	Effect Size for DD Treatment Studies Comparing Pre- and Post-treatment Data	Effect Size for Individual Treatment Studies of Childhood Trauma
Overall Outcomes	.71	.82
Depression	1.12	.98
Dissociation	.70	.94
General distress	1.09	.49

Note. Data from a review of dissociative disorders treatment studies and six treatment outcome studies of individual therapy for adults in which at least 25% of the sample reported childhood abuse (data from Brand, Classon, McNary, & Zaveri, 2009). DD = Dissociative Disorders

patients in a setting in which it was unlikely that therapists may have "iatrogenically" suggested or reinforced DID symptoms,[7] and in which dissociative symptoms were not specifically addressed. An assessment one year prior to hospitalization showed that patients' dissociative symptoms were stable prior to inpatient treatment, thus eliminating the possibility that symptoms changed due to the passage of time or regression to the mean.

The authors compared a control group of complex trauma inpatients with childhood sexual abuse (CSA) without a CDD diagnosis to a CSA group with CDD diagnoses at four time points: one year before admission, admission, discharge, and one-year follow-up (Jepsen et al., 2014). The CDD group was more symptomatic across all measures, including dissociation, at all time points. Although both groups showed statistically significant decreases in general psychiatric symptoms, at discharge, the CDD patients showed lower rates of reliable overall improvement, and a slower process of improvement across symptoms, with no effect on dissociation, and only a small effect at follow-up. The interaction between dissociation and worsening in interpersonal functioning prior to treatment predicted poor outcome at one-year follow-up in the DD group (Jepsen et al., 2014). These findings prompted the program directors to develop specialized treatment for CDD patients that specifically targets dissociated self-states and amnesia, evaluation of which is underway (E. Jepsen, personal communication, June 2013).

The largest study to date of DID and DDNOS, called the Treatment of Patients with Dissociative Disorders (TOP DD), prospectively studied the outcomes of 280 DID or DDNOS patients and 292 therapists from 19 countries at four times over 30 months of treatment. (Therapists were able to participate regardless of whether their patient participated, which resulted in slightly more therapists than patients.) The cross-sectional results showed patients in the earlier stages of treatment had higher levels of symptoms of dissociation, PTSD, and overall distress; more hospitalizations; and less adaptive functioning than patients in the later stages of treatment (Brand, Classen, Lanius, et al., 2009). The prospective, 30-month follow-up results showed even more improvements. Specifically, patients showed decreased dissociation, PTSD, general distress, depression, suicide attempts, self-harm, dangerous behaviors, drug use, physical pain, and hospitalizations as well as improved functioning as reported by patients and therapists (Brand, McNary, et al., 2013). After initial relatively rapid improvement, the rate of

7. Critics of the phasic trauma model (TM) treatment for DID opine that trauma is not central to the etiology of DID. According to their theory, dissociation is caused, perpetuated, and worsened by clinicians who believe in the TM of dissociation and who reinforce this belief directly or indirectly (Lilienfeld et al., 1999). This model of DID is variously known as the Iatrogenic, Sociocognitive, or Fantasy Model. For a more complete critique of this view, see Dalenberg et al., 2012; Gleaves, 1996; Gleaves, May, & Cardena, 2001; Kluft, 1989; Loewenstein, 2007).

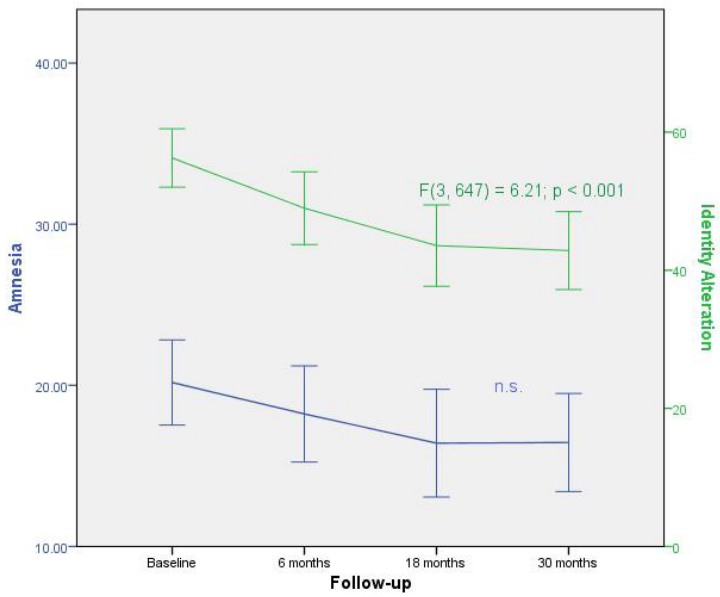

FIGURE 1. Mean Amnesia and Identity Alteration Over Four Assessments in Dissociative Disorders Patients in TOP DD Participants with 95% Confidence Intervals. Adapted from Brand, B. L., & Loewenstein, R. J. (2014). Does phasic trauma treatment make patients with dissociative identity disorder treatment more dissociative? *Journal of Trauma & Dissociation*. Reprinted by permission of Taylor and Francis, LLC (http://www.tandfonline.com)

change slowed over the course of 30 months for most outcomes; therefore, effect sizes are not able to sufficiently capture the complexity of the changes. More patients were involved in volunteer jobs and/or attending school and socializing, and reported feeling good at the 30-month assessment. Patients progressed from early stages of treatment to more advanced stages more often than they regressed from an advanced to early treatment stage, according to therapists' reports (Brand, McNary, et al., 2013).

Although some studies have shown that traumatized patients with the highest level of dissociation were not as responsive to treatment (D'Andrea & Pole, 2012; Fraser & Raine, 1992; Jepsen, Langeland, & Heir, 2013; Jepsen et al., 2014; Resick, Suvak, Johnides, Mitchell, & Iverson, 2012), the TOP DD patients with the highest levels of dissociation, as well as those with the most severe depression, showed decreases in both types of symptoms over time (Engelberg & Brand, 2012; Brand & Stadnik, 2013). There were more patients who showed "sudden improvement" versus "sudden worsening" across a range of symptoms (defined by a 20% increase or decrease in symptoms) at one or more time points (Myrick, Brand, & Putnam, 2013). The sudden improvers had significantly fewer episodes of revictimization and stressors compared to those who worsened, suggesting that revictimization and/or day-to-day stressors may have contributed to worsening in treatment. Sustained worsening occurred in only a very small minority (1.1%) of the patients. This rate of worsening compares favorably to that found in studies of general psychiatric patients (Whipple & Lambert, 2011). Patients showed a decrease in the frequency of identity alteration and hearing the voices of self-states (see Figures 1 and 2; Brand & Loewenstein, 2014), and a trend-level improvement in amnesia, but no worsening in this symptom, as predicted by the critics (i.e., Gee et al., 2003). This indicates that DID treatment facilitates integration, thereby reducing compartmentalization into self-states. The patients' functioning si-

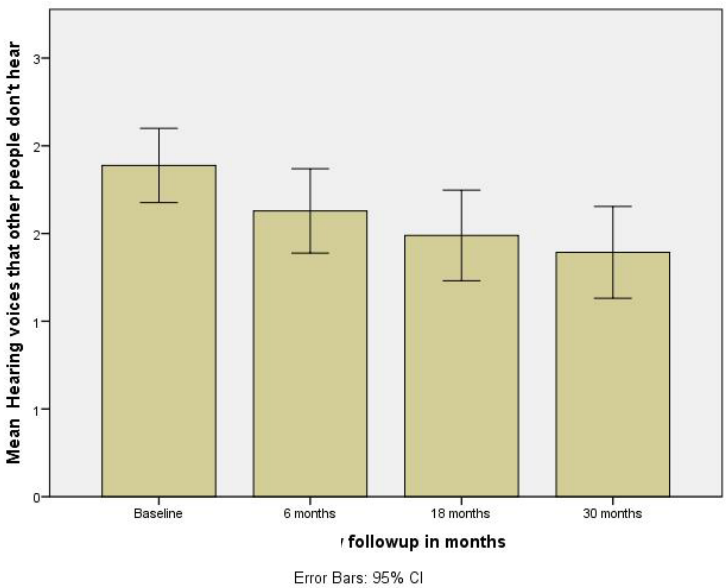

FIGURE 2. Mean Hearing Voices Over Four Assessments in Dissociative Disorders Patients in TOP DD Study. Adapted from Brand, B. L., & Loewenstein, R. J. (2014). Does phasic trauma treatment make patients with dissociative identity disorder treatment more dissociative? *Journal of Trauma & Dissociation*. Reprinted by permission of Taylor and Francis, LLC (http://www.tandfonline.com)

multaneously improved (see Figure 3; Brand & Loewenstein, 2014).

In summary, the TOP DD study documented that a wide range of symptoms and adaptive functioning improve while utilization of intensive interventions decrease during treatment for DID. The TOP DD study meets the standards set forth by Dimidjian and Hollon (2010) for having broad outcome measures so that potential harm can be detected and the researchers specifically investigated worsening, yet found that rates of improvement outweighed worsening. Further, factors external to treatment (e.g., revictimization, health and financial difficulties) appear to have contributed to the worsening that occurred in a fraction of the participants (Myrick et al., 2013).

Specialized treatment for DD is associated with significant cost savings, although reductions are most notable in patients with less chronic treatment courses (Fraser & Raine, 1992; Loewenstein, 1994; Ross & Dua, 1993). However, even chronic cases can often benefit from treatment. For example, a British woman with DID was misdiagnosed with conditions other than DID for 13 years, resulting in her decompensating to such a regressed state that she required frequent hospitalizations and daily monitoring (Lloyd, 2011). Within a year of being diagnosed and treated for DID, she had less frequent psychiatric crises and had not needed any subsequent hospitalizations. Her stabilization following recognition and treatment for DID is reflected in her annual treatment costs dropping from £29,492 ($47,187) pre-DID diagnosis to £10,695 ($17,112) post-DID diagnosis, representing an annual savings of £18,797 ($30,075). Ross and Dua (1993) document similar findings with a patient who had cost $45,800 per year (in 1992 Canadian dollars) for 19 years before DID diagnosis, and $14,602 per year for the treatment subsequent to the diagnosis of DID and initiation of appropriate treatment.

In summary, systematic evidence has consistently shown that the Phasic Trauma Model for DID treatment is beneficial across a wide variety of outcomes, treatment set-

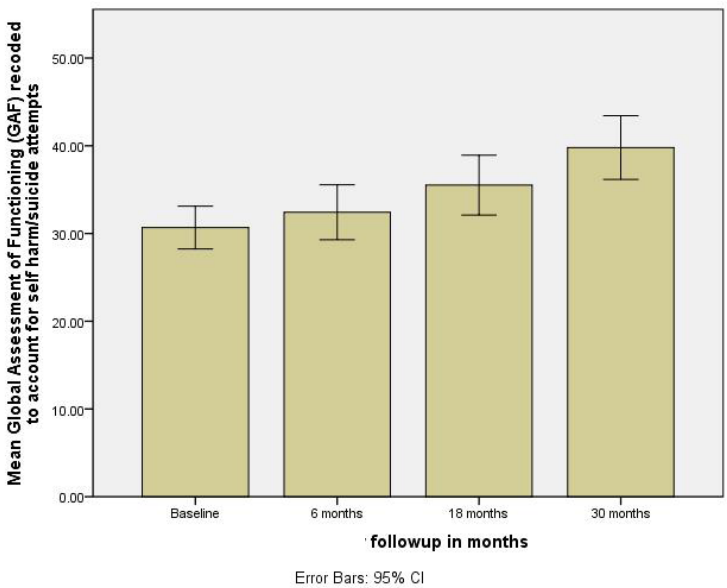

FIGURE 3. Global Assessment of Functioning Over Four Assessments in Dissociative Disorders Patients in TOP DD Study. Adapted from Brand, B. L., & Loewenstein, R. J. (2014). Does phasic trauma treatment make patients with dissociative identity disorder treatment more dissociative? *Journal of Trauma & Dissociation*. Reprinted by permission of Taylor and Francis, LLC (http://www.tandfonline.com)

tings, researchers, and cultures. Treatment that does not address DID symptoms of amnesia and identity alteration does not appear to improve dissociation, although other outcomes may improve. In addition, DID treatment consistent with expert guidelines is associated with significant cost savings.

CONCERNS ABOUT HARM

Despite this evidence base, a few vocal critics continue to argue that DID treatment is "harmful." As noted above, the standard of DID care is well articulated and clinicians whose treatment falls below the standard should be held accountable. In any treatment model of any patient with any diagnosis, it is not rational to assume that all clinicians provide harmful treatment to a specific type of patient because a few clinicians' treatment has fallen below the standard of care. It is illogical to think that the solution to these unfortunate isolated cases is to deprive all DID patients of evidence-based, beneficial treatment focused on their dissociative symptoms.

An important measure for protecting patients is to provide therapists with rigorous training, grounded in evidence-based practices, about the assessment and treatment of DD patients. The ISSTD has developed an extensive international therapist training program, available in small classes throughout North America, as well as web-based seminars in English, German, and Spanish. This training course has already taught over 2,200 therapists the phasic treatment model for DD (personal communication, Lynette Danylchuk, Director of the Professional Training Program of ISSTD, November 4, 2013). Similarly, the DeGPT, or German Speaking Society for Psychotraumatology, has provided certification in complex trauma and dissociative disorders to over 1,000 clinicians (personal communication, Reinhard Drobetz, Ph.D., Scientific Referee of DeGPT, September 12, 2013).

FAILURE TO REVIEW SCIENTIFIC EVIDENCE AND RELIANCE ON OPINION PIECES

Critics of DID treatment argue that the disorder is typically only diagnosed in North America and/or by a small number of DID specialists, which they believe supports the notion that the disorder is iatrogenically created by therapists and other cultural influences (Lilienfeld, 2007; Lynn, Fassler, Knox, & Lilienfeld, 2006; Lynn et al., 2012; Paris, 2012). The reality is that DID is recognized, diagnosed, and treated in many countries, including some in Europe, North and South America, Asia, and the Middle East, with prevalence of DID typically around 1% of the general population (Spiegel et al., 2011). For example, the TOP DD study had a sample of 292 participating therapists from 19 countries in North America, Europe, Africa, Asia, and the Middle East (Brand, Classen, Lanius, et al., 2009). Each therapist reported on only one patient, making it clear that therapists around the world diagnose and treat DID.

The critics fail to acknowledge, let alone explain, the consistent evidence from the wide variety of studies that document the treatment progress of DID patients across a range of outcomes. Lynn and colleagues (2012) attempted a DID treatment review, yet cited only a single study conducted on DID treatment: a case series study from almost 30 years ago that did not collect systematic data on patients (Kluft, 1984). The bulk of this "review" consisted of the author's own non-empirical, theory-focused publications. They failed to cite any of the 13 DID treatment studies with systematic data that were available at the time they wrote their review. Similarly, Paris (2012) contended that, "treatment [of DID] was never shown to be successful" (p. 1078), yet he also failed to cite much of the available literature. Only 14% of his 48 references were peer-reviewed articles from the prior 12 years, and 70% of his references were non-peer-reviewed materials (Brand, Loewenstein & Spiegel, 2013).

In Lilienfeld's article, "Psychological Treatments That Cause Harm" (2007), he failed to cite even one DID treatment study from the five case/case series studies and four treatment studies that were published before 2007. It is striking that an article offering broad claims about the purported harmfulness of DID treatment overlooked every peer-reviewed published treatment outcome study. Similarly, Lynn and colleagues (2006) fail to cite a single data-based study of DID treatment despite the title of their book being *Practitioner's Guide to Evidence-Based Psychotherapy*.

LACK OF EMPIRICAL EVIDENCE THAT DID TREATMENT IS HARMFUL

The critics fail to mention that there is no empirical, peer-reviewed study that has shown that DID treatment is harmful. Critics of DID treatment sometimes dismiss the DID treatment studies to date, noting that they are not RCTs (e.g., Lynn et al., 2012; Paris, 2012). Naturalistic, uncontrolled longitudinal trials may be more ethical and feasible than RCTs with complex patients with chronic suicidality and have provided important treatment outcome data (e.g., Brand, McNary et al., 2013; D'Andrea & Pole, 2012).

RELIANCE ON NON-PEER-REVIEWED ANECDOTES AND UNFOUNDED CLAIMS

Instead of relying on peer-reviewed cases and outcome studies, the critics rely on non-peer-reviewed literature, such as an autobiographical account written by a patient (MacDonald, 1998). This autobiography is one of the few pieces of "evidence" used by Gee, Allen, and Powell (2003) to attempt to substantiate their claim that DID treatment is harmful. Anecdotal stories with-

out data are the least rigorous type of "evidence" upon which to base claims of harmful (or beneficial) treatment (Dimidjian & Hollon, 2010). Sometimes the critics quote sources of "data" that are not easily accessible for review and that have not been peer-reviewed. For example, Gee and colleagues (2003) cite a brief submitted to a judge in Australia in a legal proceeding as evidence that DID patients become more symptomatic during treatment. Claims made in legal briefs are necessarily meant to "win" at trial, and do not meet the same data-driven, unbiased standards as do peer-reviewed scientific studies. Gee and colleagues (2003) make the strong statement that, "employment rates dropped 10-fold" (p. 115) during DID treatment based on a non-peer-reviewed study, with incompletely described methodology conducted by the Washington Department of Labor and Industries. One of us was able to contact the author of this study, but the latter stopped responding to queries after being asked specifically about its methodology (personal communication from Loni E. Parr, R.N. to B.L. Brand, October 29, 2013). Data published subsequently from the TOP DD study shows that rates of attending school and/or volunteering and GAF scores *increase* among DID patients during treatment (see Figure 3; Brand, McNary, et al., 2013; Brand & Loewenstein, 2014).

Gee and colleagues (2003) also misrepresented data from Gleaves, Hernandez, and Warner (1999) in their re-analysis of the Gleaves and colleagues data. Therapists reported that 73% of 446 DID cases had corroborated symptoms of DID prior to DID diagnosis and 67% prior to treatment. Gee misinterpreted the Gleaves and colleagues data as showing an increase in amnesia during DID treatment. In a later published reply, Gleaves and colleagues (2003) argued that, "what Gee et al. described as a gain in 100 cases of childhood amnesia was completely due to missing data from the 'prior to therapy' question … Gee's continued misinterpretation of the survey data is based on their equating absence of documentation with documentation of absence" (p. 117). In addition to misinterpreting missing data, Gee and colleagues presented these data as if they were from a treatment study, which they were not.

The critics cite malpractice suits as evidence that DID treatment is harmful (e.g., McHugh, 2013). There have been malpractice suits for treatments of most major psychiatric and medical disorders. If a plaintiff wins in a lawsuit against a clinician for malpractice, it does not follow that the established treatment model itself is at fault. Rather, the judgment is that the treatment fell below the standard of care. All treatments, including those for DID, should be consistent with the current standard of care. It is illogical to conclude that because a few therapists have failed to do this for individual DID patients, all DID treatment is harmful.

INACCURATE ASSUMPTIONS ABOUT THE NATURE OF DID TREATMENT

The critics of DID treatment wrongly assume that memory "recovery" is the "initial focus of therapy" (Gee et al., 2003, p. 115). DID experts have found that poorly educated therapists who focus on "memory recovery" usually cause marked worsening of symptoms in their patients (Loewenstein & Wait, 2008). A survey of DID expert therapists found that at no stage in treatment was the processing of trauma memories one of the top 10 most frequently recommended treatment interventions, not even during the middle phase when DID patients discuss trauma in detail in some sessions (Brand, Myrick, et al., 2012). Instead, the experts preferentially advocated teaching and practicing containment of traumatic memories. Containment techniques are the opposite of exploring trauma memories. Here, patients are assisted in achieving greater distance from, and mastery over, intrusive flashbacks of traumatic memories. This finding reveals

a theme of DID treatment that has been missed by the critics: DID patients are typically *flooded with posttraumatic intrusions* and do not need help "recovering" traumatic memories. Instead, they need help attenuating and containing them, and reducing the extent to which current functioning is impaired by flashbacks, posttraumatic reactivity, and dissociative symptoms.

This approach is consistent with the stage-oriented psychotherapy developed by Cloitre and colleagues (2010) for the treatment of complex childhood trauma. Her phase-based skills and exposure treatment of individuals with PTSD from chronic early life trauma was shown in an RCT to produce greater benefit and fewer adverse effects than either skills training or exposure alone. This approach, like that espoused by DID experts, emphasizes stabilization and self-regulation skills before exposure to trauma-related memories (Cloitre et al., 2011; ISSTD, 2011).

Cloitre, Petkova, Wang, & Lu Lassell (2012) conducted a dismantling study in which three elements of psychotherapy (training in affect and relationship management, discussion of trauma narratives, and supportive counseling) were examined. The three elements were equally effective in reducing PTSD symptoms among those low in dissociation. However, for those with moderate dissociative symptoms, the combination of skills training and trauma narratives provided better outcome, while supportive counseling helped to maintain post-treatment gains. Resick and colleagues (2012) compared cognitive processing therapy to cognitive therapy alone or written accounts about the trauma alone. For high dissociators, the combination of cognitive processing and written accounts worked better, while low dissociators responded better to the cognitive processing without the written accounts. These studies show dissociative individuals fare best with phase-oriented treatment that involves techniques designed to teach emotion regulation before focusing directly on resolving trauma. The dissociation scores in these two studies were less severe than found in DID samples. These studies show that even at moderate levels of dissociation treatment needs to be modified to be beneficial to dissociative individuals.

CONTRADICTORY SUGGESTIONS FOR DID TREATMENT

Lynn and colleagues (2006) advocate that therapists avoid what they refer to as "suggestive procedures," including "guided imagery," with DID patients (p. 252). Despite this advice, Lynn and colleagues add the conflicting notion that imagery for integration of DID alternate identities—such as streams flowing together—could be used to treat DID (p. 254). In the DID literature, this type of intervention is viewed as an adjunctive technique to facilitate unification of DID alternate identities (ISSTD, 2011; Kluft, 1982). Further, this sort of intervention should *only* be used in the context of well-constructed phasic treatment of DID. It can be harmful to use this type imagery without sufficient preparation and informed consent for patients to integrate self-states (Kluft, 1993). The critics fail to add the cautions for this adjunctive technique's use, while conflating a technique to facilitate treatment goals with treatment itself. Not recognizing the inherent contradictions in arguing that DID treatment is harmful, they advocate a procedure that is a recognized guided imagery/hypnotic technique straight from the DID literature. However, some of these authors' suggestions for DID treatment, such as development of self-regulation using behavioral, cognitive, and affective-regulatory strategies, are entirely consistent with the ISSTD treatment guidelines (pp. 136-138, ISSTD, 2011[8]) and the later DID experts' survey (Brand,

8. In 2006, they could have referenced the prior edition of the ISSTD guidelines, which are quite similar to the current guidelines. See International Society for the Study of Dissociation (2006).

Myrick, et al., 2012). These critics appear to have little familiarity with what the expert consensus-based ISSTD treatment guidelines advocate for DID treatment, yet argue that this treatment model is harmful.

STRAINED LOGIC AND LACK OF PARSIMONY IN INTERPRETATIONS OF DATA

The critics frequently claim that dissociated self-states are created via hypnosis (Lilienfeld, 2007; Powell & Gee, 1999) despite evidence that DID patients who have been hypnotized do not differ from DID patients who have not been hypnotized in terms of types of self-states, symptoms, psychiatric history, or abuse history (Putnam, Guroff, Silberman, Barban, & Post, 1986). In a brief report that purports to find that hypnosis has iatrongenic effects on DID, Powell and Gee (1999) examined Ross and Norton's (1989) study that found that the number of self-states did not differ between patients who had been hypnotized versus those who had not. Despite the equivalence of means, Powell and Gee compared the groups' standard deviations for the number of self-states. Based on finding that the standard deviations were larger among hypnotized patients, Powell and Gee concluded that using hypnosis could have iatrogenic effects. This speculation is questionable at best. It is unclear why they did not give credence to the more parsimonious explanation they offered but discounted: that therapists who use hypnosis receive more referrals for DID patients because hypnosis is a useful adjunctive modality for treating DID (ISSTD, 2011).

Powell and Gee (1999) dismissed another study that found no differences in numbers of self-states according to whether patients had been hypnotized or not (Putnam et al., 1986), arguing it may have been underpowered due to using Bonferroni corrections, which are widely used to correct for error rates, particularly in large data sets to avoid spurious correlations (Kirk, 1982). Elsewhere, Powell and Howell (1998) criticize another DID treatment study (Ellason & Ross, 1997) for *not* controlling for error rates. Despite the serious problems with Powell and colleagues' papers, they are among the most commonly cited pieces of "evidence" relied upon to support the argument that DID treatment is harmful (e.g., Lilienfeld, 2007; Lynn et al., 2006; 2012).

Lilienfeld (2007) offers another example of strained logic in his argument that DID treatment is supposedly harmful. He states that "the presence of alters can impede treatment progress" (p. 60), based on a .48 correlation found by Coons (1986) between the number of alters and the length of time required to achieve integration of dissociated self-states, an outcome of treatment that has been shown to improve patient functioning (e.g., Brand, Classen, McNary, & Zaveri, 2009; Ellason & Ross, 1997). Given that the number of dissociated self-states provides a rudimentary assessment of the degree of internal fragmentation of a given patient, it is logical that there would be a positive, significant correlation between the number of self-states experienced by patients early in treatment and length of time in treatment. Severity markers are often related to length of treatment as well as treatment response for a variety of disorders (Blom et al., 2007; Haby, Donnelly, Corry, & Vos, 2006). If Lilienfeld's logic were extended to depression, it would mean that a positive correlation between the severity of depression at baseline and length of treatment would be grounds for concluding that treatment for depression is harmful.

MISUNDERSTANDING AWARENESS OF SELF-STATES

Those who contend that DID treatment is harmful equate the increased awareness of dissociated self-states that often occurs with DID patients over the course of

treatment with the *creation* of self-states, concluding that treatment is harmful because it creates self-states (Lilienfeld, 2007; Piper & Merskey, 2004). If this line of reasoning were accurate, it would be akin to saying that in undiagnosed bipolar disorder patients, the disorder is created by clinicians who help patients become more aware that they have changes in mood states. Clinicians do not create bipolar disorder, schizophrenia, or any other disorder that patients may not recognize until a clinician helps them identify symptoms and make sense of their experiences as disorders.

Because DID requires the presence of amnesia, DID patients are, by DSM-5 definition (American Psychiatric Association, 2013), unaware of some of their behavior in different states. Progress in treatment includes helping patients become more aware of, and in better control of, their behavior across all states. To those who have not had training in treating DID, this increased awareness may make it seem as if patients are creating new self-states, and "getting worse," when in fact they are becoming aware of aspects of themselves for which they previously had limited or no awareness or control. Although some DID patients create new self-states in adulthood, clinicians strongly advise patients against so doing (Fine, 1989; ISSTD, 2011; Kluft, 1989).

UNSUBSTANTIATED CLAIMS THAT DID TREATMENT MAKES PATIENTS MORE DISSOCIATIVE

Critics of DID therapy opine that treatment will result in increased symptoms of dissociation over time as patients become influenced by therapists who recognize and treat DID (Gee et al., 2003). This opinion is inconsistent with the results of meta-analyses and prospective inpatient and outpatient studies which generally find moderate to large within individual effect sizes for reductions in dissociation, self-harm, and hospitalizations, among others (Brand, Classen, Lanius, et al., 2009; Brand, Classen, McNary, & Zaveri, 2009; Brand, McNary, et al., 2103). Gee and colleagues (2003) suggest that the most direct way to examine the possibility that DID treatment has iatrogenic effects on DID patients is to measure alter identity symptoms over time in treatment. They speculate that "there will be an increase in symptoms during therapy that coincides with the increased exposure to various forms of social influence concerning DID" (p. 114). Contrary to this hypothesis, dissociative symptoms including hearing voices and feeling as if one is different people *decreased* among the TOP DD patients over time in treatment (see Figures 2 and 3; Brand, McNary, et al. 2013; Brand & Loewenstein, 2014). Moreover, trauma treatment that does not address dissociated self-states results in little improvement in dissociation (Jepsen, Langeland, & Heir, 2013; Jepsen, Langeland, Sexton, & Heir, 2013).

DID patients spend an average of 6–12 years in treatment before correct diagnosis, receiving multiple incorrect diagnoses and undergoing costly and ineffective treatments (Loewenstein, 1994; Putnam et al., 1986; Spiegel et al., 2011). This means that these patients have been exposed to clinicians who did not make the diagnosis of DID and/or who treated the patient for other disorders. Were these patients easily suggestible, and were the disorder illusory, or its symptoms prone to quick improvement, non-DID treatment should have reduced, eliminated, or significantly improved symptoms during the first decade in the mental health system. Instead, patients often became more disabled during the years of misdiagnosis and misdirected treatment (Lloyd, 2011; Mueller-Pfeiffer et al., 2012). Even if they receive trauma-based treatment that does not specifically address self-states and amnesia, dissociation does not substantially improve (Jepsen, Langeland, & Heir, 2013; Jepsen et al., 2014). This failure to diagnose and treat DID over many years may represent the *real* iatrogenic harm (Kluft, 1989).

WHAT CONTRIBUTED TO THE NOTION THAT DID TREATMENT IS HARMFUL?

Despite lack of research data to support them, these views have found a place in the peer-reviewed literature (e.g., Giesbrecht, Lynn, Lilienfeld, & Merckelbach, 2008). The available evidence supports the link between trauma and dissociation, and not the idea that fantasy-proneness creates a reverse association between dissociation and trauma (Dalenberg et al., 2012, in press). Editors and reviewers have accepted the seemingly authoritative comments of senior writers espousing what is now an obsolete approach to etiology, diagnosis, and treatment DD, based in 19th-century theories of hysteria (McHugh, 1992) and outmoded, oversimplified views of hypnosis, that is, the sociocognitive model of hypnosis (Radtke & Spanos, 1981). The history of medicine shows that it may take time to overcome the vociferous support of the venerable, but incorrect, "received wisdom" (Carter & Carter, 2005; Marshall & Adams, 2008).

Based on the current literature, it is clear that clinicians also *can* harm DID patients if they are not trained in or fail to provide treatment consistent with the expert consensus phasic treatment model (e.g., focus on trauma memory before stabilization), do not maintain adequate boundaries, and/or become overly fascinated with the overt phenomena of self-states, among others (Chu, 1988; Fine, 1989; Kluft, 1988a). Widespread training in correct assessment and treatment of dissociation and DID is needed to prevent harm to patients, not withholding evidence-based phasic, trauma-informed DID treatment.

SUMMARY AND FUTURE DIRECTIONS

In contradiction to the claim that DID treatment is harmful, peer-reviewed research shows that trauma-informed, phasic treatment is consistently associated with a wide range of benefits across cultures, researchers, and when administered by a variety of clinicians. Further, the treatment model and research are consistent with outcome studies in patients with complex trauma with moderate dissociation (Cloitre et al., 2010; Cloitre, Petkova, et al., 2012; Resick et al., 2012). The authors who opine that DID treatment is harmful have relied on anecdotal cases, misrepresentations of data, claims of damage in legal cases that are not substantiated in the scientific literature, and opinion pieces that overlook data-based peer-reviewed treatment studies. The critics of DID treatment have made strong statements that are not substantiated by current evidence regarding such treatment.

The current literature provides considerable empirical evidence that DID treatment is beneficial. While RCTs have not been conducted with DID, current evidence is consistent with the conclusion that DID treatment is responsible for improvements in DID patients' symptoms and functioning. Given the severe symptomatology and dysfunction associated with DID, as well as the toll it exacts from individuals who suffer from it and the agencies that fund and provide treatment, harm may come from depriving patients of treatment that is consistent with DID treatment guidelines (ISSTD, 2011; Brand, Lanius, et al., 2012). Further harm may occur if clinicians believe the unsubstantiated claim that this type of DID treatment is harmful and provide treatment that falls below the standard of care for DID. We do agree with Lynn and colleagues (2012) that treatment for individuals with DID is an important area that merits considerably more research. However, the evidence base makes it clear that well-conducted, phasic, trauma-focused treatment is helpful for people with dissociative disorders.

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