MULTIPLE PERSPECTIVES ON MULTIPLE SELVES: INVESTIGATING CLINICIANS’ KNOWLEDGE, BELIEFS, AND EXPERIENCES RELATED TO DISSOCIATIVE IDENTITY DISORDER

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CLINICIAN PERSPECTIVES ON DID

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ABSTRACT

Dissociative identity disorder (DID) is a complex, posttraumatic developmental disorder that has received varying research attention in the last 30 years (Brand & Loewenstein, 2010). Despite increased awareness and understanding of DID, patients with this disorder spend an average of nearly seven years in the mental health system before receiving an accurate diagnosis (Putnam et al., 1986). Delayed and incorrect diagnosis is associated with costly, ineffective, and/or inappropriate treatments (Leonard & Tiller, 2016). Clinician factors believed to contribute to delayed DID diagnosis include skepticism or disbelief as well as lack of training and knowledge (Brand et al., 2016). While significant research on this topic was conducted 15 to 30 years ago, few studies have assessed the current stance of practitioners, and even less research has explored factors underlying variation in their beliefs, knowledge, training, and experience. Accordingly, this study investigated clinicians’ knowledge, beliefs, training, and clinical experiences related to DID through a mixed-methods design. Eighty-three U.S. mental health professionals recruited from eight professional organizations completed an online survey that included demographic questions as well as a DID questionnaire. Descriptive analyses indicated that participants demonstrated varying levels of disbelief, knowledge, training, and experience related to DID. While most participants believed DID is a valid disorder (73.5%), only 38.4% were likely or extremely likely to believe a new patient who reports having the diagnosis. Thematic analyses (Braun & Clarke, 2006) revealed that, though stigma persists, most participants believed in the trauma model of DID. Findings suggest that many clinicians, especially those specializing in trauma, dissociative disorders, and/or psychodynamic therapy, find it challenging yet rewarding to work with DID, believe awareness about DID is an important area of research, and want to
increase their awareness and knowledge about DID. Implications for DID assessment and treatment, as well as for future research, clinician training, and supervision are explored.
DEDICATION

I would like to dedicate this work to all of the courageous, resilient, and creative individuals coping with the aftermath of trauma, and especially to those brave enough to come forward with their experience of DID.
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I want to take this opportunity to thank all the incredible people who have contributed to this dissertation, both directly and indirectly, though I am certain that words will fall short of adequately expressing my deep appreciation for each one of you.

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Chapter I: Introduction and Background

No other documented disorder has inspired comparable arguments about whether it exists at all independent of iatrogenesis.

— Nancy McWilliams (2011, p. 334)

History of DID Diagnosis

The study of dissociative identity disorder (DID) has contended with a great deal of disbelief. Although the first published cases of DID pre-date the 19th century, well over a hundred years would pass before theorists would begin taking dissociative symptoms more seriously (Brand et al., 2016). For decades, DID patients were written off as fakers, master manipulators, or second-rate actresses more deserving of contempt than genuine care and clinical attention (Herman, 1997). Too unbearable to imagine, their reports of childhood sexual abuse were quickly dismissed, and, like most victims of unfathomable trauma, they were shamed into silence… at least for a while.

By the middle of the 20th century, the tide began to turn, and dissociative pathology started garnering both public and professional interest. Among the many social, scientific, and political forces responsible for this shift, some of the most influential included renewed recognition of the widespread prevalence and impact of trauma, feminist documentation of the effects of incest and domestic violence, and continued scientific interest in the effects of war on the psyche (Brand et al., 2016). According to Howell (2005, p. viii), “following the Vietnam War, which prompted the formulation of the diagnostic term posttraumatic stress disorder (PTSD), not only the atrocities of war but other, more commonplace atrocities such as child sexual abuse suddenly became more thinkable.”
Increased global awareness of dissociation culminated in the 1980 inclusion of DID, then multiple personality disorder (MPD), in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (3rd ed.; DSM-III; American Psychiatric Association, 1980)*. Today, the latest edition of the *DSM (5th ed.; DSM-5; American Psychiatric Association, 2013)* defines *DID* as an identity disruption characterized by the presence of two or more distinct personality states (experienced as possession in some cultures) as well as recurrent episodes of *amnesia*, or gaps in autobiographical memory.

**Validity of DID Diagnosis**

The diagnosis of DID has since accrued a substantial body of supportive evidence across multiple research areas. Its well-documented prevalence discredits the commonly held misconception that DID is an exceedingly rare, ‘exotic’ mental illness (McWilliams, 2011). A small community study found that the 12-month prevalence of DID among adults in the United States was 1.5% (Johnson, Cohen, Kasen, & Brook, 2006). Research supporting the diagnostic validity of DID has also accumulated (Gleaves, May, & Cardeña, 2001). In an empirical overview, Dorahy, Lewis, and Mulholland (2014) demonstrated that the content, criterion, and construct validity for DID are well established. The consistent clinical presentation of DID across cultures and research studies provides support for the content validity of the diagnosis, while high inter-rater reliability on structured clinical interviews for diagnosing DID meets the standard for criterion validity. Further, despite the degree of comorbidity with other disorders, DID can accurately be distinguished from other psychiatric conditions and healthy controls using structured interviews and self-report measures of dissociation.
Misdiagnosis of DID

Despite these triumphs, the war rages on. DID is significantly under- and misdiagnosed. Research from the late 1980s suggested that patients with DID spend an average of nearly seven years in the mental health system before receiving the diagnosis (e.g., Putnam, Guroff, Silberman, Barban, & Post, 1986; Ross, Norton, & Fraser, 1989). Consistent with this, a more recent survey study (Leonard, Brann, & Tiller, 2005) of 55 Australian patients with dissociative disorder diagnoses found that the delay before diagnosis was greater than three years in 57% of patients and greater than 10 years in 25% of patients. Moreover, only 11% received the correct diagnosis from the first clinician they consulted, and a staggering 35% saw six or more clinicians before receiving their diagnosis. It is not surprising that the majority (64%) of these patients felt that the delay had caused at least moderately adverse consequences. Beyond the emotional stress of being passed around from one clinician to the next, misdiagnosis of DID may lead to inappropriate, ineffective, costly, or even harmful treatments (American Psychiatric Association, 2013; Leonard & Tiller, 2016).

Statement of the Problem

Given the importance of early and accurate diagnosis, it is essential to determine why DID is so often under- and misdiagnosed and to take steps towards addressing these barriers. Prior research has suggested that lack of training and knowledge, paired with skepticism about DID, contribute to the gross under recognition and delayed diagnosis (Brand et al., 2016). While significant research in this area was conducted in the 1990s and early 2000s, few studies have assessed the current stance of practitioners in the field, and even less research has explored factors underlying clinicians’ varying levels of belief, knowledge, training, and clinical
experience related to DID. Research in this area could help identify populations of clinicians with the greatest need for further education and training on working with DID patients.

To address these gaps in the literature, this study investigated mental health professionals’ knowledge and beliefs about DID as well as their training and experience relevant to this population through an online survey study of psychologists, social workers, and psychiatrists in the United States. The literature review that follows aimed to (a) present a general overview of dissociation and DID; (b) evaluate the empirical research on DID diagnosis; (c) explore barriers to DID diagnosis, assessment, and treatment; and (d) propose a mixed-methods survey study that will serve as a preliminary investigation into these areas. A clear delineation of the primary study aims and hypotheses of the current study, derived from the available literature, is presented at the end of the literature review.
Chapter II: Literature Review

In what disorder we lived, how many fragments of ourselves were scattered, as if to live were to explode into splinters.


**Conceptualization of Dissociation**

Developing a working conceptualization of dissociation is no simple task. Researchers have used the term *dissociation* in a myriad of different ways, resulting in a great deal of confusion and inconsistency in the literature (Brand & Frewen, 2017). According to Van der Hart, Nijenhuis, and Steele (2006), “often in a single discussion, the term *dissociation* can be used to denote a process, an intrapsychic structure, a psychological defense, a deficit, and a wide array of symptoms” (p. 2).

The *DSM-5* (American Psychiatric Association, 2013) defined dissociation as “a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior” (p. 291). In other words, dissociation involves a rigid separation of realms or parts of experience that would normally be connected (Howell, 2005, 2011).

**Peritraumatic and Structural Dissociation**

To further clarify the process of dissociation, it is necessary to differentiate between two types of dissociation—peritraumatic and structural dissociation. *Peritraumatic dissociation* refers to dissociation that is experienced during or immediately after exposure to psychological trauma (Brand & Frewen, 2017). It is typically a transient state that decreases gradually over several weeks or months after trauma exposure as the individual resolves their fears and other trauma-induced feelings (e.g., anger, guilt, shame) and cognitions (e.g., self-blame; Brand &
Frewen, 2017). In some cases, however, dissociative experiences do not progressively subside, and the individual is at increased risk for developing psychopathology, including PTSD and a range of dissociative disorders (Brand & Frewen, 2017).

Unlike peritraumatic dissociation, which stresses alterations in consciousness, *structural dissociation* emphasizes a division within an individual’s identity, ego, or sense of self (Brand & Frewen, 2017). More specifically, *structural dissociation* refers to “an enduring organized division of the experiential contents of the self, and implies inadequate integration” (Howell, 2005, p. 23). It involves a deficiency in the cohesiveness and flexibility of the personality structure. Van der Hart and colleagues (2006) have argued that this “does not mean that the personality is completely split into different ‘systems of ideas and functions,’ but rather that there is a lack of cohesion and coordination among these systems that comprise the survivor’s personality” (p. 4). In other words, structural dissociation can be understood as:

A process by which a piece of traumatic experience, because it is too overstimulating to be processed and recorded along the usual channels, is cordoned off and established as a separate psychic state within the personality, creating two (or more) ego states that alternate in consciousness and, under different internal and external circumstances, emerge to think, behave, remember, and feel. (Davies & Frawley, 1994, p. 62)

As suggested here, this form of dissociation is most notably exhibited in cases of DID. Dissociative experiences like absorption, altered states, depersonalization, and derealization, in contrast, may reflect alterations in consciousness but do not necessarily involve structural dissociation (Brand & Frewen, 2017; Howell, 2011).
Function of Dissociation

While dissociative processes may differ in kind and degree, all forms of dissociation are widely recognized to be a natural response to trauma. Per McWilliams (2011), “Any of us, if confronted with a catastrophe that overwhelms our capacity to cope, especially if it involves unbearable pain and/or terror, might dissociate” (p. 124). In line with this perspective, dissociative disorders are placed next to the trauma- and stressor-related disorders in the DSM-5 (American Psychiatric Association, 2013) to reflect the close relationship between these diagnostic classes.

The function of dissociation is to provide protective psychological containment of or detachment from traumatic experiences, especially ones that are chronic and that occur in early childhood (Brand & Loewenstein, 2010). Elizabeth Howell, a leading psychoanalyst in the field of dissociation, described this process:

Even though dissociation can arise from other sources as well, problematic or maladaptive dissociation is often a chronic, rigidified outcome of trauma. Initially, it is adaptive, protecting the traumatized person from unbearable pain and knowledge and preserving a sense of safety and control in dangerous and overwhelming stressful circumstances (Putnam, 1997; Maldonado and Spiegel, 1998; Brenner, 2000) and thereby enhancing survival (Freyd, 1996). When the continuity of being is traumatically interrupted, when whatever has happened is too frightening to be assimilated, people may “trance out,” develop “psychic numbness” (Lifton and Marcuson, 1990), go into “neutral gear” (Terr, 1994), or all of these. (2005, pp. 23-24)
As illustrated by this excerpt, while dissociation may be an adaptive way of coping or a survival strategy at the time of the trauma, it can have negative consequences when used pervasively over an extended period of time.

Dissociative symptoms have the ability to disrupt every area of psychological functioning (American Psychiatric Association, 2013). In particular, dissociation can lead to changes in the way memory is encoded and stored, resulting in a fragmentation and compartmentalization of memory as well as difficulties retrieving memories (Brand & Loewenstein, 2010). When connections among normally related mental processes are severed, a coherent, integrated sense of self cannot develop. Instead, the self or ego gets divided into two or more self states that function independently, leading in extreme cases to DID (Davies & Frawley, 1994).

Spectrum of Dissociative Processes

Dissociation has been conceptualized as existing along a continuum from normative to severe (Brand & Frewen, 2017). Alterations in consciousness such as “spacing out” and absorption (e.g., becoming so engrossed in a book that one is unaware of one’s surroundings) are often considered the best examples of “normative” dissociative experiences as they occur nearly universally and are typically transient and mild (Van der Hart et al., 2006). The identity alteration seen in DID, on the other hand, exemplifies the most severe form of structural dissociation (Brand & Frewen, 2017). Although mild dissociative phenomena like absorption generally do not involve structural dissociation, Van der Hart and colleagues (2006) propose that all trauma-related disorders, as defined by the DSM-IV (American Psychiatric Association, 1994), involve some degree of structural dissociation, with acute stress disorder and PTSD being the simplest and DID being the most complex. They note that many survivors of trauma
experience structural dissociation without the elaboration and liberation of some dissociative parts found in DID.

**Overview of DID**

**DSM-5 Diagnostic Criteria**

As previously noted, the *DSM* (American Psychiatric Association, 2013) broadly defined DID as an identity disruption characterized by the presence of two or more distinct personality states as well as recurrent episodes of amnesia. To receive a *DSM-5* (American Psychiatric Association, 2013) DID diagnosis, an individual must the following criteria:

A. Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.

B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The disturbance is not a normal part of a broadly accepted cultural or religious practice. Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play.
E. The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures). (p. 292)

Clinical Features

In contrast to sensationalized media accounts of DID, the majority of patients with this disorder do not present to clinical attention with overt displays of alternate personality states (American Psychiatric Association, 2013). Most estimates suggest that these florid presentations occur in only about 5 – 6% of patients with dissociative identity disorder (International Society for the Study of Trauma and Dissociation [ISSTD], 2011; Kluft, 1985 [as cited in Brand & Loewenstein, 2010]). Instead,

The DID patient is a single person who experiences himself or herself as having separate alternate identities that have relative psychological autonomy from one another. At various times, these subjective identities may take executive control of the person’s body and behavior and/or influence his or her experience and behavior from “within.” Taken together, all of the alternate identities make up the identity or personality of the human being with DID. (ISSTD, 2011, p. 120)

The alternations in identity for individuals with DID tend to be more subtle and transient discontinuities in sense of self and agency, accompanied by related variations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning (American Psychiatric Association, 2013).

Rather than displaying visibly distinct alternate identities, “the typical DID patient presents a polysymptomatic mixture of dissociative and posttraumatic stress disorder (PTSD) symptoms that are embedded in a matrix of ostensibly non-trauma-related symptoms (e.g.,
depression, panic attacks, substance abuse, somatoform symptoms, eating-disordered symptoms)” (ISSTD, 2011, p. 118). Indeed, a majority of patients with DID present with a comorbid psychiatric condition, and symptoms of these co-occurring disorders are likely to be most immediately apparent. Some studies (Ellason & Ross, 1996; Rodewald, Wilhelm-Gößling, Emrich, Reddemann, & Gast, 2011) have suggested that patients with DID meet criteria for an average of five to eight comorbid psychiatric disorders, with 75% meeting criteria for at least five co-occurring disorders (as cited in Brand, 2016).

Given the close relationship between dissociative disorders and trauma- and stressor-related disorders, it is not surprising that traumatic conditions are frequently comorbid with DID. According to the DSM-5 (American Psychiatric Association, 2013), most individuals with DID develop PTSD. Other disorders that commonly co-occur with DID include depressive disorders, a range of trauma- and stressor-related disorders, personality disorders (especially avoidant and borderline), conversion disorder, somatic symptom disorder, eating disorders, substance-related disorders, obsessive-compulsive disorder, and sleep disorders. Importantly, if individuals are not assessed and treated specifically for their DID, they are likely to receive treatment for the comorbid psychiatric disorder(s) only, resulting in limited treatment response, demoralization, and disability (American Psychiatric Association, 2013).

Theoretical Models

Two primary classes of theories have emerged in the literature for understanding DID: (a) the trauma and attachment model and (b) the fantasy or sociocognitive model. While it is outside the scope of this dissertation to provide a comprehensive discussion of current theories about the development of DID, these two models have been briefly summarized below.
**Trauma model.** As the name suggests, the trauma model of DID maintains that there is a direct, causal relationship between trauma and dissociation (Brand & Brown, 2016). From this perspective, DID is conceptualized as a childhood onset, posttraumatic developmental disorder in which the child lacks the ability to consolidate a unified sense of self (Brand & Loewenstein, 2010). According to trauma theories of dissociation, detachment from emotional and physical pain during trauma can result in alterations in memory encoding and storage, which in turn lead to both fragmentation and compartmentalization of memory as well as impairments in retrieving memory (Brand & Loewenstein, 2010). With respect to DID, it is believed that, “Exposure to early, usually repeated trauma results in the creation of discrete behavioral states that can persist and, over later development, become elaborated, ultimately developing into the alternative identities of dissociative identity disorder” (Brand & Loewenstein, 2010, p. 66). Many theorists have noted that these traumatic experiences tend to “occur in the context of relational or attachment disruption that may precede and set the stage for abuse and the development of dissociative coping (Barach, 1991; Liotti, 1992, 1999)” (ISSTD, 2011, p. 122).

**Fantasy or sociocognitive model.** The fantasy model, in contrast, asserts that, “dissociation causes fantasy-proneness and/or suggestibility, which in turn lead to confabulated traumatic memories (Giesbrecht et al., 2008; McNally, 2003; Merckelbach, Horsequenberg, and Schmidt, 2002; Merckelbach and Muris, 2001)” (Brand & Brown, 2016). Extending upon this line of thinking, other researchers have suggested a sociocognitive model of DID, which argues that, “patients become convinced that they possess multiple selves as a by-product of suggestive media, sociocultural, and psychotherapeutic influences” (Lynn, Lilienfeld, Merckelbach, Giesbrecht, & van der Kloet, 2012, p. 51). Among the many influences believed to contribute to the development of DID from this perspective are patient suggestibility and therapist cueing.
Empirical Evaluation of DID

Etiological Research

Contrary to the fantasy/sociocognitive model’s criticisms about DID, an accumulating body of evidence supports the validity of the diagnosis. There is clear, consistent etiological evidence for the role of trauma, especially early and chronic childhood trauma, as a precursor to DID (e.g., Brand & Loewenstein, 2010; Leonard et al., 2005). According to Brand and Loewenstein (2010), there is robust support for a link between dissociation and many types of trauma that “has been validated across cultures in clinical and nonclinical samples using both cross-sectional and longitudinal methodologies as well as in large population studies and in well-designed prospective, longitudinal studies” (p. 62).

A number of theorists have considered the specific roles of childhood sexual and physical abuse in the etiology of DID. The DSM-5 (American Psychiatric Association, 2013), for instance, has argued that interpersonal physical and sexual abuse are associated with an increased risk for DID, citing research that estimates the prevalence of childhood abuse and neglect among individuals with DID across the United States, Canada, and Europe to be around 90%. Consistent with this, Brand and Frewen (2017) reported that, “People with DID report almost universally having experienced childhood sexual abuse, childhood physical abuse, or both, with 95–97% frequency (e.g., Putnam, Guroff, Silberman, Barban, & Post, 1986; Ross, 1991)” (p. 222).

Results from other research studies have supported a link between childhood abuse and dissociative pathology. For example, Saxe and colleagues (1993) compared overall rates of physical and sexual abuse between psychiatric inpatients with and without dissociative disorders in the United States. In this study, inpatients scoring above 25 on the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986) met criteria for the dissociative disorders group (n =
15), while those scoring below five met criteria for the comparison group \( n = 15 \). The authors found that overall rates of sexual abuse and physical abuse for the dissociative disorders group (100% and 86%, respectively) were significantly higher than those for the comparison group (21% and 36%, respectively). These findings were even more pronounced for earlier reports of abuse. Rates of sexual abuse during early childhood (ages zero to six), latency (ages seven to 11), and adolescence (ages 13 to 18) in the dissociative disorders group were 40%, 60%, and 80%, respectively, compared to 0%, 21%, and 14% in the comparison group. Similarly, rates of physical abuse during childhood, latency, and adolescence were 50%, 71%, and 57%, respectively, in the dissociative disorders and 7%, 14%, and 21% in the comparison group.

A more recent study (Foote, Smolin, Kaplan, Legatt, & Lipschitz, 2006) also found evidence for a link between dissociative disorders and physical and sexual abuse in childhood. Logistic regression analysis of data from 231 psychiatric outpatients in the United States revealed that patients who met dissociative disorder criteria reported histories that were marked by significantly more prolonged and severe childhood physical abuse (odds ratio = 5.86) and childhood sexual abuse (odds ratio = 7.88) compared to those who did not meet dissociative disorder criteria.

Other researchers (e.g., Brand & Loewenstein, 2010; Lyons-Ruth, 2003) have more specifically posited that early relational traumas, including attachment difficulties and parental unavailability, are strong predictors of dissociative symptomatology. For example, Lyons-Ruth (2003) analyzed data from two longitudinal attachment studies of families at social risk and concluded that disorganized attachment behaviors and emotionally unavailable caregiving during the first two years of life play an important role in the genesis of later dissociative pathology.
Cross-Cultural Research

Another common criticism of DID from the sociocognitive model’s perspective is that it is a culture specific phenomenon found primarily in Western societies (see Boysen & VanBergen, 2013). Recent research, however, suggests that this critique may be unfounded. A number of studies have shown the stability of the diagnostic criteria for DID across various cultures (Leonard et al., 2005).

Although more cross-cultural research is needed, many studies conducted outside the United States have found rates of DID comparable to those reported in the United States. For instance, Şar, Akyüz, and Doğan (2007) investigated the lifetime prevalence of DSM-IV (American Psychiatric Association, 1994) dissociative disorders among 628 women in the general population in Turkey and found that 18.3% ($n = 115$) met criteria for any dissociative disorder and 1.1% ($n = 7$) met criteria for DID. Another research team (Sar, Koyuncu, et al., 2007) assessed rates of dissociative disorders in a clinical sample in Turkey. Of the 43 emergency unit patients evaluated in this study, 15 (34.9%) were diagnosed as having a dissociative disorder, and six of these (14%) had DID. In a Canadian sample, 10 of 229 (3.3%) general adult psychiatric inpatients had “clinically confirmed MPD” (Ross, Anderson, Fleisher, & Norton, 1991). Moreover, in 10 studies conducted in six countries, DID was found to affect 3.9% of 1,529 general adult psychiatric inpatients who had never received a prior diagnosis of DID and did not purport to have the disorder (Ross, Duffy, & Ellason, 2002).

A more exhaustive review of the cross-cultural literature on the prevalence of DID is beyond the scope of this study (for a review, see Dorahy et al., 2014; Yu et al., 2010). See Table 1 for a summary of epidemiological studies on DID and dissociative disorders across adult populations.
Neurobiological Research

Neurobiological investigations of DID constitute a burgeoning area of research. To date, several brain regions have been implicated in the pathophysiology of DID, including the orbitofrontal cortex, the hippocampus, the parahippocampal gyrus, and the amygdala (American Psychiatric Association, 2013). For instance, Vermetten, Schmahl, Lindner, Loewenstein, and Brenner (2006) used magnetic resonance imaging to measure hippocampal and amygdalar volumes in female patients with DID \((n = 15)\) and female subjects with DID or any other psychiatric disorder \((n = 23)\). The authors found that women with DID have a 19.2% reduction in hippocampal volume and a 31.6% reduction in amygdalar volume compared to the healthy controls. They proposed that smaller hippocampal and amygdalar volumes in DID could be related to stress exposure associated with early abuse. In support of this, Brand and Frewen (2017) have argued that neurobiological findings are consistent with the hypothesis that dissociation is a response to trauma among some individuals. Nonetheless, Vermetten et al.’s study had a number of limitations that reduce the causal inference of the findings (e.g., failing to test for age as a moderator when the comparison subjects were significantly younger than the DID patients).

Other authors have proposed hypotheses about the roles of specific brain regions in dissociation and DID. For example, according to Brand and Frewen (2017),

Research also implicates the function of primary sensory and motor cortices, frontal and prefrontal cortex, and basal nuclei during transitions between identity state (i.e., sense of self) in people with DID (Reinders et al., 2014; Savoy, Frederick, Keuroghlian, & Wolk, 2012; Wolk, Savoy, & Frederick, 2012), whereas temporal lobe abnormalities also may partly underlie the experience of dissociative voice hearing. (p. 227)
While promising, the neuropsychopharmacology of DID is a fairly new and undeveloped area of study. As such, the results from these types of studies are varied and lack sufficient replicability and should thus be interpreted with caution. A full discussion of neurobiological studies of DID is beyond the scope of this dissertation. For a comprehensive review on the topic, the reader is referred to Dorahy et al. (2014); see also Brand and Frewen (2017); Howell (2011, Chapter 6).

**Barriers to DID Diagnosis, Assessment, and Treatment**

Despite mounting evidence supporting the validity of the DID diagnosis, researchers have shown that these patients continue to be severely under- or misdiagnosed. Misdiagnosis of DID may lead to either no treatment or treatment targeting a comorbid diagnosis only, resulting in limited treatment response, discouragement, and disability (American Psychiatric Association, 2013). Given these consequences, significant research has focused on identifying obstacles to DID diagnosis. Several factors—including both patient and clinician barriers—appear to contribute to the delays to DID diagnosis.

**Patient Barriers**

**Reluctance to disclose symptoms.** A major patient barrier to DID diagnosis that has frequently been discussed in the literature is reluctance to disclose symptoms. They may hide or underreport them out of embarrassment or mistrust, which is understandable given their history of not being believed by others (Leonard & Tiller, 2016). In other cases, they may not even be aware of their symptoms. It is not uncommon for a patient with DID to attribute his/her/their memory gaps to being a “forgetful” person, especially if this is the only available explanation.

**Comorbidity and differential diagnosis.** The complex clinical presentation of DID may also create confusion about the diagnosis. As previously discussed, patients with DID commonly present with at least one other co-occurring psychiatric disorder. Because the dissociative
symptoms are typically subtle, or may only emerge under certain circumstances, comorbid conditions may cover up DID (Leonard & Tiller, 2016). Most commonly, DID is confused with psychotic disorders, mood disorders, and borderline personality disorder (BPD) (for an additional review of the differential diagnosis, see Brand & Loewenstein, 2010). Careful assessment is needed to determine whether symptoms reflect a comorbid condition or are manifestations of the underlying DID. For instance, what may appear to be an auditory hallucination or delusion found in a psychotic disorder may actually be intrusions between alternate identities into the patient’s consciousness (Brand & Loewenstein, 2010). Similarly, a rapid shift in mood could reflect the emotional dysregulation seen in BPD, the emergence of an alternate identity seen in DID, or both. Further complicating matters, patients with BPD are known to dissociate under situations of extreme stress.

**Clinician Barriers**

While complex clinical presentations and reluctance to disclose symptoms make some cases of DID difficult to detect, clinicians who ask the right questions and consider DID in their differential diagnoses can usually make the diagnosis in a single assessment (Ross, 2015). Accordingly, identifying clinician barriers to DID diagnosis has been an important focus of research.

**Professional skepticism and disbelief.** One such roadblock to early and accurate DID diagnosis that has emerged from previous research is professional skepticism or disbelief. In spite of mounting evidence supporting the diagnosis of DID, controversy still centers on the basic question of whether the disorder exists at all (Brand et al., 2016; Ginzburg, Somer, Tamarkin, & Kramer, 2010). Survey studies of mental health professionals in at least six countries have found evidence for skepticism about DID. For instance, out of 250 Australian
clinicians, 35% of those surveyed regarded dissociative disorder diagnoses as dubiously valid and 10% considered them to be invalid (Leonard et al., 2005). A recent study of 183 clinical psychologists in the United Kingdom found similar results (Ost, Wright, Easton, Hope, & French, 2011). When asked to indicate the extent to which they believed patient reports of having DID could be taken as essentially accurate, 35.5% said “Sometimes,” 15.9% said “Rarely” and 2.7% said “Never.”

Research conducted in North America also found evidence for skepticism about DID among mental health practitioners. Pope, Oliva, Hudson, Bodkin, and Gruber (1999) surveyed 301 American psychiatrists and found that only 35% of respondents \( n = 106 \) believed that DID should be included without reservations in the *DSM-IV* (American Psychiatric Association, 1994), and 20% \( n = 59 \) believed that there was little or no evidence of the validity of DID. To compare the opinions of American psychiatrists about dissociative disorder diagnoses with those of Canadian psychiatrists, Lalonde, Hudson, Gigante, and Pope (2001) administered the same survey used by Pope et al. (1999) to a large sample of Canadian psychiatrists \( N = 403 \) and found that only 22% \( n = 94 \) believed that DID should be included without reservations in the *DSM-IV* (American Psychiatric Association, 1994), and 33% \( n = 117 \) believed that there was little or no evidence of the validity of DID. Though the authors concluded that Canadian psychiatrists endorsed significantly more skepticism about the diagnostic legitimacy and scientific validity of DID compared to their American counterparts, they did not offer an explanation for these findings. They did, however, observe that one of the few significant differences between the two groups was that Canadian psychiatrists were less likely to be psychodynamically oriented than were American psychiatrists, and that psychodynamically
oriented psychiatrists were more accepting than were biologically oriented ones of the nosologic status of DID. The implications of this finding are examined in more detail later.

**Lack of training and knowledge.** In addition to professional skepticism, lack of training and knowledge also appear to contribute to the under- and misdiagnosis of DID (Hayes & Mitchell, 1994). Mental health professionals who believe DID is exceedingly rare are unlikely to assess for it or consider it in their differential diagnoses. While not commonplace, DID has a well-documented prevalence that is especially high in clinical samples, where individuals with DID are more likely to be found due to their highly impairing symptoms. Brand and Loewenstein (2010) have proposed that the prevalence of DID in psychiatric inpatients and outpatients ranges from 1% to 20%, depending on the sample. Consistent with this, a study of 82 psychiatric outpatients in the United States (Foote et al., 2006) found that 29% of those interviewed met criteria for a DSM-IV (American Psychiatric Association, 1994) dissociative disorder diagnosis and 6% met criteria for DID. Many clinicians, especially those working in inpatient or emergency department settings, will (knowingly or not) encounter DID at some point in their professional careers.

Despite this prevalence, lack of training in DID diagnosis, assessment, and treatment may be widespread. Hayes and Mitchell (1994) asked U.S. clinicians to diagnose clinical vignettes and found that only 21.9% of the multiple personality disorder (MPD) cases were diagnosed accurately whereas 54.2% of the schizophrenia cases were diagnosed accurately. Inaccuracy in diagnosing MPD was predicted by skepticism about MPD ($r_s = .33$, $p < .05$). In other words, the clinicians who were most skeptical about MPD were also most likely to misdiagnose it. Hayes and Mitchell offered the following interpretation of this finding:
This tendency to misdiagnose MPD most likely contributes to the consistent finding that clients with MPD spend an average of 7 years in the mental health system before receiving an accurate diagnosis (Coons, Bowman, & Milstein, 1998; Putnam, Guroff, Silberman, Barban, & Post, 1986; Ross, Norton, & Fraser, 1989; Schultz, Braun, & Kluft, 1989). (pp. 413-414)

Of note, analysis of variance revealed that skepticism about MPD was inversely related to professional activities related to learning about the condition, including the number of professional books on MPD that respondents had read ($r = -.39, p < .01$) and the number of professional conferences respondents had attended at which they learned about MPD ($r = -.24, p < .01$).

In another study (Stokoe, 2014), 61 of 138 (44%) practicing therapists in England described a full understanding of DID and six (4%) outlined all four criteria of the DSM-IV (American Psychiatric Association, 1994) DID diagnosis. The researcher concluded that this result implied less than half of participants (44%) had a working knowledge of the presentation of DID, with over half (56%) unable to identify key features of the disorder. A notable number of participants also lacked knowledge of DID treatment approaches. Participants were asked to describe the approach they would most likely use if they were to work with a DID patient. Of those who responded ($n = 129$), 23% said that they would not know which approach to use due to a lack of knowledge, experience, training, or evidence base.

**Hypothesized Moderators of Clinician Barriers**

Disbelief about DID and lack of knowledge, awareness, and training related to the disorder are ongoing problems that appear to contribute to misdiagnosis. However, there is variation among practitioners in terms of both of these areas. Why do some clinicians
demonstrate greater disbelief about DID? And why do some practitioners seek out more knowledge, experience, and training in this area? This study considers the possibility that professional discipline and theoretical orientation may be two such factors at least partially accounting for these differences.

**Professional discipline.** Professional discipline is hypothesized to impact skepticism, as clinicians working in different roles have varying degrees of exposure to patients. Though psychiatrists have much larger caseloads than psychotherapists, they spend less time on average with each patient. Typically, patients may meet with a psychiatrist for a 20-minute appointment once every few weeks or months. In contrast, most psychotherapy patients attend weekly, 50-minute sessions with their psychologists. For this reason, psychologists may have more opportunities to build a trusting relationship with the patient that would facilitate disclosure of symptoms. In addition, this affords them greater opportunities to potentially observe the patient in different alternative identity states. Another reason why psychiatrists may be more skeptical than other clinicians is because their training emphasizes the medical model of mental illness, whereas psychologists are more likely to be exposed to various models, including the trauma model of dissociation.

A small number of studies have considered the impact of professional discipline on skepticism about DID. In their survey study of mental health professionals, Hayes and Mitchell (1994) found that skepticism scores of MPD were higher for psychiatrists compared to social workers. However, no differences in skepticism were observed between psychologists and either social workers or psychiatrists. In contrast, Dunn, Paolo, Ryan, and Van Fleet ‘s (1994) survey study of Veteran Affairs (VA) psychologists and psychiatrists in the United States reported significant differences between these two groups. When asked if they believed in the existence of
MPD, 75.4% of psychiatrists and 83.1% of psychologists indicated that they did. The authors conducted separate chi-square analyses to evaluate whether belief in MPD was related to profession, among other factors, and found evidence that it was. Follow-up proportional analyses revealed that more psychologists (89.7%) than psychiatrists (81.9%) believed that MPD is an actual clinical disorder.

No study to this investigator’s knowledge has been able to replicate this finding of a significant difference in skepticism between these two groups. Somer (2000) found no differences between Israeli psychologists and psychiatrists on either belief about the validity of DID or average number of dissociative disorder patients diagnosed. Another study (Cormier & Thelen, 1998) surveyed 425 clinicians in the United States and found that participants with Doctor of Psychology (Psy.D.) degrees reported being significantly more familiar with the research than those with Doctor of Philosophy (Ph.D.) degrees, though they found no differences between the two groups in terms of skepticism, attitudes about MPD, or exposure to MPD.

Nonetheless, a fairly recent study found some evidence for a difference between these professional disciplines in terms of their knowledge and training in detecting DID. Dorahy et al. (2005) asked Northern Irish clinical psychologists \( (n = 27) \) and psychiatrists \( (n = 29) \) to complete clinical vignettes designed to assess their ability to detect DID. They concluded that psychologists more accurately detected DID than did psychiatrists (41% compared to 7%, respectively). This finding thus supports the hypothesis that psychologists, compared to psychiatrists, may be more familiar with DID, and knowledge of DID has been shown to be inversely correlated with skepticism in some studies. For instance, Hayes and Mitchell (1994) found that greater amounts of skepticism about MPD among mental health professionals were invariably associated with less knowledge about MPD.
**Theoretical orientation.** In addition to discipline, the theoretical orientation of the clinician may also impact their level of skepticism about DID and their knowledge of the condition. Compared to cognitive-behavioral clinicians, psychodynamic clinicians may be more likely to endorse a trauma or attachment model of dissociation than a sociocognitive or medical one. In addition, psychodynamic therapists are more likely to assess patient’s historical factors after the intake (when patients may not disclose abuse histories), as links between past and present behavior are a central focus of dynamic treatment. Cognitive-behavioral therapists, in contrast, generally focus on antecedents of behaviors in the recent past. Finally, other aspects of the treatment frame make dynamic clinicians more likely to encounter, and thus be less skeptical about, dissociative phenomena. Agenda setting in behavioral treatments may interfere with spontaneous reports of information, and the generally shorter treatment durations of these treatments may also inhibit patient disclosure and therapist ability to notice shifts in presentation.

A very limited number of studies have empirically investigated the impact of theoretical orientation on skepticism about DID. To this researcher's knowledge, only two such studies exist, both of which support the hypothesis that psychodynamic clinicians are less skeptical than behavioral ones. In their study of U.S. clinicians, Cormier and Thelen (1998) found that participants with a predominantly cognitive-behavioral orientation reported greater skepticism and more negative attitudes about MPD than did participants with a dynamic orientation. Consistent with this, in Pope et al.’s (1999) survey study of American psychiatrists, psychodynamic respondents were more likely than biological ones to indicate that DID should be included in the *DSM-IV* (American Psychiatric Association, 1994) without reservations (46% vs. 28%; Wald test \(X^2 = 6.97, df = 1, p = .008\)) and that DID was supported by strong evidence (32% vs. 14%; \(X^2 = 9.40, df = 1, p = .002\)). The authors performed logistical regression analyses to
assess the link between acceptance of DID and a number of demographic variables and found that the only associations that approached statistical significance were those involving theoretical orientation.

**Objectives of the Current Study**

**Primary Aims and Hypotheses**

**Aim 1.** This study hopes to replicate and extend the existing literature on mental health professionals’ knowledge, beliefs, experiences, and training related to DID by investigating these areas in a population of U.S. psychologists, social workers, and psychiatrists. A mixed-method design was selected in order to collect descriptive quantitative data as well as more in-depth qualitative data through an anonymous, online survey format. Through emphasizing training, supervision, and additional competency building professional activities, the results of this study may have important implications for DID diagnosis, assessment, and treatment.

Driven by the literature, the following hypotheses were proposed for this aim:

1. Mental health professionals will endorse varying levels of disbelief about the validity of the DID diagnosis.
2. Mental health professionals will demonstrate varying levels of knowledge about DID.
3. Most clinicians will report little or no experience working therapeutically with DID patients.
4. BPD, psychotic disorder, and PTSD will be the top three most commonly considered differential diagnoses among clinicians. This hypothesis is supported by Somer’s (2000) finding that the most frequently considered alternative diagnoses to DID among Israeli clinicians were: BPD (24% of respondents), psychotic
disorder/schizophrenia (23%), PTSD/anxiety disorder (10%), malingering (8%), and depressive disorder (7%).

5. Most clinicians will report little or no experience receiving postgraduate training or supervision in DID. This hypothesis is congruent with Stokoe’s (2014) finding that less than half of the therapists in the study (45.7%) reported that they had received training and/or supervision either directly or indirectly relevant to working with a client with DID.

**Aim 2.** A second goal of this study is to explore why some clinicians are more skeptical and less knowledgeable about DID compared to others. At present, only a handful of studies have considered factors that might distinguish informed and believing clinicians from uniformed and disbelieving ones. To address this gap in the literature, another aim of this study is to investigate the impacts of two such factors—professional discipline and theoretical orientation—on clinicians’ knowledge, beliefs, experiences, and training related to DID. These factors were selected because of their limited research attention and because of their potential to differentially impact clinical training and thus exposure (or lack thereof) to models and beliefs about DID.

Stemming from the research, the following hypotheses guided this aim:

6. Psychiatrists will endorse greater disbelief and less knowledge, training, and experience compared to psychologists and social workers. This hypothesis is based on the theoretical assumptions and prior research described above.

7. Cognitive-behavioral clinicians will endorse greater disbelief and less knowledge, training, and experience compared to psychodynamic clinicians. This hypothesis is based on the theoretical assumptions and prior research described above.
Exploratory Aims

In addition to obtaining descriptive quantitative data, this study will also collect more in-depth qualitative data from participants through anonymous responses to original, open-ended online survey questions. These responses will be analyzed for themes to help generate questions and hypotheses for future research. In analyzing the qualitative data, this study aims to explore the following questions:

A. How have therapeutic experiences with DID shaped clinicians’ knowledge, beliefs, and practices in this area?

B. How do clinicians know when to assess for DID in their patients?

C. How have clinicians prepared to work with DID patients?

D. Do clinicians’ want to learn about and work with DID?
Chapter III: Method

Participants

Recruitment

Recruiting participants for internet-based research from lists related to the subject matter is a common strategy believed to improve the validity of the research (Buchanan & Smith, 1999). In line with this, a convenience sample of mental health professionals (N = 83) was recruited from professional organization email listservs and LinkedIn pages via online advertisements and flyers (see Appendices A and B, respectively). The advertisement included a brief description of the study, information about IRB approval and eligibility, contact information for the researchers, and a link to participate in the online survey. The sample was initially limited to licensed clinical psychologists, licensed clinical social workers (LCSW), and board-certified psychiatrists in order to increase the likelihood that respondents would be engaged in the delivery of direct therapeutic services. However, the final dataset was expanded to include participants from other professional backgrounds, namely counseling psychologists and social workers with other degrees and licensures (e.g., LMSW). Mental health professionals who were at the graduate level, of other disciplines (e.g., mental health counselors), or living and/or working outside of the United States were excluded from participation in this study.

To recruit participants of diverse theoretical orientations, clinical interests, and professional degrees, 12 professional organizations that differed across these areas were contacted for permission to advertise the study. Of these, eight agreed to advertise the research. The diversity of the sample was thus limited by this response rate. For instance, 62.5% of the organizations are associated with the American Psychological Association (APA), although membership to APA-associated groups is not exclusive to psychologists. In addition, 25.0% of
the organizations have a trauma focus and 12.5% have a psychodynamic focus. For summaries of
the characteristics of all professional organizations contacted for recruitment and of the 8
organizations from which participants were ultimately recruited, see Tables 2 and 3, respectively.

**Demographics**

Of the 91 individuals who initiated the online survey platform, 88 consented and met
criteria to participate, and 83 of those response sets (91.2%) were sufficient for use in the data
analysis (i.e., completed at least 44% of the survey). Of the final 83 participants, 75 completed
100% of the survey (90.4%), whereas one completed 82% (1.2%), one completed 72% (1.2%),
two completed 62% (2.4%), and four completed 44% (4.8%). Most participants were female
(78.3%), White (88%), licensed clinical psychologists (67.5%), and aged fifty or older (63.9%).
Complete demographic information is provided below.

**Professional organization membership.** Participants indicated that they learned about
the study from various sources: 39.8% responded to an advertisement on the APA Division 39
(Psychoanalysis) listserv, 18.1% responded to an advertisement on the ISSTD listserv, 7.2% responded to an advertisement on the APA Division 17 (Counseling Psychology) listserv, 7.2%
responded to an advertisement on the APA Division 29 (Psychotherapy) listserv, 7.2% responded
to an advertisement on the Society for the Exploration of Psychotherapy Integration (SEPI)
listserv, 4.8% responded to an advertisement on the National Association of Social Workers
(NASW) LinkedIn page, and 1.2% responded to an advertisement on the APA Division 56
(Trauma Psychology) listserv. In addition, 14.5% of participants learned about the study from
other sources, including colleagues (2.4%), email notifications (1.2%), dissociation or DID
listservs (7.2%), and relatives (1.2%).
**Sociocultural identities.** Participants included individuals of all ages: 4.8% were in their twenties, 15.7% were in their thirties, 15.7% were in their forties, 20.5% were in their fifties, 28.9% were in their sixties, 12.0% were in their seventies, 1.2% were in their eighties, and 1.2% were in their nineties or older. Most participants identified as female (78.3%), while 19.3% identified as male, 1.2% identified as transgender, and 1.2% identified as other gender. In addition, the sample was 88% European origin/White, 4.8% other race/ethnicity, 2.4% Latino/a/Hispanic, 2.4% American Indian/Alaska Native/Aboriginal Canadian, 1.2% African-American/Black/African origin, 0.0% Asian-American/Asian origin/Pacific Islander, and 1.2% bi-racial or multiracial. Other racial/ethnic backgrounds identified by participants included Israeli (1.2%), Jewish (1.2%) and Mediterranean (1.2%).

**Professional discipline and theoretical orientation.** Fifty-six participants (67.5%) identified as clinical psychologists (44.6% PhD and 22.9% PsyD), 22 participants (26.5%) identified as social workers (22.9% LCSW, 3.6% other social work degree), one participant (1.2%) identified as a board-certified psychiatrist (MD), and two participants (2.4%) identified as counseling psychologists (1.2% practicing and 1.2% retired). Most participants identified their theoretical orientation as psychodynamic/psychoanalytic (54.2%) or integrative/eclectic (19.3%). Additional theoretical orientations represented in the sample included behavioral/cognitive-behavioral (CBT; 2.4%), dialectical behavior therapy (DBT; 1.2%), existential/humanistic (1.2%), family/systems (3.6%), interpersonal therapy (IPT; 1.2%), and other (14.5%). Table 4 provides the frequency percentages of the other theoretical orientations.

**Clinical experience and practice.** Overall, the sample consisted of well-seasoned practitioners. More than half of the sample (56.6%) had 16 or more years of post-graduate experience. More precisely, 21.7% had zero to five years of post-graduate experience, 10.8% had
six to 10 years of post-graduate experience, 10.8% had 11 to 15 years of post-graduate experience, 13.3% had 16 to 20 years of post-graduate experience, and 43.4% had 21 or more years of post-graduate experience. Participants varied with respect to clinical caseload, or the typical number of clients seen per week: 6.0% saw one to five clients weekly, 15.7% saw six to 10 clients weekly, 21.7% saw 11 to 15 clients weekly, 15.7% saw 16 to 20 clients weekly, 14.5% saw 21 to 25 clients weekly, and 22.9% saw 26 or more clients weekly.

A majority of participants (73.5%) currently work in private practice, and 65.1% identified this as their primary practice setting as well. Additional practice settings included community mental health center (12.0% overall, 8.4% primary), forensic/justice (2.4% overall, 2.4% primary) hospital (6.0% overall, 2.4% primary), inpatient psychiatric hospital (1.2% overall, 0.0% primary), partial hospitalization/intensive outpatient program (2.4% overall, 1.2% primary), outpatient psychiatric clinic/hospital (7.2% overall, 3.6% primary), university counseling center (6.0% overall, 6.0% primary), veteran affairs medical center (3.6% overall, 3.6% primary), and other (12.0% overall, 6.0% primary). Other primary practice settings were military treatment facility (1.2%), PHP and ART (1.2%), residences (1.2%), and retired (1.2%). Table 5 provides the frequency percentages of the other current practice settings.

Most participants (98.8%) currently work with adult clients (18 to 64 years), while 14.5% work with children (3 to 12 years), 32.5% work with adolescents (13 to 17 years), 54.2% work with older adults (65 or more years), 32.5% work with couples, 19.3% work with families, and 1.2% work with groups. Adults/older adults were the most common primary client group (92.8%), followed by children/adolescents (3.6%), couples (1.2%), and other (1.2%; practice evenly divided between adults and children/adolescents).
Participants varied in their specialties/areas of expertise. The most common specialties were trauma and PTSD (79.5%), anxiety (66.3%), depression (65.1%), and dissociative disorders (43.4%). Table 6 provides the frequency percentages of all specialties/areas of expertise.

A majority of the sample (n = 66; 79.5%) had expertise/training in one or more therapeutic modalities, including accelerated experiential dynamic psychotherapy (AEDP; n = 4), DBT (n = 28), eye movement desensitization and reprocessing (EMDR; n = 25), mindfulness-based approaches (n = 42), sensorimotor psychotherapy (n = 14), and other (n = 23). The most common other responses for expertise/training modalities were psychoanalysis (n = 6), hypnosis (n = 5), and somatic experiencing (n = 4). Table 7 provides the frequency percentages of the other expertise/training modalities.

Materials

The researcher developed a 38-item survey (see Appendices C and D for the written and online formats, respectively) to obtain an overview of clinicians’ demographics as well as their knowledge, beliefs, training, and clinical experiences and practices with respect to DID. The use of an original questionnaire in the absence of pre-validated measures is consistent with Stokoe (2014), whose doctoral dissertation examined questions similar to those of the current study. The survey is composed of four sections designed to assess demographic information (15 items), knowledge and beliefs about DID (8 items), experiences working therapeutically with DID (8 items), and experiences learning about DID in training and supervision (7 items). Of the total items, 31 are closed-ended questions and statements (81%) and seven are open-ended (19%). Some closed-ended questions provide the option to elaborate upon responses. Response to open-ended items constituted the qualitative section of the survey, while responses to closed-ended
items were used for quantitative analysis. Because this survey was designed for the purposes of this study, information on reliability and validity information are unavailable.

**Demographic Questionnaire**

Demographic questions inquired about United States residency, age, gender, race/ethnicity, profession, years of post-graduate experience, current and primary practice setting, theoretical orientation, expertise/training in other therapeutic modalities, client caseload, current and primary client populations, and clinical specialty/area of expertise. Participants were asked to select one or more responses from the list provided for each demographic question. For example, to assess for client caseload, participants were asked, “What is the typical number of clients that you see each week?” Many questions also included an “Other” response with the option of writing a different answer.

**DID Questionnaire**

Knowledge and beliefs about DID were assessed through two open-ended and six closed-ended questions modeled after the 17 rationally derived items designed by Hayes and Mitchell (1994) to measure skepticism and knowledge about DID (Madden, 2004). Modifications to Hayes and Mitchell’s (1994) instrument were made to reflect changes in the diagnostic criteria for DID and dissociative disorders. Three of the closed-ended items in this section were rated on 5-point Likert scales from 1 (Strongly disagree; Not at all familiar; Extremely unlikely) to 5 (Strongly agree; Extremely familiar; Extremely likely), respectively. Sample items of closed-ended questions include: “How familiar are you with the literature on DID?” and “How likely are you to believe a new patient that comes in and tells you that s/he/they has DID?” A sample item of an open-ended question is the following statement: “Please describe what you look for as red flags (e.g., clear signs and symptoms) to assess for DID.
Experiences and beliefs about DID diagnosis, assessment, and treatment were assessed through three open-ended and five closed-ended questions. Sample items of the former include statements such as: “Please describe your therapeutic modality/approach to treatment” and “If you have worked with patient(s) with DID, please briefly describe your own reactions and experiences.” Sample items of the latter include questions such as: “Have you ever assigned a diagnosis of DID?” and “Would you consider treating a patient with DID?”

Experiences learning about DID in training and supervision were assessed through two open-ended and five closed-ended questions. Each closed-ended question includes “Yes” and “No” response choices, with some offering the option of elaborating upon the selected response. Sample items include questions such as: “Are you involved in individual supervision?” and “Would you be interested in receiving further training on assessing and treating DID?” A sample of an open-ended question is the following statement: “Please describe anything else that has prepared you for working with people with DID.”

**Design and Procedure**

The Rutgers University Intuitional Review Board approved all study procedures. The survey was adapted to an online format using Qualtrics software provided by Rutgers University. The researcher input survey questions, responses, and instructions into the Qualtrics software to develop the online survey. Before sending the survey to prospective participants, a colleague of the principal investigator piloted it to assess for clarity of instructions and content, to ensure comprehensibility and functionality, and to gain an estimate of the expected completion time. Once reviewed, the online survey was made accessible to participants via a website link.

All participants provided online informed consent before proceeding with the survey. Information about the study procedures, risks, benefits, confidentiality, and contact persons was
discussed in the online consent page. Interested individuals were also informed that their data is completely anonymous and that participation in the study is voluntary and may be discontinued at any time. They were also told that they could skip any questions they did not wish to answer. Because written consent could not be obtained, participants were asked to click an on-screen button to indicate if they consented to participate and would like to continue to the survey. Individuals who declined to provide consent were immediately exited from the online survey platform. Participants who consented to participate in the research proceeded to the online survey, which included demographic and background questions as well as questions assessing their beliefs, knowledge, training, and experience related to DID.

**Data Collection and Analysis**

Survey responses were anonymously collected and stored in the Qualtrics system. Data was collected on a rolling basis, and the number of responses obtained was not limited in advance due to an inability to predict how many participants would provide answers that would be complete enough for inclusion in the data set. After an extended period of time during which no additional responses were obtained, data collection was closed, and all data were exported from Qualtrics into Microsoft Excel for analysis. The researcher then manually transferred the data from Microsoft Excel into IBM SPSS Statistics (Version 25) and created variables for each item and response set.

**Quantitative Analysis**

A combination of quantitative and qualitative data was obtained. Since this study used an original survey in lieu of a pre-validated measure, the data analysis was primarily descriptive in nature. Descriptive statistics were obtained by analyzing the frequency percentages of responses to closed-ended survey questions. This study planned to use one-way analysis of variance
(ANOVA) to test the exploratory aims and hypotheses regarding the distinct impacts of theoretical orientation and professional discipline on beliefs, knowledge, awareness, and clinical experiences and practices pertaining to DID. However, power calculations (Cohen, 1977, pp. 311-314) revealed that 80% power for a medium effect would need 156 participants to test professional discipline (psychologists vs. social workers vs. psychiatrists) as an independent variable (IV) on DID items and 124 participants to test theoretical orientation (psychodynamic clinicians vs. cognitive-behavioral clinicians) as an IV on DID items. The final sample of 83 participants was thus insufficient to test these hypotheses via the originally proposed methods. Instead, an alternative exploratory data analytic plan was used that involved comparing descriptive findings for DID items based on demographics.

**Qualitative Analysis**

To supplement the quantitative data, a qualitative approach was used to analyze participant responses to open-ended survey questions. In particular, *thematic analysis*, a method for identifying, analyzing, and reporting patterns (i.e., themes) within qualitative data, was selected for the qualitative data analysis (Braun & Clarke, 2006). Thematic analysis involves “systematically work[ing] through qualitative data in order to identify common threads of meaning, [grouping] these together into categories of meaning and [then clustering] these into higher-order themes” (Willig, 2013, p. 178). This study used a data-driven, *inductive approach* to thematic analysis where the themes or patterns that are identified are firmly grounded in the data and do not reflect *a priori* theoretical assumptions (Boyatzis, 1998; Willig, 2013).

According to Howitt (2010), thematic analysis is a useful analytic approach to qualitative data when: the data collection is complete, there are no strong theoretical perspectives driving the analysis, the data consist of detailed textual material, and the data are rich (i.e., full of detail
and information). Since all of these preconditions are met by this study, thematic analysis was deemed the most appropriate data analytic method. Moreover, other methods that are often viewed as more rigorous (e.g., grounded theory) were ruled out because they tend to require continually adapting, adjusting, and changing the study questions, as well as the population sampled, in response to new information, and this process was not feasible (Willig, 2013).

According to Willig (2013), “thematic analysis has only relatively recently been recognized as a qualitative research method in its own right, and there are now a number of clear and comprehensive accounts of how to carry out high quality thematic analysis (see e.g., Braun and Clarke 2006; Fereday and Muir-Cochrane 2006; Joffe 2012)” (p. 179). The well-founded criticism that thematic analysis is a poorly demarcated yet widely-used qualitative analytic method (e.g., Boyatzis, 1998) can be adequately addressed by both following a rigorous, step-by-step guide and providing a clear and transparent description of the data analysis process.

In line with this, Braun and Clarke’s (2006) guidelines for conducting a thematic analysis were used to examine all qualitative data. This method was selected in particular because it is often cited as the best available systematic approach to thematic analysis (e.g., Howitt, 2010; Willig, 2013). In this model, Braun and Clarke (2006) outline six phases of thematic analysis: (a) data familiarization; (b) initial code generation, with an emphasis on line-by-line coding; (c) search for themes based on initial coding; (d) review of themes; (e) theme definition and labeling; and (f) report writing (for a visual depiction of this model, see Howitt, 2010, Figure 7.3, p. 170). The analysis involves a constant moving back and forth between the entire data set, the coded extracts of data, and the analysis of the data.
Quantitative Findings

Aim 1

To assess participants’ knowledge, beliefs, therapeutic practices and experiences, and training and supervision pertaining to DID, frequency percentages of responses to corresponding survey items were obtained. These findings are described below.

Beliefs about DID. The hypothesis that mental health professionals would endorse varying levels of belief about the validity of the DID diagnosis was supported.

**Diagnosis.** All but one participant \((n = 82)\) rated the extent to which they agree that DID is a valid, distinct clinical diagnosis. Of the total sample, \(37 (44.6\%)\) strong agreed, \(24 (28.9\%)\) agreed, \(11 (13.3\%)\) neither agreed nor disagreed, \(4 (4.8\%)\) disagreed, and \(6 (7.2\%)\) strongly disagreed. Further, when asked to rate how likely they were to believe a new patient who reports having DID, four of 78 participants (4.8% of the total sample) indicated “Extremely likely,” 26 participants (31.3%) indicated “Likely,” 41 participants (49.4%) indicated “Neutral,” five participants (6.0%) indicated “Unlikely,” and two participants (2.4%) indicated “Extremely unlikely.”

Moreover, approximately half of the sample \((51.8\%; n = 43\) of 77 total respondents) believed that DID is under- and misdiagnosed in the US, despite growing support for its validity, in comparison to just 1.2% of participants who believed that DID is overdiagnosed in the United States, despite little or no empirical support for its validity. Other participants felt they had insufficient knowledge or competence to make a determination about validity (34.9%), a few participants (4.8%) believed that there is insufficient empirical research at present to make a determination about the validity of DID, and some did not respond to the question (7.2%).
**Etiology.** Beliefs about the etiology of DID were also assessed through a prompt that asked participants who believe that DID is a distinct, valid clinical disorder to describe what they consider to be the etiology of the disorder. Seventy-three participants (85.9% of the total sample) answered this question. Responses tended to consist of a few words or phrases, with only a handful of participants writing more than two lines. As such, although it was an open-ended prompt, the responses were, overall, far too brief for a qualitative exploration of themes and were therefore treated like quantitative data instead.

Nearly all participants (91.8%) who responded to this prompt indicated that “trauma” is an etiological factor for DID. Many specified the type and nature of the trauma. Thirty-nine participants (53.4%) cited “childhood” or “early” trauma, while 28 (38.4%) mentioned “severe,” “chronic,” or “persistent” trauma and two (2.7%) referenced “intentional” trauma, including mind control and ritual abuse. Some participants (15.1%) described the mechanisms through which they believed trauma contributed to the development of DID, emphasizing “dissociation” and “identity fragmentation.” Relatedly, a number of participants (15.1%) discussed experiences of abuse in the etiology of DID. Regarding types of abuse, “neglect” or emotional abuse was most commonly mentioned (12.3%), followed by “sexual abuse” (6.8%) and then “physical abuse” (2.7%). Other antecedent causes mentioned by participants included attachment or interpersonal difficulties (19.2%), such as “severe attachment issues,” “attachment disruption,” and “relational/interpersonal trauma” as well as biological/constitutional/genetic factors (12.3%), such as “epigenetics,” “inherent biological factors,” and “neurobiological and developmental vulnerabilities.” While only two participants (2.7%) expressed feeling “unsure” or unable to answer the question (e.g., “Don’t have enough information to say”), it is possible that some participants who did not respond to the prompt ($n = 12$) did so for this reason.
Knowledge about DID. The hypothesis that mental health professionals would demonstrate varying levels of knowledge about DID was also supported. Seventy-eight of 83 participants indicated their familiarity with the literature on DID. Of these, 20 participants (24.1% of the total sample) rated themselves as “Extremely familiar,” while 22 (26.5%) rated themselves as “Moderately familiar,” 15 (18.1%) rated themselves a “Somewhat familiar,” 19 (22.9%) rated themselves as “Slightly familiar,” and two (2.4%) rated themselves as “Not at all familiar.”

Participants indicated that they had learned about DID from a variety of sources, including first person accounts (47%), graduate school courses (30.1%), continuing education (69.9%), multilevel professional certification (14.5%), media (22.9%), professional literature (79.5%), and professional supervision (54.2%). An additional 18 participants (21.7%) learned about DID from other sources, including clients (n = 5), dissociation listservs (n = 3), postdoctoral training (n = 2), consultation groups (n = 1), colleagues (n = 2), personal research or writing (n = 2), and ISSTD training (n = 1). In addition, 78 participants indicated whether they were aware of evidence-based treatments (EBTs) for DID. Of these, 31 participants (37.3% of the total sample) indicated that they were aware of EBTs for DID, in comparison to 24 participants (28.9%) who were not aware, and 23 participants (27.7%) who were unsure.

Clinical experiences with DID. The hypothesis that most clinicians would report little or no experience working therapeutically with a DID patient was not supported.

Treatment. Participants were asked if they had worked therapeutically with a DID patient as well as if they would consider doing so. Of note, while 43 of 75 participants (51.8% of the total sample) said they had worked with a DID patient, only 34 (41.0% of the total sample) said they would definitely consider treating a DID patient. However, an additional 31 participants
(37.3%) would “Maybe” consider treating a DID patient and only 10 (12.0%) would not consider it. Similarly, 21 participants (25.3%) said they had never worked therapeutically with a DID patient and 11 (13.3%) were unsure if they had, indicating, “Possibly, but I didn’t realize they had DID at the time.” Some participants did not specify if they had worked with a DID patient (n = 8) or if they would consider doing so (n = 8).

Assessment. To evaluate experiences with DID diagnosis and assessment, participants were also asked if they have ever assigned a diagnosis of DID to a patient. Of the 76 participants who responded to this question, 36 (43.4% of the total sample) indicated “Yes,” 29 (34.9%) indicated “No,” and 11 (13.3%) indicated, “Yes, but only as a rule-out or provisional diagnosis.” Participants indicated that they used variety of clinical tools to assess for dissociative symptoms. Most participants (71.1%) said they assessed for dissociative symptoms with a clinical interview. The most commonly used assessment measure was the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986), reportedly used by 37.3% of participants. Following this, 18.1% of participants have used the Structured Clinical Interview for Dissociative Disorders (SCID-D/SCID-D-R; Steinberg, 1994; Steinberg et al., 1994), 15.7% have used the Multidimensional Inventory of Dissociation (MID; Briere, 2002), 6.0% have used the Dissociative Disorders Interview Schedule (DDIS; Ross, Heber, Norton, & Anderson, 1989), and 1.2% have used the Questionnaire on Experiences of Dissociation (QED; Riley, 1988). An additional 19.3% of participants indicated that they used other assessment tools. Of these, 4.8% used the Somatoform Dissociation Questionnaire (SDQ-20 and SDQ-5; Nijenhuis, Spinhoven, van Dyck, van der Hart, & Vanderlinden, 1996), 3.6% used clinical observation in ongoing treatment, 2.4% used the Adolescent and Child Dissociative Experiences Scales (A-DES and C-DES; Armstrong, Putnam, Carlson, Libero, & Smith, 1997), 2.4% used the Cambridge Depersonalization Scale (CDS;
Sierra & Berrios, 2000), and 2.4% used the Trauma Symptom Inventory (TSI; Briere, 1995), among others. Furthermore, 3.6% of participants indicated that they do not assess for dissociative symptoms at all.

**Differential diagnosis.** In addition to understanding what tools clinicians use to assess for DID, it is important to consider what differential diagnoses they consider in making this determination. The hypothesis that the top three most commonly considered differential diagnoses among clinicians would be BPD, psychotic disorder, and PTSD was supported. Participants were asked to indicate what they think are the most common differential diagnoses for DID by ranking their top three choices from a list of nine diagnoses. For the first choice, PTSD was the most commonly selected differential diagnosis (42.2%), followed by BPD (27.7%) and then schizophrenia/psychotic disorder (8.4%). For the second choice, schizophrenia/psychotic disorder was the most commonly selected differential diagnosis (21.7%), closely followed by BPD (20.5%) and then PTSD (18.1%). For the third choice, BPD (16.9%) and schizophrenia/psychotic disorder (16.9%) tied for the most commonly selected differential diagnosis followed by somatic symptom disorder (12.0%). The most commonly selected ranking order ($n = 9$) of differential diagnoses was:

1. PTSD
2. BPD

The second most commonly chosen ranking order ($n = 5$) involved these same three differential diagnoses but in a slightly modified order:

1. PTSD
2. Schizophrenia/psychotic disorder
3. BPD.

Table 8 provides the frequency percentages for all differential diagnosis responses.

**DID training and supervision.** Many participants said that they currently receive some form of supervision of their clinical work. Of the 73 participants who responded, 38 (45.8% of the total sample) are involved in individual supervision and 47 (56.6%) are involved in an ongoing supervision group. More importantly, 57 participants (68.7%) have received training and/or supervision either directly or indirectly relevant to working with someone with DID. The hypothesis that most clinicians would report little or no experience receiving postgraduate training or supervision in DID was therefore not supported. Participants also expressed strong interest in receiving additional training and education in this area. Fifty-nine of 73 participants (71.1% of the total sample) said they would be interested in receiving further education on DID, and 58 of 74 participants (69.9% of the total sample) said they would be interested in receiving further training on assessing and treating DID.

**Aim 2**

An additional aim of this study was to investigate the impacts of professional discipline and theoretical orientation on participants’ beliefs, knowledge, therapeutic experiences, and training related to DID.

**Theoretical orientation.** Due to limited representation of cognitive-behavioral therapists in this sample (2.4%), the hypothesis that cognitive-behavioral clinicians, compared to psychodynamic clinicians, would endorse greater disbelief and less knowledge, training, and experience related to DID could not be examined. Descriptive comparisons could also not be made due to insufficient representation of theoretical orientations in the sample.
Professional discipline. The sample consisted of 58 psychologists (56 clinical psychologists and two counseling psychologists), 22 social workers (19 LCSW and three other), and one psychiatrist. Social workers at all stages of licensure were combined into one group for ease of comparison. Because only one psychiatrist participated in this study, the hypothesis that psychiatrists would endorse greater disbelief and less knowledge, training, and experience compared to psychologists and social workers could not be examined. More broadly, due to limited representation of professional groups in the sample, there was inadequate power to assess for an effect of professional discipline through Univariate regression analyses (one-way ANOVAs). Instead, preliminary descriptive statistics comparing responses by professional group are presented. These results are only presented for clinical psychologists and social workers given the lack of psychiatrist representation in this sample. To obtain these findings, the researcher split the SPSS file by professional group (clinical psychologist versus social worker) and then compared responses to DID items between the two groups.

Overall, clinical psychologists and social workers appeared to endorse similar beliefs about DID as well as levels of knowledge, awareness, and experience with this population. For instance, 44.6% of clinical psychologist respondents and 40.9% of social worker respondents indicated that they have assigned a diagnosis of DID. Another similarity was in their choice of differential diagnoses for DID. For top ranked differential diagnosis, PTSD was the most selected diagnosis and BPD was the second most selected diagnosis for both clinical psychologists (37.5% and 30.4%, respectively) and social workers (54.5% and 22.7%, respectively). Furthermore, 23 of 52 clinical psychologists (41.1% of total group) and 10 of 20 (45.5% of total group) social workers said they would definitely consider treating a DID patient, while 12.5% of clinical psychologists and 13.6% of social workers said they would not consider.
Finally, social workers and clinical psychologists seemed to report similar amounts of clinical experience with DID. Twenty-eight of 52 clinical psychologists (50.0% of the total group) and 12 of 19 social workers (54.5% of the total group) said they have worked therapeutically with one or more patients with DID.

In spite of the overall similarities between the two professional groups, a slight trend was observed that social workers seemed to endorse greater belief in the validity of DID than did clinical psychologists. For example, 81.9% of social workers agree ($n=8$) or strongly agree ($n=10$) that DID is a valid, distinct clinical diagnosis, while 69.6% of clinical psychologists agree ($n=14$) or strongly agree ($n=25$) with this statement. Additionally, 15 of 20 social workers (68.2% of the total group) said DID is under- and misdiagnosed in the US despite growing support for its validity, compared to 26 of 53 clinical psychologists (46.4% of the total group).

Social worker respondents also appeared to be more inclined to believe a new patient who reports having DID than were clinical psychologist respondents, as assessed through self-report. Eighteen of 53 clinical psychologists (32.2% of the total group) and 11 of 21 social workers (50.0% of the total group) said they were likely ($n=17$ and 8, respectively) or extremely likely ($n=1$ and 3, respectively) to believe the patient. However, social workers also endorsed more disbelief on this question, with 13.6% of social workers indicating they were unlikely ($n=2$) or extremely unlikely ($n=1$) to believe a new patient who reports having DID, compared to only 5.4% of clinical psychologists who were unlikely ($n=3$) or extremely unlikely ($n=1$) to believe the patient. One explanation for this contradictory finding is that a majority of clinical psychologists (57.1% of the total group) but only a third of social workers (31.8% of the total group) endorsed a neutral response to this question.
In addition, compared to clinical psychologists, social workers appeared to have both greater familiarity with the DID literature and increased awareness of evidence-based treatments (EBTs) for DID. Of their total groups, 48.2% of psychologists said they were moderately ($n = 15$) or extremely ($n = 12$) familiar with the literature on DID, while 59.1% of social workers endorsed moderate ($n = 6$) or extreme ($n = 7$) familiarity. Relatedly, 19 of 53 clinical psychologists (33.9% of the total group) and 10 of 21 social workers (45.5% of the total group) were aware of EBTs for DID.

Of note, specialization in both trauma/PTSD and/or dissociative disorders may be confounding variables. A vast majority of social worker participants (90.9%) specialize in trauma and PTSD, compared to 75.0% of clinical psychologist participants. Relatedly, 39.3% of clinical psychologists and 59.1% of social workers said they specialize in dissociative disorders.

**Qualitative Findings**

In line with the procedure for thematic analysis proposed by Braun and Clarke (2006), a six-stage qualitative analysis was conducted separately for responses to four open-ended survey items—20, 31, 35, and 38 (see Appendix C for the specific item prompts).

1. In the first phase of the analysis, participant responses were read several times and copied onto a document. A more detailed examination of this data set involved writing notes for coding inside the right-hand margin. These notes comprised an initial list of potential themes based on concepts and phrases in the data that the researcher considered interesting and significant or that appeared to represent a pattern.

2. Once familiarized with the data, the researcher proceeded to the second phase of analysis, which involved working systematically through the entire data set and coding line-by-line for as many potential themes as possible. According to Braun and Clarke (2006), a theme
“captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set” (p. 10).

3. In the third phase of the analysis, different codes were sorted into potential themes, and the relevant coded data extracts within the identified themes were collated (see Appendix E for an example of a data extract with focused codes applied). An initial visual representation of themes, or a thematic map, was developed to help sort the different codes into themes.

4. Initial themes were reviewed and refined in the fourth phase of analysis until they appeared to form a coherent pattern in relation to the data set. This stage required several iterations of refinement.

5. The fifth phase involved naming, defining, and further refining the themes for analysis by going back and forth between the themes and the data set (see Appendices F, G, H, and I for examples of developed visual representations of major themes).

6. Finally, the sixth phase of the analysis aimed to provide sufficient evidence of the themes within the data. To achieve this, the researcher identified statements from the data or ‘extracts’ that illustrated each of the themes and subthemes. These illustrative extracts were further examined in order to relate them back to the research question and the relevant research literature in order to produce a scholarly report.

Once the themes and subthemes were finalized, the researcher coded the responses accordingly and entered the data into SPSS in order to calculate the frequencies at which each theme and subtheme appeared. Extracts from participant responses illustrating aspects of each theme and subtheme are presented below, organized by research question. To enhance clarity, extracts were modified for minor spelling and grammatical errors when appropriate. Of note, participant responses to certain items often included elements of more than one theme and
subsequently received focused codes belonging to multiple themes and/or subthemes when indicated. As such, overlapping themes and subthemes in the extracts are unavoidable.

**Experiences and Reactions to DID Work**

Participants were asked to describe their experiences and reactions to working with DID patients. This study analyzed these responses for common themes in order to explore how therapeutic experiences with DID have shaped clinicians’ knowledge, beliefs, and practices. Of the total 83 participants, 59 responded to this prompt. After discarding non-applicable responses (e.g., “N/A”), 50 responses remained and were used in the analysis. After completing the first two phases of the analysis, different codes were sorted into themes and subthemes, which were subsequently reviewed and refined in more than a dozen iterations. Ultimately, three major themes containing three subthemes each were identified. Focused codes were also identified for each of these themes (see Appendix F).

1. **Therapy Process and Outcome**
   - 1a. Patient Qualities and Presentation
   - 1b. Treatment Progress and Outcome
   - 1c. Treatment Challenges and Concerns

2. **Service and Support Considerations**
   - 2a. Professional Support
   - 2b. Controversy
   - 2c. Practice Considerations

3. **Qualities and Considerations for the Therapist**
   - 3a. Therapist’s Role and Skills
   - 3b. Therapist Growth and Fulfillment
   - 3c. Impact on the Therapist

*Figure 1.* Themes and subthemes identified for experiences and reactions to DID work.

1. **Therapy process and outcome.** Thirty-one participants (62.0% of respondents; 37.3% of total sample) discussed aspects of the therapy process and outcome when working with DID
patients. Subthemes identified for the category of therapy process and outcomes were: (a) patient qualities and presentation, (b) treatment progress and outcome, and (c) treatment challenges and concerns.

1a. Patient qualities and presentation. Nineteen participants (38.0% of respondents; 22.9% of total sample) mentioned qualities of DID patients or aspects of their clinical presentation. Regarding patient qualities, participants frequently expressed admiration, awe, and respect for the strength, courage, and resilience of individuals with DID. For example, one participant described DID patients as “incredibly resilient people” [Participant 46], while another expressed “tremendous respect, for their courage, integrity, and intelligence” [Participant 18].

Several participants discussed their appreciation for the way individuals with DID cope with overwhelming experiences of trauma. For instance, “DID is a brilliant, creative, sophisticated response to overwhelming/threatening/immobilizing experiences. I'm in awe of the gifts and resources that folks with DID have within them” [Participant 55]. Another participant shared, “I have enjoyed working with clients with DID, am absolutely awed by their intelligence and ingenuity in adapting to impossibly traumatic childhoods and impressed by their courage and growth in recovery” [Participant 7]. Others expressed feeling “deeply admiring of the resourcefulness and resilience” [Participant 71] and having “respect for the various coping strategies and capacities the parts hold” [Participant 42].

Participants also discussed the many talents of DID patients, frequently describing them as highly creative and intelligent individuals. One participant said, “I have found those I have treated for a while to be extremely motivated and unusually intelligent. They tend to be creative individuals with many talents” [Participant 51], while another stated, “They are typically the most brilliant people I have interacted with in my practice or life” [Participant 78]. Further, one
participant seemed to attribute their preference for treating DID patients to their many strengths:

“I prefer working with DID to most other clinical groups. They are creative, highly attentive (paradoxically) and generally very intuitive and spiritual people, tapped into a level of consciousness that people without trauma often lack” [Participant 40].

In addition to discussing patient qualities, participants also emphasized aspects of the clinical presentation of DID, including symptom presentation, stereotype conformity or disconformity, level of functioning, and reactions to the DID diagnosis. Several participants described the complexity of DID and the “confusing symptom picture” [Participant 11]. One participant discussed their unique framework for understanding DID patients: “I have found that getting to know the patient's symptom is like developing an understanding of a family system or a particular social group or culture. This is both challenging and fascinating” [Participant 7]. Another described the unique presentations of DID patients—“Each person presents in very unique ways -- no two treatments are the same”—and noted that they do not typically present with the flagrant, stereotype shifts in self-states that are portrayed in the media, “The shifts in states are often less exaggerated than seen in the media, though are discernible, subtler than stereotypes indicate” [Participant 45].

Relatedly, one participant also seemed to debunk common myths about DID. In particular, this individual challenged popular perceptions of DID patients as severely impaired and challenging to work with by discussing the range in levels of functioning s/he/they had observed in these patients over the years:

I first met someone with DID in the early 1990s working in a CMHC. I treated four others with DID at that setting—they were all poor with severe symptoms including significant self-harm. I have also treated people with DID in my private practice. Several
of these people have had alters with much higher functioning and significant accomplishment, while also being sporadically suicidal, extremely anxious, and depressed. [Participant 13]

Importantly, while some expressed a dislike for the work as a result of the complicated clinical presentation, more participants emphasized finding the work enjoyable, meaningful, or interesting, either in spite of or as a result of these very complexities.

1b. Treatment progress and outcome. Ten participants (20.0% of respondents; 12.0% of total sample) discussed treatment progress and outcomes in working with DID patients. Many participants discussed the “slow progress” [Participant 57] made in treatment with these patients. One wrote, “I wish there was a better way to help them” [Participant 57].

Participants also described their experiences reaching treatment milestones and encountering treatment failures. One participant described specific, behavioral improvements that s/he/they observed in his/her/their patient after several years of treatment:

My primary experience was with one patient for several years with DDNOS, who, over several years, experienced considerable improvement (got off disability, returned to work, found and married her husband, significantly reduced chronic pain condition, increased capacity to live in the present (much less triggered), improved interpersonal relationships, etc.). [Participant 19]

Others described their emotional reactions to reaching milestones in their treatments with DID patients. For instance: “I am frequently amazed by the progress that they make when using the model we have developed, particularly after not being helped for a very long time or being helped to a certain level but not actually healing” [Participant 78]. Another stated:

For those who have never had their experience honored or "seen" by anyone else, the
experience of being heard/seen, developing the language to communicate their
experience to others, to communicate and embrace internal affective states which were
here-to-fore internal enemies, is thrilling for both self and patient. [Participant 35]

When treatment failures or stagnates occurred, participants tended to refer their DID
patients to specialists, who they believed could better help their patients, or to psychiatrists, who
they believed may be able to move the work along. For example: “I worked with a patient but the
patient failed to make consistent progress, and I felt she needed more help than I could offer her.
Patient was referred to someone who had more experience with DID” [Participant 11]. One
participant stated, “A few other patients that were likely DID or DDNOS I was much less
effective with and eventually (in less than 6 months) referred them elsewhere” [Participant 19].
Similarly, another shared:

She eventually was willing to see a psychiatrist (I referred her to someone with
experience with DID) and a low dose of anti-psychotic medication made a huge
difference in her symptoms. We have spent many, many years to get her to a place where
her relationships are healthier and she is able to stand up for herself. [Participant 67]

In addition to making referrals, participants seemed to frequently utilize supervision and
consultation when feeling stuck or out of their area of expertise with a DID patient. Examples of
this are discussed below under Professional Support (subtheme 2a).

1c. Treatment challenges and concerns. Eighteen participants (36.0% of respondents;
21.7% of total sample) discussed challenges and concerns encountered in the treatment of DID.
Many participants described these patients as challenging and difficult to treat. Some noted that
they lacked the expertise needed to work with this population. As described above, this
frequently resulted in referring the patient to a provider better equipped to treat the DID patient.
In line with this, a few participants described their difficulties recognizing DID in their patients. For example:

I went through a long period of "waking up" to the DID in my clients, whom I had been treating long term in a PTSD framework (with Borderline personality disorder overtones). I finally started to recognize it when I had three different patients who were from totally different geographic regions who described self-states with the same names. That woke me up. [Participant 33]

For others, treatment challenges were attributed to patient factors, such as the complexity of DID with its frequently comorbid or co-occurring disorders. For instance, one participant stated, “I believe it’s the most complex of disorders to treat, especially with the various kinds of comorbidity (PTSD, substance abuse, self-harm and suicidality, eating disorders, trust issues, developmental trauma, etc.)” [Participant 45].

In addition, participants frequently cited challenges related to managing crises, safety concerns, and other high-risk patient behaviors. In describing these concerns, participants tended to touch on the anxiety that they incited. For example, one participant shared, “I was puzzled and very worried about the patient as she was engaging in some very dangerous behaviors” [Participant 67]. Another participant described experiencing “frustration and anxiety around chronic suicidality” [Participant 42], while another stated that “safety concerns (e.g., chronic suicidal ideation, self-harm)” can be “anxiety provoking” [Participant 22]. One participant offered a more detailed explanation of the types of safety issues and treatment-interfering behaviors s/he/they has encountered in his/her/their work with DID patients:

They are frequent crises and therapy interfering behaviors / challenging symptoms to address. For example, clients I work with swallow batteries and glass; insert foreign
objects into their ears and under their skin; and frequently attempt suicide (e.g. attempt to jump off of bridges, repeatedly overdose on medications, stab self, set self on fire, lay down in the road, jump into lakes trying to drown, etc.). They also often have co-occurring high risk behaviors such as promiscuity, poor boundaries/placing themselves at risk by associating with felons/dangerous persons, have significant substance dependence issues (i.e. at risk for overdosing) and eating disorder behaviors (e.g. low weight, purging multiple times daily) that also put their lives at risk. Interpersonally, they are often challenging, as they tend to engage in verbal aggression and physical aggression at times (e.g. broke a metal chair in half on the wall during session). I find it (understandably) stressful to respond to these behaviors at times. [Participant 57]

In describing the various aspects of the therapy process and outcome, it is notable that participants tended to express a range of feelings and reactions, and only rarely did they describe a wholly negative experience. Even when participants felt that their treatment had failed, they did not necessarily view the work unfavorably. For instance, one participant stated:

I have found these patients very difficult to treat, and they tend to leave me to find other therapists who can do it better. However, I have found those I have treated for a while to be extremely motivated and unusually intelligent. They tend to be creative individuals with many talents, and interesting to work with, though I do not think I have done so successfully. [Participant 51]

While this speaks to the complexity and difficulty of working with DID, it suggests that many clinicians were also able to derive some meaning and satisfaction from the experience.

2. Service and support considerations. Eighteen participants (36.0% of respondents; 21.7% of total sample) touched on aspects of service and support considerations in describing
their reactions and experiences to clinical work with DID. Subthemes for service and support considerations were: (a) professional support, (b) controversy, and (c) practice considerations.

2a. Professional support. Professional support was the most frequently cited subtheme for this category. Thirteen participants (26.0% of respondents, 13.0% of total sample) referenced a need for some form of professional support when working with DID patients, most commonly in the form of supervision or consultation. Participants often expressed deep appreciation for the support they received. For instance, one participant shared having “gratitude for consultation groups with colleagues who also engage in this kind of work” [Participant 42]. Another wrote, “It takes a village to help a person heal from DID. Peer supervision is very important!!” [Participant 45].

In many cases, participants discussed seeking support as a way to manage their own feelings that arose in the treatment (i.e., countertransference). For example:

I immediately got consultation in my first case because I wasn't sure if this was DID or something else, and I continued consultation throughout treatment. I also always get consultation with a DID patient now as it helps me work through countertransference.

[Participant 9]

One participant shared, “I have felt almost voyeuristic watching the client's subtle changes, which is not a good feeling and one I have discussed in consultation” [Participant 39]. Another expressed, “The work is slow and at times can be overwhelming, so having good consultation can be really helpful” [Participant 41].

Others echoed this sense of needing support to cope with feeling overwhelmed or anxious. One participant described his/her/their reaction to the work succinctly as: “Confusion. Need to consult. Feeling overwhelmed” [Participant 28]. Another shared, “I do find it
indispensable to have access to support from other experienced clinicians to maintain my own clarity and balance” [Participant 49].

While most participants seemed to seek support in the form of consultation or supervision, one participant described the value of working within a group practice: “These patients are very difficult to work with and usually require a therapist in a group practice, so that backup and psychiatric consultation are available” [Participant 73].

Additionally, a few participants discussed utilizing support to gain more expertise in treating DID or to otherwise improve their confidence in their ability to help these patients. For example:

At first I didn't understand why my approach to working with her (AEDP) was making things work. I then received consultation from someone better trained in complex trauma and dissociative disorders, and then helped me help my patient understand more about different parts of their mind, and those factors that triggered her more extreme reactions (including in-session switching and dissociation). [Participant 19]

Relatedly, one participant reported that s/he/they “educated [him/herself] and sought consultation around the DID symptoms” [Participant 67], while another sought additional training: “At first I was a bit freaked out. But now that I have had specific training I feel as if I mostly know what I am doing” [Participant 53].

2b. Controversy. Surprisingly, only six participants (12.0% of respondents; 7.2% of total sample) discussed experiences with controversy in their work with DID patients. A few participants discussed difficulties related to encountering skepticism or disbelief by the field. For example, one participant shared, “This was very early in my analytic training, and I remember being hesitant to describe the patient and her symptoms to my supervisors and colleagues for fear
of not being believed” [Participant 25]. Another discussed having trouble accessing support due
to the controversy: “It has been isolating at times as others deny or misunderstand the diagnosis
and thus difficult to get supervision or consultation around DID issues” [Participant 7].

Two participants expressed struggling with their own skepticism in the work. One
described feeling “shock, guarded skepticism” [Participant 79], among other emotions. Another
expressed ambivalent beliefs: “I have had a few clients who were clearly (in my clinical opinion)
malingering this diagnosis, and they had a very ‘stagey’ presentation. I guess this has made me
skeptical, but I definitely believe that DID is legitimate” [Participant 39].

**2c. Practice considerations.** Five participants (12.0% of respondents; 7.2% of total
sample) touched on practice considerations for the therapist working with DID patients. Often,
participants discussed these considerations in light of the difficulties they encountered in their
work with this population. For instance, a few participants emphasized needing to be mindful of
the number of DID patients in their clinical caseload for this reason. One stated, “The work is
very intense and time-intensive. I have to limit the number of DID clients I see at one time,
especially if they are in the early (pre-stabilization) process of treatment” [Participant 45].
Another shared, “It can be very stressful to work with multiple clients with DID. They are
frequent crises and therapy interfering behaviors/challenging symptoms to address” [Participant
57]. In addition, one participant did not feel qualified to work with this patient population:
“Prefer not to serve these clients as I am not an expert” [Participant 80].

**3. Qualities and considerations for the therapist.** Forty-two participants (84.0% of
respondents; 50.6% of total sample) discussed qualities and considerations for the therapist,
making this category the most commonly observed in the sample. Subthemes for this category
included: (a) therapist’s role and skills, (b) therapist growth and fulfillment, and (c) impact on
3a. Therapist’s role and skills. Fifteen participants (30.0% of respondents; 18.1% of total sample) described aspects of the therapist’s role or skills in DID treatment. Participants tended to emphasize the challenges they encountered when working with DID patients, especially with respect to the patients’ changing self-states. For example:

Another challenge involves developing a plan from session to session. Because it is often unknown which personality will present to session, it feels as though one needs to have multiple strategies in mind to address the needs of each personality. It is a challenge to keep good track of where we are headed and what my evolving objectives and strategies are. [Participant 37]

Others echoed feeling overwhelmed, confused, or uncertain at various stages in the work. However, this was often viewed as par for the course. In other words, many participants considered feelings of uncertainty and overwhelm a necessary component of, rather than barrier to, the treatment process. For instance, one participant stressed the importance of embracing this feeling of not knowing in the work:

I can often feel like I do not know exactly what I am doing as I enter their dissociative field. I have learned to engage and stay with this level of not knowing until we inevitably get to a clearer picture. The work can be exhausting, as it requires focus on multilevel cues. I have also learned to go slowly, with safety being the first order of business with all of a client’s parts, before processing trauma memories. [Participant 4]

As demonstrated by this excerpt, in addition to highlighting the challenges of the work, many participants also emphasized ways they learned to cope with these complexities. One participant, for example, shared that DID patients, “require an organized clear presence in me,
and that's what I try to provide” [Participant 23]. Another stated, “I followed my own gut a lot in working with her” [Participant 67].

Participants also tended to speak to the learning curve in the work, especially with respect to treating DID patients’ various parts. For instance, one participant shared that his/her/their “initial fascination/absorption” was “followed by years of learning to shore up my boundaries, keep an even handed response to various presentations, and expanding my understanding of dissociative processes beyond their occurrence in DID” [Participant 44]. Another stated:

I've learned to welcome the internal “persecutors.” They are protectors who've protected in the only way they knew—by trying to keep the person from trusting anyone, etc. As soon as I see evidence of them now, I respect the limits they are trying to set and speak to the ways they are trying to safeguard the client. [Participant 45]

Moreover, one participant described how s/he/they was able to use countertransference self-state enactments in the treatment to facilitate growth:

Countertransference reactions have been strong at times - and initially confusing as I found myself in different "countertransference self-states" so to speak that sometimes rapidly changed within a session. Another example is of me feeling as though I'm in one of the persons' self-states and she is in another - this is usually behaviorally enacted and I would recognize it after the fact. When we could talk about this in the treatment that was a significant milestone among the many others that preceded it. [Participant 9]

Further, several participants emphasized aspects of the therapeutic relationship. One participant observed that, “Maintaining boundaries is the most important part of the therapeutic relationship” [Participant 46]. Another stressed the importance of supporting the patient’s framework for understanding herself and her symptoms in order to build rapport:
When the patient told me about her diagnosis, I could see she was very gratified to have a framework for understanding herself that maintained the splitting she had developed. I validated and supported her working with a therapist who would help her using that framework. [Participant 3]

3b. Therapist growth and fulfillment. Twenty-six participants (52.0% of respondents; 31.3% of total sample) discussed aspects of the therapist’s growth and fulfillment in working therapeutically with DID. In particular, many participants described the positive feelings (e.g., enjoyment, satisfaction, joy, interest) they experienced in the work. Often, positive emotions were connected to the challenges of the work (e.g., “It’s a complex, engaging, and really meaningful process to be in” [Participant 41]).

A number of participants seemed to describe a sense of compassion satisfaction, or pleasure derived from rewarding or challenging work. One participant said that working with DID patients is “often very challenging work, but incredibly satisfying as people heal” [Participant 31]. Another stated, “My experience in working with clients with DID is that they are a pleasure to work with. I say this because I enjoy the immense challenge they present” [Participant 43]. Similarly, one participant expressed:

This patient (above) was difficult due to her tendency toward self-harm and the related need to hospitalize her on several occasions. She was also engaging to work with, as her pain was great and she was actively trying hard to cooperate with treatment and to get better. [Participant 69]

Others appeared to derive sense of fulfillment from witnessing DID patients’ progress in treatment. For instance, after describing feeling “exhausted” at times in the work, one participant shared, “But, I love being able to be creative with my patients and I feel it a great privilege to
witness their treatment gains” [Participant 22]. Another described the “entire range of relational emotional experiences I have with clients during the work,” which included “delight at progress and resilience of my clients” [Participant 42].

As the above example suggests, learning about DID patients’ strengths also appeared to be a rewarding and fulfilling experience for participants. Many described a sense of awe, amazement, or appreciation for their patients’ resilience in coping with trauma. For example, one participant shared: “I have enjoyed working with clients with DID, am absolutely awed by their intelligence and ingenuity in adapting to impossibly traumatic childhoods and impressed by their courage and growth in recovery” [Participant 7]. Another stated, “I am in awe of how the brain copes with extreme trauma and have compassion for those clients that have this disorder” [Participant 48], while yet another observed that, “the capacity in which a person can compartmentalize and detach as a way to survive is profound” [Participant 46].

In addition, several participants discussed their growth as psychotherapists. They tended to describe increased confidence in their clinical skills as they learned more effective ways of treating, often through supervision, consultation, or additional training. One participant discussed how working with DID patients contributed more globally to his/her/their professional development, stating that working with DID patients had a “profound impact on my way of thinking about therapy and human being and consciousness” and led to “greatly increased awareness of the pervasiveness of trauma and the impact on developing humans” [Participant 44].

**3c. Impact on the therapist.** Twenty-three participants (46.0% of respondents; 27.7% of total sample) discussed the (adverse) impact on the therapist working with DID. Participants emphasized strong countertransference reactions (e.g., anger, disgust); signs of burnout (e.g.,
feeling drained, exhausted, or overwhelmed); feeling lost of incompetent (i.e., questioning competence as a clinician); self-care needs; and exposure to trauma/abuse or risk of vicarious trauma or secondary traumatic stress.

Regarding countertransference and signs of burnout, many participants discussed feeling negative emotions in their work with DID patients. For example, one participant stated that it is, “hard work, emotionally draining” [Participant 1]. Another specified experiencing “strong countertransference reactions (anger, confusion, feeling exhaustion)” [Participant 60], feelings that were commonly echoed by other participants. For instance: “I can feel exhausted following a session due to intense affect, dissociation, and intense traumatic transference-countertransference” [Participant 22].

Two participants described having bodily reactions to the work. One stated, “I often have somatic counter-transference reactions as well as moments of feeling confused and loosing time” [Participant 63], while the other expressed, “I have intense visceral and emotional responses to many persons with DID. Some of these responses are positive, others mixed, and some are frankly very negative. My responses usually correspond with the person's own major projections” [Participant 36].

In addition, two participants explicitly described needing to attend to self-care needs as a result of their countertransference reactions and signs of burnout. One stated, “At times I have been exhausted, which is why our model addresses therapist self care and boundaries” [Participant 78], and the other reiterated this idea, “I often feel disoriented after a session with a DID client and need to take some time to do self-care” [Participant 39].

Further, several participants discussed the risk of vicarious trauma or secondary traumatic stress for therapists as a result of hearing about the trauma and abuse endured by their DID
patients:

I think that the risk of experiencing vicarious trauma is very high with this patient population. I have found myself feeling tremendous grief and horror as I came to understand the early experiences of my patient. This was a significant factor for me and I have had to work very hard to manage my own responses, keep myself from becoming too upset and activated, so that I can maintain my ability to think clearly. [Participant 37]

Another participant described the pain of hearing DID patients’ abuse:

They have all experienced horrific trauma that no child or person should have to experience. It is painful at times to be a witness to this. It is painful to even read their records (e.g. horrifically abused and neglected by parents). [Participant 57]

Relatedly, one participant stated, “Their experiences are often hard to hear, and I think therapists are at risk of secondary trauma” [Participant 23].

**Red Flags for Assessing DID**

Participants were asked to describe what they look for as red flags (e.g., clear signs and symptoms) to assess for DID. This study analyzed these responses for common themes in order to explore how clinicians know when to assess for DID in their patients. Of the total 83 participants, 73 responded to this prompt. All of these responses were used in the analysis. After completing the first two phases of the analysis, different codes were sorted into themes and subthemes, which were subsequently reviewed and refined in more than a dozen iterations. Ultimately, three major themes containing three subthemes each were identified. Focused codes were also identified for each of these themes (see Appendix G).
1. **Dissociative Features and Symptom Clusters**

   1a. Dissociative Process  
   1b. Identity Alteration and Fragmentation  
   1c. Psychiatric Comorbidity

2. **Therapist’s Subjective Experience**

   2a. Observed Shifts in Presentation  
   2b. Verbal and Nonverbal Indicators  
   2c. Therapist Reactions

3. **Objective Reports and Historical Indicators**

   3a. Historical Indicators  
   3b. Collateral and Self-Reports  
   3c. DID Assessment Tools

*Figure 2.* Themes and subthemes identified for red flags to assess for DID.

**1. Dissociative features and symptom clusters.** Sixty-two participants (84.9% of respondents; 74.7% of total sample) identified dissociative features and symptom clusters as red flags to assess for DID. Subthemes identified for this category were: (a) dissociative process, (b) identity alteration and fragmentation, and (c) psychiatric comorbidity. It was not uncommon for participants to touch on many of these subthemes in a single response, especially the first two subthemes. For example:

   Loss of time, feelings of depersonalization, lack of memory for important events or large chunks of time (ex: 4th grade), finding writings/drawings that the person does not remember doing, feelings of de-realization, discontinuity in self presentation and sense of self. [Participant 39]

Other participants similarly emphasized aspects of both dissociative process and identity alteration. One stated, “Episodes of fugue or amnesia; depersonalization and/or derealization; identity confusion or alteration; auto-hypnotic experiences; somatoform dissociation to name a few” [Participant 9], while another listed, “Dissociation; switching; memory lapses/lost time;
confusions resulting from activities among alters (i.e. alters unaware of each other)” [Participant 24]. One participant emphasized these same symptoms while also noting that there can be “disremembered behaviors or periods of behavior very inconsistent with other periods of life” [Participant 44]. Despite the fact that dissociative process and identity alteration were sometimes described together, as these examples illustrate, there was enough differentiation between these themes to warrant dividing them into two discrete subthemes. Subthemes for this category are described and illustrated below.

1a. Dissociative process. Fifty-seven participants (78.1% of respondents; 68.7% of total sample) referenced aspects of dissociative process, including dissociation; depersonalization and/or derealization; amnesia or “lost time;” confusion or disorientation; and other memory gaps, lapses, or deficits. Notably, nearly a third of participants who answered this prompt (n = 22) mentioned some form of dissociation as a red flag to assess for DID. Many participants vaguely cited “dissociation” or “dissociative states” as a red flag, while others emphasized the frequency or continuity of the dissociation. For example, some discussed looking for “periods of dissociation” [e.g., Participant 29], “frequent symptoms of dissociation” [Participant 82], or “dissociation in interpersonal interaction” [Participant 27]. Another participant specified looking for “body dissociation” and “attention ‘lapses’ during sessions” [Participant 63] as red flags to assess for DID. Others referenced particular forms of dissociation. For instance, eight participants mentioned depersonalization, and six participants mentioned derealization.

Another dissociative symptom commonly discussed was dissociative amnesia. Although the term amnesia or amnesic was only referenced by 11 participants, a tremendous number of participants discussed symptoms of lost time (n = 37) or memory impairment (n = 25). Regarding memory difficulties, participants tended to describe memory lapses (e.g., “odd lapses
in memory” [Participant 20]), memory gaps, lost memories, or inconsistent memory (e.g., “irregular shifts in memory” [Participant 8]). Importantly, one participant specified that the amnesia observed here is not due to the effects of a substance: “losing time in the absence of drugs/alcohol” [Participant 49].

Memory loss or amnesia was described in terms of both current and past difficulties with memory. Regarding current difficulties, participants often emphasized the experience of losing time, “missing time” [e.g., Participant 82], or other evidence of memory deficits in the present-day. For example, one participant stated, “Unexplained lapses in memory, especially relatively sudden awareness that past minutes/hours have gone by with no awareness” [Participant 33], while another described, “time loss lasting hours/missing time they are unable to account for” [Participant 46]. Additionally, one participant specified, “Self reports of having a bad memory” and “reports of frequent ‘spaciness’” [Participant 49]. With respect to past difficulties, participants tended to discuss gaps in the person’s autobiographical memory or periods of time for which the person had no memories, such as “missing memories of early years of childhood” [Participant 30] and “lack of memories for extended or identifiable time periods” [Participant 2].

1b. Identity alteration and fragmentation. Thirty participants (41.1% of respondents; 36.1% of total sample) cited identity alteration and/or fragmentation as a red flag to assess for DID. For example, one participant stated, “identity fragmentation; lack of coherent sense of self” [Participant 55]. Of note, this subtheme encompasses participant responses referencing global or non-specific identity shifts and is distinguished from participant responses mentioning observed identity shifts within or between psychotherapy sessions (subtheme 2a).

One aspect of identity alteration and fragmentation discussed by participants was switching self-states. Several participants described “diverse self states” [Participant 52] as a red
flag to assess for DID. One participant discussed “distinct nonintegrated identities with characteristic behaviors and personality” [Participant 62], while another specified, “different aged parts making contact at different times, often without recall, parts speaking with different accents and experiences, without memory of each other” [Participant 51].

Relatedly, many participants described changes in personality, mood, or affect as a red flag for DID. Some emphasized the severity of these shifts (e.g., “severe mood shifts” [Participant 60]; “profound ‘personality’ changes” [Participant 2]; “severe changes in emotional or behavioral expression” [Participant 81]), while others stressed the rapidity (e.g., “rapid mood changes” [Participant 48]).

1c. Psychiatric comorbidity. Eighteen participants (24.7% of respondents; 21.7% of total sample) referenced psychiatric comorbidity as an indicator to assess for DID. They tended to discuss comorbid psychiatric disorders, complex trauma symptoms, auditory hallucinations, high-risk behaviors (e.g., suicidality, self-harm), and acute somatic or psychotic episodes. Several participants identified multiple, comorbid conditions as a red flag.

Participants described a range of comorbid psychiatric conditions, especially mood, anxiety, posttraumatic, eating, somatic, and substance use disorders. For example, one participant said, “Usually a cluster of symptom presentation with dissociative symptoms and PTSD symptoms present within a context of depression, somatoform spectrum disorder, substance use or addiction” [Participant 9]. Another stated, “Multiple past diagnoses, especially complex trauma, eating disorders, substance abuse, mood disorders, suicidality” [Participant 44].

Several participants also described experiences or behaviors that are commonly symptomatic of complex trauma, like “flashbacks” [Participant 79] and “chronic terror” [Participant 18], though they did not always explicitly identify them as such. For example,
participants discussed experiences such as “severe emotional and physical numbing” [Participant 46] and “excessive anxiety alternating with numbness” [Participant 49] as well as “experiences of detachment—from body, from emotions” [Participant 55] as red flags for DID.

A few participants discussed high-risk behaviors, including suicidality ($n = 3$) and self-harm ($n = 3$). At times, these behaviors were listed alongside other comorbid conditions or concerns. One participant said, “Also look for comorbid disorders like substance abuse, self-harm, suicidality, and/or eating disorders -- all common in individuals with DID” [Participant 45]. Another stated, “suicidal behavior, self-injurious behaviors (e.g. cutting, insertion, swallowing), aggressive behaviors … PTSD symptoms, somatic symptoms, pseudo seizures / conversion disorders symptoms, and auditory hallucinations” [Participant 57].

In addition to risky patient behaviors, acute or severe psychiatric episodes or symptoms were also discussed. While only one participant referenced psychotic symptoms, eight identified hearing voices or auditory hallucinations as a red flag for DID. For example, participants described phenomena like, “auditory hallucinations (inside the mind)” [Participant 22]; “a sense of not being alone in one’s mind; voices” [Participant 55]; and “hearing internal voices” [e.g., Participant 45]. A few participants specifically differentiated the type of auditory hallucinations they believed to be red flags for DID from those typically seen in schizophrenia and other psychotic disorders. For instance, “complaints of hearing voices without other evidence of psychotic symptoms” [Participant 13] and “report of ‘voices,’ which are not consistent with psychosis” [Participant 35].

2. **Therapist’s subjective experience.** Forty-one participants (56.2% of respondents; 49.4% of total sample) identified aspects of the therapist’s subjective experience as red flags to assess for DID. Subthemes identified for this category included: (a) observed shifts in
presentation, (b) verbal and nonverbal indicators, and (c) therapist reactions.

2a. Observed shifts in presentation. Twenty-six participants (35.6% of respondents; 31.3% of total sample) referenced observed shifts in patient presentation as an indicator to assess for DID. Participants tended to discuss marked changes they had observed—within or between psychotherapy sessions—in how their patients’ presented. For instance: “When they arrive in my office and seem to have a completely different personality (including different memories) than the one I am accustomed to meet with and do not seem to know me” [Participant 67]. Other examples of this included: “strikingly different presentations within or between session” [Participant 13]; “discernible changes in patterns of verbal, nonverbal affective and behavior presentation” [Participant 45]; and “shifts in appearance, affect, posture, tone, perspective, attitude” [Participant 71].

As these last two extracts illustrate, many participants were specific about the kinds of changes they had observed in their patients, often highlighting differences in behavioral, affective, bodily, and postural presentations. For example, one participant stated, “Over time, pronounced different presentation--different vocal tones, affects, preoccupations” [Participant 21]. Another expressed: “Shifts in self-state in the room during psychotherapy sessions, including affective, postural, vocal, and other changes as well as any overt verbalized content that indicates a shift of some greater or lesser magnitude” [Participant 6].

One participant who had no experience treating DID also identified observed shifts in presentation as a red flag: “I have never worked directly with a DID client before. As best I can understand I would look for rapid, marked discontinuities in presentation/mannerisms in session” [Participant 34]. In addition, one participant offered a possible explanation for why the presentation of DID patients may change: “My experience has been that a DID client slips into a
different personality as result of inability to tolerate feelings arising from particular questions” [Participant 61].

2b. Verbal and nonverbal indicators. Seventeen participants (23.3% of respondents; 20.5% of total sample) discussed verbal and nonverbal indicators in session as red flags to assess for DID. In particular, participants identified physiological/somatic indicators \((n = 5)\), bodily signs and indicators \((n = 7)\), verbal/language indicators \((n = 14)\), and nonverbal peculiarities \((n = 7)\). Some participants touched on one or a few of these areas, while others identified signs that cut across all of these categories (e.g., “slight changes in body language, tone, facial expression” [Participant 46]).

Regarding physiological and somatic indicators, several participants discussed somatic symptoms they had observed in their patients. For example, one participant identified responses like vasoconstriction or dilation, flushing, sweating/cold sweats, and paleness as physiological/somatic indications to assess for DID [Participant 78]. Another noted that “abrupt somatic and emotional trauma intrusions in the session” [Participant 42] are a cue to assess for DID. One participant observed that somatic symptoms tended to emerge in connection with or in response to specific material in sessions: “severe headaches when certain topics are broached, physiological (ANS) signs of chronic freeze or immobilization, chronic terror” [Participant 18]. As these examples suggest, many of the physiological and somatic indicators that participants observed in sessions with DID patients appeared to resemble symptoms of complex trauma or PTSD. One participant seemed to more explicitly connect somatic symptoms to the kind of structural dissociation seen in DID, stating: “Self-states may take control of behavior, executive function, and even have different physiological reactions (including some experiencing chronic pain for example - one area I work with - and another not experiencing it or experiencing it
differently)” [Participant 9].

A few participants discussed bodily signs and indicators as red flags for DID. However, they tended to group these with other indicators (e.g., behavioral, affective, vocal), and only rare did participants specify the types of bodily changes they had observed. Several participants discussed changes or shifts in posture or body language. One participant provided a list of bodily responses s/he/they looks for, including muscle rigidity, psychomotor agitation, involuntary movement, tremors, heightened startle response, and postural changes [Participant 78]. This same participant also listed various respiration changes, like distressed or rapid breathing and holding breath, as cues to assess for DID.

Several participants either alluded to or explicitly discussed verbal/language indicators of DID. They tended to emphasize shifts in vocal tone or difficulties presenting a coherent narrative. A few participants noted more abstract indicators, such as “fluctuations in the capacity for meaning making” [Participant 8] and “inability to verbalize thoughts, feelings” [Participant 16]. One participant provided a comprehensive list of “in session physiological cues of neuro-dissociative states and stress response” from his/her/their Adaptive Internal Relational (AIR) Network Model that included the following verbal/language indications:

**Verbal Changes:**

- Shaking voice
- Crying or pleading
- Changes in tone, rate or volume
- Changes in language or words used

- Difficulty verbalizing
CLINICIAN PERSPECTIVES ON DID

Stuttering
Lack of language
Repetitive words or use of language
Overly detailed reporting

Changes in Writing:
Using non-dominant hand
Different script
Developmentally younger
Shifts in style of prose. [Participant 78]

Participants also identified nonverbal peculiarities that they believed to be red flags to assess for DID. Some described changes in facial expression and/or gesticulation that they had observed in DID patients. One participant, for example, discussed “tracking shifts in facial expressions and gestures that may indicate discontinuity between self states or internal dialogue” [Participant 55]. In addition to more general facial indicators, several participants emphasized peculiarities related to eye movement. For instance, one participant described, “The ‘look’” [Participant 23], while another pointed to behavioral signs like a “vacant stare” [Participant 37]. One participant listed various eye movement changes believed to be red flags, including eye rotation, fixed gaze, glassy eyes, rapid blinking, rapid eye movement, and pupil dilation [Participant 78].

2c. Therapist reactions. Eight participants (11.0% of respondents; 9.6% of total sample) emphasized therapist reactions in describing what they look for as red flags to assess for DID. Two participants explicitly cited their own countertransference (i.e., emotional reactions to
patients). For example, one participant said s/he/they “tracks counter-transference experiences of
depersonalization or splitting” [Participant 73]. Another participant described his/her/their
experience of “awakening” to DID:

I was ignorant about DID until 2010 when I had an awakening experience of someone
presenting florid symptoms of DID. It was quite a shock. Dr. F.W. Putnam describes his
own awakening to the reality of DID in his 2016 book. [Participant 36]

Others had not yet had an awakening experience like the one described above. In fact,
four participants who responded to the prompt indicated that they lacked sufficient experience or
knowledge in this area. Subsequently, two of these individuals felt unable to provide an answer.
One stated, “don’t have enough information to say” [Participant 70], while the other explained,
“I have never encountered DID in a first hand clinical encounter and would actually feel quite
unprepared to assess/diagnose” [Participant 74]. Given that 10 participants did not respond to the
prompt at all, it is possible that one or more of these individuals also felt like s/he/they lacked the
experience or training needed to provide an informed response.

3. Objective reports and historical indicators. Thirty-seven participants (50.7% of
respondents; 44.6% of total sample) identified objective reports and historical indicators that
were red flags to assess for DID. Subthemes identified for this category were: (a) historical
indicators, (b) collateral and self-reports, and (c) DID assessment tools.

3a. Historical indicators. Seventeen participants (23.3% of respondents; 20.5% of total
sample) referenced historical indicators as red flags to assess for DID. Focused codes for this
sub-category included a trauma history, unsuccessful past treatment, and other information
obtained from medical records.

Many participants (n = 16) referenced the patient’s trauma history as a flag to consider
evaluating for DID. For example, one participant said that a "trauma history is “in and of itself is a red flag, cue to assess/be curious” [Participant 55]. More specifically, participants tended to describe an early and severe trauma history as a sign to assess for DID. One stated, “mentioning intense childhood trauma or sexual abuse” [Participant 47], while another said, “prolonged developmental trauma beginning before the age of six” [Participant 46].

In addition, a few participants identified unsuccessful past treatment or multiple prior diagnoses as red flags to assess for DID. For example, one participant said, “Severe childhood trauma, multiple treatments without success, history of multiple mental health diagnosis” [Participant 53]. Another stated, “repeated hospitalizations and multiple diagnoses with little treatment progress.”

3b. Collateral and self-reports. Twenty-two participants (30.1% of respondents; 26.5% of total sample) discussed information from self- and/or collateral reports that they believed were signs to consider DID in their patients. For example, “verbal reports from patient during assessment and treatment; verbal reports from prior clinicians, family members and others obtained during collateral contact; medical records (prior diagnoses, etc.)” [Participant 6].

While only one participant said, “Clients who say they have been so diagnosed” [Participant 51], a significant number of participants discussed considering patients’ self-reports of behaviors consistent with DID symptoms to be red flags. For instance, many participants considered patient reports of dissociative experiences outside of the therapy to be signs to assess for DID. These included reports of “losing time” as well as examples of behaviors that may have occurred in dissociative self-states or identities. For example, “Reports of memory problems such as losing time, finding objects they didn't know they purchased, not remembering how they got to a particular destination” [Participant 37]. Another participant emphasized this same
phenomenon: “reported history of losing time, finding ones self in a location and not remembering how one got there” [Participant 63]. One participant described “finding writings/drawings that the person does not remember doing” [Participant 39] as another example of dissociative behavior. Another noted that the dissociative and/or amnesic behavior is often corroborated by collateral sources: “Patient self report of blocks of time lost and evidence that volitional activity not in keeping with patient's usual behavior continued during that period, patient's self report that others close to him/her noticed these same patterns” [Participant 34].

In addition to reports of dissociative behaviors, references to the self by different names or discussing different ways of being were also considered by many participants to be a red flag for DID. Participants used a range of language to highlight these indicators. They discussed patient behaviors like “referencing the self by different names, or referring to self in the third person” [Participant 42]. Other examples included: “references to self states as discrete entities” [Participant 69], the “client’s discussion of different ways of being, parts” [Participant 47], and the patient’s “subjective sense of feeling separated inside” [Participant 46]. Two participants elaborated on how this phenomenon may manifest with patients. One expressed, “Self-report of distinct "parts" or experiences where others call the client by a different name or strangers appearing to know the client. Self-report of an internal system of distinct, separate parts” [Participant 82], while the other said, “Additionally, the person may experience him/herself as having distinct personalities or self-states, and these distinctive self-states are not necessarily (but may be) in communication with one another; the combination of self-states is the identity of the person” [Participant 9].

3c. DID assessment tools. Eight participants (11.0% of respondents; 9.6% of total sample) emphasized using DID assessment tools in identifying red flags to further assess for
DID. Several participants \((n = 4)\) mentioned using specific, validated assessment instruments for dissociation. For example, one participant said, “assess with the Multidimensional inventory of dissociation (MID) and the dissociative experiences scale (DES)” [Participant 57]. Another participant explained how s/he/they combines a symptom checklist with more formal assessment measures: “Dr. R.P. Kluft's checklists of the more subtle signs and symptoms are reliable. High scores on the DES, especially the "Taxon” questions, are very informative, and I also use the SCID-D and MID” [Participant 36]. Relatedly, one participant discussed using his/her/their own checklist, which s/he/they provided in the response. Another described a more informal assessment procedure, “Positive response to queries such as, Are you ever surprised to find yourself doing something, eating or having something you don't remember ordering or buying, in a place you don't remember traveling to?” [Participant 71]. Further, one participant listed “social and vocational impairment” [Participant 68], which seemed to suggest that s/he/they considered marked functional impairment to be a red flag to assess for DID.

**Preparation for DID Work**

Participants were asked to describe anything else that has prepared them for working with individuals with DID. This study analyzed these responses for common themes in order to explore how clinicians have prepared to work with DID patients. Of the total 83 participants, 50 responded to this prompt. After discarding non-applicable responses (e.g., “N/A”), 48 responses remained and were used in the analysis. After completing the first two phases of the analysis, different codes were sorted into themes and subthemes, which were subsequently reviewed and refined in more than a dozen iterations. Ultimately, two major themes containing three subthemes each were identified. Focused codes were also identified for each of these themes (see Appendix H).
1. Personal and Support Factors

1a. Supervision and Consultation
1b. Barriers to Accessing Support
1c. Personal Experiences

2. Education and Training

2a. Literature and Broad Education
2b. Advanced or Specialized Training
2c. Clinical Experiences

Figure 3. Themes and subthemes identified for other preparation for DID work.

1. Personal and support factors. Thirty-one participants (64.6% of respondents; 37.3% of total sample) identified personal and support factors that they believed helped prepare them for working with individuals with DID. Subthemes identified for this category were: (a) supervision and consultation, (b) barriers to accessing support, and (c) personal experiences.

1a. Supervision and consultation. Twenty-three participants (47.9% of respondents; 27.7% of total sample) believed that supervision and consultation helped prepare them to treat DID. Participants discussed individual and/or group supervision, peer or professional consultation, consultation groups, support groups (e.g., online groups), advanced study groups, mentor experience, and nonspecific support from colleagues. The types of support most commonly discussed by participants were supervision (n = 9), consultation (n = 9), and professional listservs (n = 8). Numerous participants engaged in more than one of these resources. For example:

Weekly individual supervision with an expert in treating dissociative disorders; monthly peer supervision group for EMDR; monthly peer supervision group for clinicians working with individuals with dissociative disorders; and monthly consultation with expert in the field Dr. Janina Fisher, PhD. [Participant 57]

In addition to typical forms of support, such as supervision, many participants seemed to
use professional dissociation and DID listservs (e.g., ISSTD; “DID listserv” [Participant 13]) for consultative purposes. One participant was explicit about this, stating that s/he/they is a “member on a professional support group—the DID listserv” [Participant 58]. Another said, “I have joined ISSTD, and I participate in high quality online peer support groups” [Participant 36]. Several participants described a high level of engagement with these listservs. For example, one participant shared, “I am a member of a private dissociation listserv and read the posts every day. I am also a member of ISSTD and of the Ritual Abuse and Mind Control listserv and read those posts every day” [Participant 51]. Another expressed feeling prepared for the work through “mostly reading about other clinicians' experience and understanding on the Dissociative Disorders Listserv” [Participant 19].

1b. Barriers to accessing support. Six participants (12.5% of respondents; 7.2% of total sample) emphasized barriers to accessing support in responding to the prompt about preparation for DID work. The most commonly identified barrier among participants was lack of training in DID work. For example, one participant said, “I do not feel I have enough training to see someone with DID” [Participant 11], while another expressed, “I was not really prepared. My training was only on what I had read on my own and in general training as a psychologist and psychoanalyst” [Participant 25].

Only one participant mentioned skepticism as a barrier to obtaining training for DID work. This individual stated: “No special preparation. I remain unconvinced that this is a specific disorder. I am a skeptic about diagnosis (DSM, ICD) as distinct from a more descriptive, individualized profile of psychological functioning” [Participant 26].

Difficulty obtaining supervision in working with DID was another barrier that one participant discussed:
I want supervision, individual or group, but due to circumstances currently do not have it. I have prepared myself with a very intensive course of self-study, I have joined ISSTD, and I participate in high quality online peer support groups. [Participant 36]

This participant appeared to compensate for the lack of supervision through other means, including self-study, joining a professional organization, and participating in support groups. While no other participants explicitly referenced difficulties obtaining supervision as a barrier to support, a few reiterated the importance of seeking extra support or training to prepare them for the work. For instance, one participant shared,

I want to clarify that although I had a lot of training in trauma work in general, when I began working with my first DID patient it was necessary to seek additional training and knowledge in order to work with this diagnosis. [Participant 37]

1c. Personal experiences. Four participants (8.3% of respondents; 4.8% of total sample) described personal experiences that helped prepare them to treat DID. Two of these individuals cited their personal therapy experience as important for this preparation (e.g., “Ongoing personal experiences in therapy, meditation practice, and yoga practice” [Participant 9]). The other two participants emphasized aspects of their personal history—“My own trauma history and capacity for dissociation” [Participant 40] and “My own family history” [Participant 43].

2. Education and training. Thirty-nine participants (81.3% of respondents; 47.0% of total sample) discussed aspects of their education and training that helped prepare them to work with individuals with DID. Subthemes identified for this category included: (a) literature and broad education, (b) advanced or specialized training, and (c) clinical experiences.

2a. Literature and broad education. Twenty participants (41.7% of respondents; 24.1% of total sample) indicated that literature or readings and broad education contributed to their
preparation for working therapeutically with DID. Participants tended to emphasize their coursework or broad education, readings/literature, online resources, and background knowledge (especially in psychodynamic theory). For example, one participant said, “A broad education, some familiarity with the history of psychoanalytic thinking and the history of consciousness” [Participant 44]. Another stated, “I have read literature from both psychoanalytic and trauma perspectives because of my interest in this work” [Participant 71]. One participant provided a detailed description of the literature s/he/they found helpful in preparing for the work:

   Psychoanalytic training, advanced study groups, and books and articles that integrate trauma literature and research, intersubjective/relational theory, and almost a century of object-relations literature that emphasizes a de-centered, multiple self as the basis of normal as well as pathological development and functioning [Participant 6].

Others referenced specific literature (e.g., “Elizabeth Howell’s books” [Participant 10]).

2b. Advanced or specialized training. Twenty-two participants (45.8% of respondents; 26.5% of total sample) believed that advanced or specialized training helped prepare them to treat DID. Many participants discussed learning from various professional activities, including conferences, meetings, seminars, workshops, and/or training courses. In most cases, participants emphasized more than one of these areas.

   In addition, a large number of participants emphasized specialized training with specific clinical populations (e.g., trauma, dissociation, others). While it is not surprising that many participants believed their training in trauma and dissociation prepared them to treat DID, it is notable that some participants identified their training in other clinical populations as useful preparation for this work. One participant, for example, described how his/her/their expertise in pain management, transcultural psychology, and BPD helped prepare him/her/them to work with
DID:

Expertise in pain management, because I find that frequently this may be the presenting problem - somatic distress - and once a person is able to exert some stabilization with his pain symptoms, trauma emerges and can be worked with. Without that training, I think - at least in the populations I work with - it would be difficult. Additionally, training in transcultural psychology, especially ongoing study and reading I do in how physical distress expresses a person’s experience differently depending upon cultural identifications. Training and experience in working with borderline personality from both DBT and psychoanalytic perspectives. [Participant 9]

Another applied his/her/their expertise in eating disorder (ED) treatment to working with DID patients: “I came to work with trauma/dissociation through my work at an eating disorders treatment center where I specialized in working with people with co-occurring addictions. Looking at ED/substance use disorder through the lens of dissociation has been enormously helpful” [Participant 55]. Further, one participant believed that training in substance use disorders was preparation for DID work: “I also have expertise in treating addictive disorders which leads me to treat a lot of trauma” [Participant 71].

Numerous participants also discussed training with specific therapeutic modalities, including EMDR (n = 3), DBT (n = 2), psychoanalytic psychotherapy and theory (n = 5), and sensorimotor psychotherapy (n = 1). For example, one participant described how his/her/their analytic training helped prepare him/her/them to treat DID: “My training in analytic theory helps me to understand diagnosis as being related to etiology rather than being an "outside-in," medical checklist of symptoms” [Participant 3]. Another participant believed his/her/their training in diagnostic evaluation was useful preparation:
I have never been a devotee of diagnoses in general, believing a human is too complex and unique to categorize. However, training in diagnostic evaluation has helped me look past previous or psychiatric diagnoses to identify the dissociation, which was missed by others. [Participant 35]

2c. Clinical experiences. Eleven participants (22.9% of respondents; 13.3% of total sample) emphasized clinical experiences, such as trauma work, that helped prepare them to work with individuals with DID. One participant said, “Preparation has been open mind, understanding the importance of the relationship, desire to constantly learn more in order to help /understand my patients more” [Participant 35]. Another simply stated, “time and experience” [Participant 41]. One participant benefitted from working with an interdisciplinary team on a DID case: “I had a client at an inpatient trauma/dissociative disorders program and learned a great deal from her therapist and psychiatrist - I spoke weekly with the therapist and 2-3 times with the psychiatrist” [Participant 55]. Several other participants also highlighted how their direct clinical experience with dissociation, trauma, or DID helped prepare them for the work. One stated that DID is an “under and misunderstood diagnosis” [Participant 61].

Reactions to this Study

Participants were asked to describe their reactions to participating in the current study. This study analyzed these responses for common themes in order to explore whether clinicians’ want to learn about and work with DID. Of the total 83 participants, 66 responded to this prompt. After discarding non-applicable responses (e.g., “N/A,” “No problem,” “Nothing in particular”), 61 responses remained and were used in the analysis. After completing the first two phases of the analysis, different codes were sorted into themes and subthemes, which were subsequently reviewed and refined in more than a dozen iterations. Ultimately, two major themes containing
two subthemes each were identified. Focused codes were also identified for each of these themes (see Appendix I).

1. **Importance and Value of the Work**
   - 1a. Applications and Contributions to the Field
   - 1b. Concerns, Critiques, and Limitations

2. **Subjective Experience and Impact**
   - 2a. Increased Awareness
   - 2b. Personal Reflection and Interest

*Figure 4.* Themes and subthemes identified for reactions to this study.

**1. Importance and value of the work.** Thirty participants (49.2% of respondents; 36.1% of total sample) discussed the importance and value of the work in describing their reactions to the current study. Subthemes identified for this category were: (a) applications and contributions to the field and (b) concerns, critiques, and limitations.

1a. **Applications and contributions to the field.** Nineteen participants (31.1% of respondents; 22.9% of total sample) discussed applications of the current study and its perceived contributions to the field. Many participants expressed feeling glad that this work was being done (e.g., “I am glad you are looking for information on this” [Participant 78]). This sentiment tended to be linked to the belief that the current study addressed an important topic area. For example, one participant stated, “I think that a large-scale examination of current attitudes may be enlightening” [Participant 33]. Another expressed feeling “glad there is more exploration happening” [Participant 41].

Others provided more specific explanations for why they believed this study addressed an important topic area. Two participants discussed how it is an understudied subject that deserves more research attention. One stated, “I am thrilled there is interest and on-going research in this
area. I believe dissociation (DID or otherwise) is far more prevalent than the mental health community at large has begun to appreciate. Research is legitimacy and power” [Participant 35], while the other shared, “I am very glad that someone is doing this research. I think that it is immensely important and a very understudied area” [Participant 39].

In addition, several participants ($n = 5$) emphasized the importance of addressing skepticism about DID. One stated, “I hope you do not hear that many people still doubt that the condition exists” [Participant 71]. Another expressed feeling “glad to hear that dissociative disorders considered seriously” [Participant 13], while yet another said, “I am beyond thrilled that clinical work with DID is being researched! I still meet with far too much skepticism from colleagues” [Participant 32]. One participant also stressed the importance of addressing the lack of knowledge, awareness, and openness to DID among practitioners, sharing personal experiences of this:

I'm glad your doing it. I hope you share your findings with the larger professional community. I currently work (via family therapy) with one young adult patient who is likely DDNOS. She has been in residential treatment on/off for years with the primary focus being her substance abuse. Unfortunately, her treatment providers have been mostly ignorant about dissociation and structural dissociation, and as a result not met this patient's needs in ways that put her in harms way. In addition, several clinicians at different treatment centers were NOT open to better understanding complex trauma and specifically structural dissociation (e.g. from me), and this came at a great cost to this patient. More people need to understand dissociation of all types, and also understand how different degrees of structural dissociation show up in therapist's offices, particularly the subtler, less dramatic presentations of structural dissociation. [Participant 19]
In addition, six participants expressed “interest in seeing the outcome data” [Participant 46] of the current study (e.g., “I’m very curious to learn your results” [Participant 57]). One stated, “I think this is a much needed project and I look forward to reading the results in a journal someday!” [Participant 7]. Others echoed this sentiment. For example, one participant said, “I am glad these questions are being asked and I look forward to reading the results” [Participant 36], while another expressed, “I’m delighted that you’re conducting this study and eager to hear the results” [Participant 55].

1b. Concerns, critiques, and limitations. Twelve participants (19.7% of respondents; 14.5% of total sample) discussed concerns, critiques, or limitations of the work in describing their reactions to the current study. Two participants doubted whether their responses were helpful. One said, “Not sure I have been helpful” [Participant 49], while the other said, more pointedly, “I can't imagine how my responses could be helpful or contribute to ‘evidence-based’ treatment/information” [Participant 2]. The latter response in particular seemed to express concerns about the value of the current study. Two participants unequivocally questioned the value or intent of this study. One expressed feeling “unclear what the point is” [Participant 4]. The other provided a more detailed rationale for his/her/their concerns. S/he/they expressed feeling,

Slightly annoyed. Concerned this is not a neutral hypothesis inquiry but more of an advocacy effort. I don't think a doctoral student really has the depth of clinical experience to evaluate this disorder as it presents in the field. It took me decades to sort out the conflicting literature and competing experts. I also had a highly regarded supervisor go down the rabbit hole with some MPD patients who ended up losing his license because of getting over involved in "satanic abuse" allegations by patients. This is tricky clinical,
legal, and ethical territory. [Participant 68]

A few participants ($n = 3$) seemed to feel like the topic of the current study was not relevant to them (e.g., “I'm answering questions about something that seems a world apart from mine” [Participant 74]). They tended to describe how it does not fit with their current professional identities as they are unlikely to encounter DID patients in their practice. For example, one participant described encountering trauma but not DID in his/her/their clinical work: “It wasn't what I was expecting, as in private practice I work with people with large traumas but enough resilience/high enough functioning to pay me; so while trauma experience is high, DID experience is less so” [Participant 5]. In describing reactions to the study, another expressed feeling, “A bit disingenuous. Doesn't really fit my time of life/present professional identity, nor the timing of my experiences with DID” [Participant 79].

In addition to questioning this study’s aims, value, or relevance, many participants described methodological concerns or limitations. One participant expressed dislike for the structure of the study, stating, “I didn’t like the part where you are asking me to write responses like this” [Participant 63]. Others raised more specific questions, issues, or concerns about the study’s methodology. For instance, two participants addressed potential limitations in the study questions. One stated, “I wonder why you left DDNOS out of the questions or differential diagnoses” [Participant 18]. The other expressed:

I don't know that the questions are representative to the idea that (all but especially traumatized) people can be dissociative or have multiple shifting self states without necessarily having a diagnosis wherein there is a DSM structured descriptive criteria for each of these self states being a discrete entity. I also don't know that I know enough about DID to have accurately answered the questions [Participant 70]
In contrast, one participant said that the “questions are pertinent” but expressed concern that the study sample might not be representative of all therapists, resulting in response bias. S/he/they said, “I hope that this will include a wide range of therapist participants and not only those already familiar with dissociation” [Participant 44]. Others \( n = 2 \) also explicitly described the study questions as “good” (e.g., Participant 31), but these responses were not coded under this subtheme.

2. Subjective experience and impact. Thirty-five participants (57.4\% of respondents; 42.2\% of total sample) discussed aspects of their subjective experience or personal impact in describing their reactions to the current study. Subthemes identified for this category were: (a) increased awareness and (b) personal reflection and impact.

2a. Increased awareness. Ten participants (16.4\% of respondents; 12.0\% of total sample) emphasized how the current study fostered increased awareness. In particular, many participants described realizing gaps or limitations in their own clinical knowledge. For example: “I was reminded of how little I knew at the time I worked with the patient I am thinking of, and of how little I know now re: current literature, clinical understanding and treatment practices” [Participant 25] and “Reminds me that I have a lot to learn working with traumatized population! Helped raise awareness” [Participant 28].

Others specifically described becoming aware of their lack of knowledge about DID. One expressed “feeling ill prepared to treat DID” [Participant 20], while another said, “It highlights how little I know about the disorder” [Participant 34]. A few participants described realizing that, although they have general trauma experience and expertise, they are less prepared to work with DID patients in particular. For example:

Makes me realize how much I don't know. I am very attuned to dissociation as it is
experienced by my clients with a trauma history, but it doesn't occur to me to give much weight to including DID as a differential diagnosis. [Participant 21]

Similarly, another stated, “The study has made me realize I am not as familiar with DID as I would like to be, although I also recognize it is not my area of expertise” [Participant 27].

Importantly, in describing how the current study increased their awareness of DID, many participants seemed to suggest that the experience of completing the study functioned as an intervention in and of itself. One participant, for example, reflected on the possible impact of his/her/their newly realized lack of knowledge about DID: “I've become more aware of a gap in my training/experience that I'd like to address, and aware that my lack of knowledge could lead to potential bias in meeting clients” [Participant 72]. Two others also expressed increased openness to learning. For instance, “I feel the need to learn more about DID” [Participant 81].

2b. Personal reflection and interest. Twenty-six participants (42.6% of respondents; 31.3% of total sample) discussed how the current study stimulated or reinforced personal reflections or interest. A majority of participants recounted globally positive reactions to participating in the study. Many (n = 14) explicitly described their experience of the study as positive, interesting, or thought-provoking (e.g., “It's been interesting and somewhat challenging” [Participant 69]; “Great. It’s a topic in which I’m very interested” [Participant 9]). Others expressed appreciation of or support for the research (e.g., “thank you for doing this work” [Participant 57]). Relatedly, a few participants expressed feeling pleased to contribute to the research (e.g., “glad to do so” [Participant 47]; “happy to help” [Participant 61]).

In addition, several participants emphasized how the experience of completing the study helped stimulate reflection. For instance, one participant said, “I have enjoyed answering your questions and the reflection on this work that it stimulated” [Participant 37], while another
expressed, “It was helpful for me to put in writing some of the observations I've made” [Participant 45]. One participant appeared both pleased and surprised at his/her/their ability to communicate knowledge on the study topic: “I actually sounded intelligent and coherent” [Participant 53]. Others shared more specific reflections that the study provoked for them. For example: “Realizing again that working with DID clients is long-term work and requires ongoing education and contact with colleagues also doing the work. These clients are interesting, rarely boring, and gratifying to work with. I have great colleagues” [Participant 42].
Chapter V: Discussion

By their very nature, human beings are so capricious, so complex, so delightfully contradictory, that they deserve not only our consideration, but our reconsideration—and our unwavering determination to withhold our opinion until we have engaged with them in every possible setting at every possible hour.

— Amor Towles, *A Gentleman in Moscow*, 2016

This study aimed to provide a preliminary, in-depth exploration of mental health professionals’ beliefs, knowledge, training, and therapeutic experiences regarding DID in order to assess the current stance of practitioners in the field and generate questions and hypotheses for future research that may be able to address gaps or unanswered questions in the DID literature. This chapter will: (a) review and interpret the main findings in light of the research questions and current literature, (b) consider the implications of these findings and their contributions to the field, (c) identify limitations or problematic aspects of the study, and (d) provide recommendations for future conceptual directions in the field.

**Interpretation of Findings**

**Summary of Participants**

A total of 83 participants completed the online survey. Most participants were White (88.0%), female (78.3%) clinical psychologists (67.5%) currently treating adult patients (98.8%) in private practice (73.5%). Participants were seasoned practitioners, with greater than half of the sample (56.6%) reporting 16 or more years of post-graduate experience. Most participants described their theoretical orientation as psychodynamic (54.2%) or integrative/eclectic (19.3%). Consistent with this, only 10 of 67 respondents mentioned CBT skills in describing their approach to DID treatment, and in all but one instance these interventions were integrated within
a psychodynamic model. In other words, if used at all, CBT skills tended to be adjunctive to psychodynamic work for DID. Further, the most common specialty area among participants was trauma or PTSD (79.5%). Dissociative disorders were the fourth most common area of expertise, reported by 43.4% of the sample. Although participants were recruited from a diverse group of eight professional organizations, participants largely learned about the study from the APA Division 39 (Psychoanalysis) listserv (39.8%) or from the ISSTD listserv (18.1%).

**Finding 1: Most Clinicians Believed that DID is a Valid Diagnosis**

Regarding beliefs about DID, 73.5% of all participants agreed or strongly agreed (28.9% and 44.6%, respectively) that DID is a valid, distinct clinical diagnosis, with a minority of participants disagreeing (4.8%), strongly disagreeing (7.2%), or neither agreeing nor disagreeing (13.3%). While this finding supports the hypothesis that clinicians would endorse varying levels of disbelief about DID, more clinicians than not appeared to believe in the validity of the diagnosis.

Other survey studies of mental health professionals have also demonstrated a range of beliefs about dissociative disorders and DID. Of those that asked questions most similar to the ones posed by this study, Dunn and colleagues (1994) found that 75% of psychiatrists and 83% of psychologists working in VA medical centers in the United States indicated that they believed in the existence of MPD. Cormier and Thelen (1988) found that 79% of American psychologist thought it was probably or definitely true that MPD should be considered a valid clinical diagnosis. In another small U.S. survey study (Madden, 2004), 79.4% of psychologists strongly disagreed/disagreed with the statement that DID does not exist, compared to 8.8% who strongly agreed/agreed that DID does not exist. Outside of the United States, Mai (1995) found that 66.1% of psychiatrists in Ontario said they believed in the existence of MPD. Somer (2000)
found that 84.5% of practicing clinicians in Israel declared at least a moderate belief in the validity of DID (Somer, 2000). In addition, Stokoe (2014) found that only three of 138 (2.2%) practicing therapists in England indicated that they did not believe in the diagnosis. One such participant, however, “quite strongly rejected [the diagnosis of DID] and referred to practitioners who did believe in it as ‘idiotic’” (p. 41). Nonetheless, some research has suggested that there may be greater disbelief in the validity of DID than was found in the present study. For instance, Lalonde and colleagues (2001) surveyed beliefs about dissociative disorders among 704 psychiatrists in Canada and the United States and found that only 22% of Canadian psychiatrists and 35% of American psychiatrists felt that DID should be included without reservations in the *DSM-IV* (American Psychiatric Association, 1994). Moreover, less than one-quarter of Canadian and American psychiatrists (11% and 21%, respectively) believed that strong scientific evidence supported the validity of DID.

With respect to beliefs about diagnosis, approximately half of participants in the current study (51.8% of the total sample) believed that DID is under- and misdiagnosed in the United States, despite growing support for its validity, compared to just one participant who believed that DID is over-diagnosed, despite little or no empirical support for its validity. About a third of participants (34.9% of the total sample) felt they had insufficient knowledge or competence to make a determination about validity, and 4.8% indicated that there is insufficient empirical research at present to make a determination about the validity of DID. In contrast to these findings, Madden (2004) found that only 14.7% of U.S. psychologists strongly agreed/agreed that DID is under-diagnosed, compared to 47.1% who strongly disagreed/disagreed with this statement. Madden’s finding, however, should be interpreted with caution, given the small sample size of this study (*N* = 34) and exceedingly low response rate (2.7%) in this study. In
another study, Mai (1995) surveyed Ottawa psychiatrists’ beliefs about factors affecting the prevalence of MPD. The author found that most psychiatrists believed that publicity about MPD affects the prevalence of this disorder (20% strongly agreed; 49.7% agreed). In addition, Mai also found that a majority of these practitioners believed that the psychiatrist’s own belief system affects the prevalence of MPD (30% strongly agreed; 35.6% agreed).

Taken together, these findings suggest that North American practitioners may demonstrate greater doubts about the prevalence and diagnosis of DID than was found among participants in this study. It is possible that lower levels of disbelief in the current study reflect changing views about DID in the field. However, another plausible explanation for the discrepancy is that the current sample included a high percentage of participants who specialize in trauma/PTSD and dissociative disorders. Instead of being generalizable to all U.S. clinicians, the results may therefore be reflective of clinicians who are especially inclined to believe in the validity of dissociative disorders and DID and to be knowledgeable, trained, and experienced in this work.

Finding 2: Stigma and Misconceptions about DID Persist Among Clinicians

While participants generally believed that DID is a valid diagnosis, they were less inclined to believe a new patient who reports having DID. Of the 78 participants who responded to this prompt, less than half reported that they were likely (33.3%) or extremely likely (5.1%) to believe the patient. This result is consistent with Ost et al.’s (2011) finding that less than a quarter of chartered clinical psychologists in the United Kingdom always (1.6%) or usually (19.7%) thought that clients’ reports of having DID (or MPD) could be taken as essentially accurate.
It is unclear why participants expressed greater disbelief regarding patient’s self-reports of having DID than they did regarding the validity of the diagnosis. One possible interpretation of this finding is that even clinicians who believe in the existence of DID may believe that a number of individuals continue to malinger or falsely claim the diagnosis. In support of this explanation, 15.7% of participants considered malingering to be one of the most common differential diagnoses for DID. As with any psychiatric disorder, a presentation of DID can be malingered. However, research studies have demonstrated that structured diagnostic interviews, including the SCID-D and MID, can be effective in differentiating factitious presentations of DID from genuine presentations of the disorder (ISSTD, 2011).

Other misconceptions or myths about DID treatment may also be prevalent among practitioners. In this study, many participants lacked awareness of evidence-based or empirically supported treatments for DID (i.e., therapies based on peer-reviewed scientific evidence), suggesting that this is another common area of misinformation among clinicians. Just over one-third of all participants (37.3%) indicated that they were aware of EBTs for DID, compared to over half who were either unaware (28.9%) or unsure (27.7%). Other studies have also found a lack of knowledge about available and evidence-based treatments for DID among practitioners. In a survey study of practicing therapists in England (Stokoe, 2014), 23% of respondents said that they would not know which treatment approach to use if they were to work with a DID patient due to a lack of knowledge, experience, training, or evidence base.

Although many participants are unaware of the research, there is in fact a large body of literature on empirically supported therapies for DID. For instance, a recent empirical investigation of DID treatment (Brand, Loewenstein, & Spiegel, 2014) found support for the existence of evidence-based treatment for DID:
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 [Randomized Control Trials (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). (p. 184)

Otherwise put, the evidence clearly demonstrates that there is a core set of interventions that are consistently effective in treating DID, whereas dissociative symptoms persist when not specifically targeted in psychotherapy.
Thematic analysis of qualitative data can help shed light on ways in which stigma and misconceptions about DID persist today. Indeed, experiences related to skepticism and controversy cut across responses to open-ended questions. In describing their experiences and reactions to DID work, 12% of participant respondents (7.2% of the total sample) discussed experiences with controversy. A few participants reported difficulties related to encountering skepticism or disbelief by the field. In particular, one participant described the work as isolating at times due to denial or misunderstanding of the diagnosis by colleagues, noting that it has subsequently been difficult to obtain supervision or consultation around DID. Another participant described how a fear of not being believed contributed to feeling hesitant to describe a DID patient and her symptoms to supervisors and colleagues. Only two participants expressed struggling with their own skepticism about DID. One of these individuals attributed this skepticism to working with a few clients who were “clearly (in my clinical opinion) malinger this diagnosis, and they had a very ‘stage’ presentation” [Participant 39]. At the same time, this participant also expressed belief in the diagnosis: “I guess this has made me skeptical, but I definitely believe that DID is legitimate.” Further, in describing their reactions to this study, five participants emphasized the importance of addressing skepticism about DID (e.g., “I am beyond thrilled that clinical work with DID is being researched! I still meet with far too much skepticism from colleagues” [Participant 32]).

Finding 3: Most Clinicians Endorsed the Trauma Model of DID

In spite of some evidence for controversy around DID, participants in this study almost universally endorsed the trauma model of DID. Nearly all participants (91.8%) who responded to a prompt about the etiology of DID emphasized trauma as a factor in the development of the disorder. Furthermore, 53.4% specified that the trauma experienced by these individuals
occurred in childhood or early development, and 38.4% indicated that severe, chronic, or persistent trauma plays a role in the etiology of DID. These findings are consistent with those of prior studies. Cormier and Thelen (1998) found that 84% of U.S. psychologists believed that the statement, “MPD likely originates in childhood,” is probably true or definitely true, and 85% believed that the statement, “MPD is related to severe child abuse,” is probably true or definitely true. In addition, a more recent study (Madden, 2004) found that 79.5% of U.S. psychologists agreed/strongly agreed that major trauma is a contributing factor to developing DID and 47.0% agreed/strongly agreed that the onset of DID is invariable in childhood.

One type of antecedent trauma noted by participants in this study was prior experiences of abuse, especially those occurring in childhood or early development. Regarding types of abuse contributing to DID, neglect or emotional abuse was most commonly mentioned among participants (12.3%), followed by sexual abuse (6.8%) and then physical abuse (2.7%). Other antecedent causes frequently proposed included attachment or relational issues or disruptions (19.2%) as well as biological, constitutional, and genetic factors (12.3%). Beliefs about the etiology of DID among participants are well substantiated. Significant research supports the notion that trauma contributes most significantly to the development of DID (e.g., Brand & Loewenstein, 2010; Leonard et al., 2005; Saxe et al., 1993). For instance, Brand and Frewen (2017) asserted that: “Although several variables, including trauma, insecure attachment, neurobiology, culture, and cognitive factors, are associated with dissociation, trauma has been the most thoroughly researched and has been found to consistently be an antecedent, causal factor for pathological dissociation” (p. 217).

Participants’ beliefs about the types of abuse involved in the development of DID are also supported by numerous studies linking childhood abuse and dissociative pathology. However,
participants may have underestimated the specific roles of physical and sexual abuse in the etiology of DID. These factors were only mentioned by a small subset of participants despite significant evidence for high rates of both sexual and physical abuse in childhood in individuals with DID (e.g., Saxe et al., 1993) and for positive relations between these types of abuse and DID (e.g., Foote et al., 2006). For example, Putnam et al. (1986) found that a history of significant childhood trauma was absent in only three of 100 MPD cases. Sexual abuse, which generally occurred in the form of incest (68%), was the most frequently mentioned form of trauma among participants in Putnam’s study (83%). Repeated physical abuse was the second most frequently reported type of trauma (75%), and it co-occurred with sexual abuse in 68% of cases. In addition, 60% of patients reported extreme neglect, and 45% reported witnessing in childhood a violent death, usually of a parent or sibling.

**Finding 4: Clinicians Varied in DID Knowledge, Experience, and Practice**

Participant responses were more varied for knowledge, clinical experience, and practices related to DID. Although many participants lacked awareness about EBTs for DID, approximately half of all participants rated themselves as extremely (24.1%) or moderately (26.5%) familiar with the literature on DID, supporting the hypothesis that clinicians would demonstrate varying levels of knowledge about DID. In line with this finding, Stokoe (2014) reported that just under half (44%) of practicing therapists in England described a full understanding of DID.

Regarding clinical experiences, 43.4% of participants said they had assigned a diagnosis of DID to a patient and 51.8% said they had worked with a DID patient. While inconsistent with the hypothesis that clinicians would report little or no therapeutic experience with DID, this finding appears consistent with prior research. For instance, Mai (1995) found that 56.7% of
Ontario psychiatrists had seen a patient with MPD, with an average (mean) of 3.7 MPD patients seen per psychiatrist. In another study (Somer, 2000), the average Israeli clinician surveyed had made 4.8 career-long dissociative disorder diagnoses and carried an average of 1.05 dissociative disorder patients in his/her/their caseload. No diagnosis or treatment of a dissociative disorder was reported by more than half of the total sample (62.6%). Moreover, 8% of the sample had diagnosed DID at some point in their careers, and 3% were treating a DID patient at the time of data collection. Similar to these findings, Ost and colleagues (2011) found that 43.7% of chartered clinical psychologist respondents reported seeing one or more cases of DID/MPD.

It is unclear why fewer participants in the present study had assigned a DID diagnosis than had worked with a DID patient, particularly as the number of respondents per question only differed by one (n = 76 and 75, respectively). One neutral explanation for this discrepancy could be that participants may not have the authority to assign diagnoses in all clinical settings. In psychiatric inpatient, outpatient, and partial hospitalization units, for example, it is not uncommon for psychiatrists to have full authority regarding decisions about what diagnoses go in a patient’s chart. Another possibility, however, is that clinicians did not assign the diagnosis to their DID patients for fear of stigma or disbelief, either from the patient, who may see the diagnosis code on a bill, or from insurance companies, whom practitioners may fear will reject or counter billing for this diagnosis. In support of this explanation, 13.3% of participants said they had only assigned a diagnosis of DID as a rule-out or provisional diagnosis.

With respect to assessment practices, participants appeared to be generally well versed in DID assessment, with 71.1% reporting that they assessed for dissociative symptoms with a clinical interview. Participants most commonly reported using the DES (Bernstein & Putnam, 1986; 37.3%), SCID-D/SCID-D-R (Steinberg, 1994; Steinberg et al., 1994; 18.1%), and MID
(Briere, 2002; 15.7%). Nonetheless, reports of assessing for dissociation in clinical interviews could be inflated, depending on how participants interpreted the question. The standard diagnostic interviews and mental status examinations that most clinicians were taught during professional training unfortunately do not typically include questions about dissociative or complex traumas symptoms (ISSTD, 2011). False negative diagnoses of DID can occur when the clinician does not include questions about dissociation and trauma in the assessment. While many participants reported that they assess for dissociation in practice, it is unknown how often they do so and to what extent they ask about these symptoms. To elucidate, qualitative analyses of participant responses revealed that clinicians look for three main types of data as red flags (e.g., clear signs and symptoms) to assess for DID:

1. Dissociative features and symptom clusters (84.9% of respondents; 74.7% of the total sample), including aspects of dissociative process, identity alteration and fragmentation, and psychiatric comorbidity.

2. Therapist’s subjective experience (56.2% of respondents; 49.4% of the total sample), including observed shifts in patient presentation, verbal and nonverbal patient indicators in session, and therapist reactions to patients.

3. Objective reports and historical indicators (50.7% of respondents; 44.6% of the total sample), including historical indicators of DID, collateral and self-reports of dissociative symptoms or DID diagnosis, and DID assessment tools (e.g., DES, MID, SCID-D).

In addition to assessing for dissociation, clinicians must be knowledgeable about differential diagnoses in order to avoid false positive diagnoses of DID (ISSTD, 2011). Consistent with the study hypotheses and empirical literature, the top three most commonly
considered differential diagnoses for DID among participants were PTSD (69.9%), BPD (65.1%), and schizophrenia/psychotic disorder (47.0%). Somer (2000) also found these to be the three most frequently considered alternative diagnoses to DID among mental health professionals in Israel, though the order in which they were considered differed slightly. Interestingly, malingering was considered as a diagnosis by only 8% of participants in Somer’s study compared to 15.7% of participants in the current study. Given that the two groups identified the same top three differential diagnoses, this finding could suggest that the misconception that DID patients are malingering has become more prevalent in the last 18 years.

**Finding 5: Clinicians Need to Seek Out DID Training**

Despite variation in DID knowledge and experience, over two-thirds of participants (68.7%) had received training and/or supervision either directly or indirectly relevant to working with someone with DID, disconfirming the hypothesis that most clinicians would report little or no experience receiving postgraduate training or supervision in DID. This finding may be reflective of a self-selection bias, whereby individuals interested in trauma and dissociation were more likely to participate in the study. The previously noted high percentage of participants specializing in trauma/PTSD and dissociative disorders is consistent with this.

In contrast to predictions, participants seem to have acquired knowledge and expertise related to DID *primarily* if not exclusively through postgraduate training, education, and supervision. Less than a third of participants (30.1%) learned about DID from their graduate school courses, compared to 69.9% who had learned from continuing education and 79.5% who had learned from the professional literature. Other sources from which participants learned about DID included first person accounts (47%), multilevel professional certification (14.5%), media (22.9%), and professional supervision (54.2%). An additional 21.7% of participants learned
about DID from other sources, such as clients, dissociation listservs, postdoctoral training, consultation groups, colleagues, personal research or writing, and ISSTD training. Consistent with these findings, Somer (2000) surveyed 211 Israeli clinicians and found that, although 62.6% of respondents reported never having encountered a dissociative disorder in practice, the sample had been exposed to a variety of sources of information on the topic, included professional literature (89.9%), lectures (54.8%), documentary films (38.5%), media (37.2%), and professional supervision meetings (32.2%).

Examined together, these findings suggest that clinicians may primarily learn about DID from sources outside of their graduate programs like professional supervision and literature, continuing education, and advanced training. In line with this, Somer (2000) found that more experienced clinicians had been exposed to more sources of knowledge on dissociative disorders and DID ($r = .17, p = .02$). Of critical importance, this finding indicates that clinicians must seek out training and education related to DID. In support of this notion, participants discussed needing to seek additional support, education, and training around DID patients in describing their experiences and reactions to the work. They tended to describe feeling overwhelmed in the work and utilizing support to gain more expertise and confidence (e.g., “I educated myself and sought consultation around the DID symptoms” [Participant 67]). Additional thematic analyses revealed that many participants emphasized the importance of advanced or specialized training, professional support, and professional literature in preparing them to work with individuals with DID. More specifically, participant responses clustered around two broad factors:

1. Personal and support factors (64.6% of respondents; 37.3% of the total sample), including supervision and consultation, barriers to accessing support (e.g.,
difficulty obtaining supervision, skepticism), and personal experiences (e.g.,
own trauma or dissociation history, personal therapy).

2. Education and training (81.3% of respondents; 47.0% of the total sample),
including literature and broad education (especially on psychoanalytic theory
and dissociation), advanced or specialized training (e.g., with specific clinical
populations as well as specific treatments, including EMDR, sensorimotor
psychotherapy, DBT, psychoanalytic therapy), and clinical experiences.

Learning how to assess, diagnose, and work with dissociation may not be a core component of
all graduate training programs in mental health. Implications for DID diagnosis, assessment, and
treatment are discussed later.

**Finding 6: Specialization in Trauma, Dissociative Disorders, and Psychodynamic Therapy**

**May Account For Clinician Differences in DID Knowledge, Beliefs, and Training**

A second aim of this study was to explore clinician variables that might be related to
differences in beliefs, knowledge, training, and experience. It was hypothesized that cognitive-
behavioral therapists and psychiatrists would endorse greater disbelief and less knowledge,
training, and experience related to DID compared to psychodynamic therapists and other mental
health professionals, respectively. However, almost no participants identified as psychiatrists ($n = 1$) or as primarily cognitive-behavioral clinicians ($n = 2$), resulting in insufficient statistical
power to test these hypotheses.

Nonetheless, the self-selection bias may in and of itself shed light on these questions.
Given the diversity of theoretical orientations and professional degrees represented across the
listservs from which participants were recruited, non-responders may have been less acquainted
with and/or interested in dissociative processes and trauma. Bias can even be observed in
considering the organizations that elected to advertise the research (see Table 2). It is possible that a higher representation of disbelief about dissociation and DID existed among the non-responders than among those who chose to respond. From this perspective, one interpretation of the abysmal representation of psychiatrists and cognitive-behavioral clinicians in this study is that these groups may be less interested, less aware, and/or more skeptical of dissociation, trauma, and DID. In comparison, higher representation of psychodynamic clinicians, clinical psychologists, and social workers suggests relatively increased interest and awareness and decreased skepticism regarding dissociative symptomatology.

Furthermore, although exploratory analyses suggested that clinical psychologists might display less belief and knowledge about DID compared to social workers, this finding may also be explained by the presence of other underlying factors. To this researcher’s knowledge, there are no existing studies comparing social workers and clinical psychologists on beliefs and knowledge about DID. Of those that come closest to addressing this question, Cormier and Thelen (1998) found that participants with PsyDs reported being significantly more familiar with the literature on MPD than did those with PhDs, $t(421) = 2.86, p < .005$, though there were no other significant differences in skepticism, attitudes about MPD, or exposure to MPD for these two groups. The most widely recognized difference between PsyD and PhD programs in Clinical Psychology is that the former tend to primarily emphasize clinical training whereas the latter tend to emphasize clinical research. On the spectrum from research to practice, social work programs are generally considered to be the most clinically focused, as they nearly exclusively emphasize this training domain. Taken together, these findings suggest that emphasis on clinical practice (over research) could explain some of the differences among professional groups regarding knowledge and beliefs about DID, with greater emphasis on clinical work being
associated with greater knowledge and less disbelief. Certainly, more research is needed to empirically test this possibility.

Another possibility is that other demographic variables account for some or all of the observed differences between social workers and clinical psychologists in the current study. Two possible confounding factors are clinician specialization in trauma/PTSD and dissociative disorders. In support of this, more social workers reported that they specialize in trauma/PTSD (90.9%) and dissociative disorders (59.1%) compared to clinical psychologists (75.0% and 39.3%, respectively). Given this finding, it seems likely that specialization in these clinical disorders, rather than professional discipline, accounted for a great deal of the differences between social workers and clinical psychologists. Clinicians who have expertise in working with trauma/PTSD and/or dissociative disorders are likely to be knowledgeable about DID and to believe in the validity of this diagnosis. As previously discussed, there is some evidence of an inverse correlation between skepticism and knowledge about DID. In one study (Hayes & Mitchell, 1994), analysis of variance revealed that skepticism about MPD was negatively correlated with professional activities related to learning about the condition, including the number of professional books read and the number of professional conferences attended that were related to MPD.

**Finding 7: Most Clinicians Were Interested in Learning More About DID**

One positive and hopeful outcome of this study is that many participants expressed increased interest in learning more about DID. In total, 71.1% of participants (80.8% of respondents) expressing interest in receiving further education on DID and 69.9% (78.4% of respondents) expressing interest in receiving further training on DID assessment and treatment.
Consistent with this, Somer (200) found that 84.6% of Israeli clinicians responded in the affirmative when asked if they would be interested in further education on dissociative disorders.

Moreover, the act of completing this study seemed to function as an intervention in and of itself for a number of participants. In sharing their reactions to this study, 12.0% of participants emphasized how their participation in the research fostered increased awareness. A number of these participants described realizing that assessing, diagnosing, and treating dissociative symptoms, especially DID, constitutes a gap in their training. In some cases, participants felt qualified to assess and treat trauma but realized that they are less prepared to work with DID. For example:

Makes me realize how much I don’t know. I am very attuned to dissociation as it is experience by my clients with a trauma history, but it doesn’t occur to me to give it much weight to including DID as a differential diagnosis. [Participant 21]

Other participants explicitly discussed how the study helped them become aware of their lack of knowledge about DID. One participant spoke to the potential costs of this gap in training: “I’ve become more aware of a gap in my training/experience that I’d like to address, and aware that my lack of knowledge could lead to potential bias in meeting clients” [Participant 72]. Others expressed realizing that they are not as familiar with DID as they would like to be and feeling the need to learn more. Relatedly, in describing what they look for as red flags to assess for DID, several participants reflected that they would feel unprepared to assess/diagnosis this condition due to lack of information or clinical experience, and one participant described the experience of “awakening” to DID in his/her/their patients. Future research may consider empirically evaluating whether completing a study on DID beliefs and practices could increase participants’ interest in further education and training in this area.
Finding 8: Working with DID is Challenging yet Meaningful

Another encouraging finding was that many participants found meaning and satisfaction in DID work. In contrast to stereotypes that individuals with DID make incredibly difficult, treatment resistant patients, participants seemed to find the work challenging yet deeply fulfilling. As one participant put it, “These clients are interest, rarely boring, and gratifying to work with” [Participant 42]. In describing their experiences and reactions to DID work, 52.0% of respondents (31.3% of the total sample) discussed aspects of personal growth and fulfillment derived from their work with DID patients.

In addition to emphasizing the positive feelings they experienced in the work, participants were also frank about the difficulties and complexities they had encountered in their work with DID. Eighteen participants (36.0% of respondents; 21.7% of the total sample) emphasized challenges and concerns encountered in the treatment of DID in describing their experiences and reactions to the work. While a few participants discussed difficulties recognizing DID in their patients, most attributed treatment challenges to patient factors, including the complexity of DID with its frequently comorbid disorders and high-risk behaviors or safety concerns (e.g., suicidality, self-harm). Participants also discussed the risks for the therapist in terms of vicarious trauma and burnout. For this reason, participants frequently stressed the importance of therapist self-care and support, especially in the form of professional supervision and consultation. Other self-care strategies included setting clear boundaries with patients and limiting the number of patients with DID seen at one time.

Nonetheless, despite or perhaps because of these challenges, many participants described deriving a sense of compassion satisfaction from the work (e.g., “often very challenging work, but incredibly satisfying as people heal” [Participant 31]). Other sources of enjoyment came
from witnessing patients’ gains, discovering their strengths, and appreciating the depth of their resiliency. DID patients were frequently described as creative, intelligent, and resourceful individuals. Participants expressed deep awe, respect, and appreciation for their resources, courage, and talents. Furthermore, in describing their reactions to this study, approximately one-third of respondents (31.1%), or 22.9% of the total sample, discussed the importance and value of the research investigation, particularly in terms of its clinical applications and contributions to the field. Many participants felt that dissociation, and especially DID, are understudied subjects that are more prevalent than the general mental health community has begun to appreciate and deserve more research attention.

**Limitations**

Several factors could have biased the findings of this study. First, because participants predominantly identified as white, cisgender women with significant experience in the field, our findings cannot be easily generalized to clinicians of other racial groups or gender identifications or to less experienced clinicians. As the sample was limited to primarily licensed mental health professionals living and working in the United States, the results can also not be extended to practitioners residing in other countries or to graduate-level clinicians. Future research should consider ways to recruit a more diverse sample of clinicians across all sociocultural identities. Moreover, given that graduate school curriculums and training models are constantly evolving, future research may wish to recruit practitioners with a wider range of experience in the field.

A related limitation concerns the self-selection bias among participants. To comply with ethical guidelines around transparency about the research, the recruitment email and flyer advertising the study to participants explicitly stated that the purpose of the study was to enhance understandings of mental health professionals’ beliefs about trauma and dissociation and the
ways they work therapeutically with patients with these difficulties in practice (see Appendices A and B). An unfortunate consequence of this strategy may have been that individuals with more interest, knowledge, and experience related to trauma and dissociation may have been more likely to participate in the study. Given the disproportionate representation of psychodynamically identified therapists in the sample, individuals of this theoretical orientation may also have been more likely to respond to the advertisement. Consequently, study findings may not be representative of the mental health community at large, especially psychiatrists, individuals less interested in trauma and dissociation, and non-psychodynamic clinicians.

Further, there may have also been a selection bias with respect to which professional organizations agreed to advertise the research. Although the researcher aimed to recruit from a diverse selection of organizations (see Table 2), only eight of the twelve organizations contacted for recruitment agreed to participate (66.7%), limiting the diversity of the sample. The organizations that declined to advertise the research included a group for cognitive-behavioral therapists that did not respond, a group for clinical psychologists that does not post student research, a group for psychiatrists that does not have an electronic listserv, and a group for clinicians interested in traumatic disorders that did not approve the request (see Table 2). Members belonging to the organizations who advertised the research were thus primarily clinical psychologists and social workers, with relatively limited representation of behavioral/cognitive-behavioral practitioners.

Another methodological limitation of this study is the use of an original survey. In lieu of available questionnaires, an original survey comprised of demographic questions and a DID questionnaire was developed. Although the survey was piloted, the reliability and validity of the measure were not established, reducing the inferential confidence (i.e., the generalizability of
findings), increasing the likelihood that an effect was missed (i.e., committing a Type II error), and minimizing the ability to determine that the questions accurately represented the constructs of interest (i.e., construct validity). Quantitative results should thus be interpreted with caution. Research on the validity and reliability of using this measure in a sample of clinicians is necessary.

Finally, there are also possible biases associated with thematic analysis. Only relatively recently has thematic analysis been recognized as a stand-alone qualitative research (Willig, 2013). While there are now a number of comprehensive guidelines for carrying out high quality thematic analyses, there is still some debate about whether thematic-analysis constitutes a distinct research method. Common criticisms of thematic analysis are that it is a poorly demarcated method that does not provide a clear theoretical basis for research and often lacks researcher transparency about how it was conducted (Braun & Clarke, 2006; Willig, 2013). To minimize potential bias related to these concerns, this study followed Braun and Clarke’s (2006) rigorous guidelines for thematic analysis, provided as much transparency about the process as possible, and applied an inductive approach to the thematic analysis in order to allow new insights to emerge from the data. Further, the current study used a mixed-methods design where the thematic analysis served primarily to shed light on quantitative findings and generate questions for future research.

**Implications**

Despite these limitations, the findings of the current study contribute to a growing understanding of mental health professionals’ beliefs, knowledge, clinical experiences, and training related to DID. This study concludes with a discussion of the implications of the
findings for future research as well as for clinical training and supervision in DID diagnosis, assessment, and treatment.

**Future Research**

The findings of this study suggest several directions for future research. First, as the current study used an original questionnaire, replication of its findings with reliable and valid instruments for assessing clinicians’ knowledge, beliefs, experiences, and training related to DID is warranted. Alternatively, future research may consider refining the measure used in this study through empirical evaluations in order to establish reliability and validity.

While there were advantages to the mixed-methods design employed in the present study, a more comprehensive qualitative investigation involving interviews of clinicians would be useful in expanding upon these findings and generating new insights into how clinicians understand or make sense of DID. In particular, future research should consider interviewing clinicians who score both low and high on knowledge and beliefs about DID in order to better understand their perspectives as well as the similarities and differences between these groups.

Future research may also build upon the findings of the current study by conducting a larger scale quantitative investigation using pre-validated, reliable measures in order to empirically assess for factors that could account for differences in clinicians’ beliefs and knowledge about DID. Extending upon the current study, it would be especially useful to examine these constructs in a sample of clinicians with greater diversity in terms of both sociocultural identities and professional identities, including theoretical orientation, professional degree, experience in the field, and specialization/area of expertise.

Another area of inquiry should involve empirically examining this study’s preliminary finding that many clinicians may need to seek out postgraduate training related to DID. Future
research should consider surveying graduate students across psychiatry, clinical psychology, and clinical social work training programs to obtain a better sense of the training they receive on trauma, dissociation, and DID. In addition, future research could examine whether clinicians receive adequate training in DID diagnosis and assessment by asking a large sample of mental health professionals to diagnose a series of clinical vignettes for various psychiatric disorders and comparing rates of accuracy in diagnosis for the DID case compared to other cases.

Lastly, qualitative investigations into the experiences of patients with DID and other dissociative disorders is greatly needed. Some of the areas in which future research could explore include DID patients’ experiences encountering skepticism and controversy; learning about, receiving, and making sense of their diagnosis; and disclosing their diagnosis to both professionals and loved ones. This line of research could be helpful in conducting a needs-assessment for DID patients. Finally, given how often DID is comorbid with PTSD, future research could also consider comparing the experiences of individuals diagnosed with PTSD only with those diagnosed with DID (with or without PTSD). Certainly, more information is needed on the differences and similarities between these diagnostic groups.

**Clinical Training in DID Diagnosis, Assessment, and Treatment**

The findings of this study also have a number of implications for clinical training and supervision in DID diagnosis, assessment, and treatment. While a majority of participants in this study believed that DID is a valid, distinct clinical diagnosis, there was considerable variation in terms of their knowledge about DID as well as their experiences diagnosing, assessing, and treating patients with this disorder in practice. A number of participants expressed feeling unprepared to work with DID due to insufficient knowledge, training, and experience. Others
described how overwhelmed they felt when first encountering DID and how they found it indispensible to seek out additional training experiences.

One implication of these findings is that many clinicians do not receive sufficient training in the diagnosis, assessment, and treatment of DID. In line with this, Brand (2016) asserted that, “Few mental health professionals receive systematic training in the assessment and treatment of trauma related psychological problems, and even fewer about traumatized individuals who have dissociative reactions (Cook et al., 2011; Courtois & Gold, 2009)” (para 1). Clinicians with inadequate knowledge and training in dissociation are likely to overlook signs of DID even when they present themselves in the therapist’s office. As the ISSTD Guidelines for Treating DID in Adults put it, “The *sine qua non* for the diagnosis of DID is that the clinician must inquire about the symptoms of dissociation” (ISSTD, 2011, p. 118). The guidelines advise clinicians to keep in mind that some persons with DID do not realize that their experience is out of the ordinary. Because the function of dissociation is to defend against unbearable realities, the presence of DID symptoms is more often than that denied and renounced by persons with DID themselves (ISSTD, 2011, p. 125).

Patient reluctance to disclose symptoms, paired with high comorbidity with other disorders, makes DID nearly impossible to detect without adequate training. Clinicians may mistakenly attribute symptoms of the disorder to other psychiatric conditions, resulting in ineffective or inadequate treatment (e.g., targeting a comorbid diagnosis only). For example, although auditory hallucinations are typically assumed to be indicators of a psychotic disorder, reports of hearing voices from a DID patient (as described by many participants in the current study) tend to refer to internal voices related to dissociated self-states rather than a psychotic thought process (Brand, 2016). Treating a patient with DID with antipsychotic medication
intended for patients with psychotic disorders could have potentially disastrous effects if the symptoms are explained entirely by the dissociative condition.

Given these costs, the findings of the current study suggest that training in the diagnosis, assessment, and treatment of dissociative pathology should be more widespread. In particular, it is essential for clinicians to receive training on conducting a focused inquiry of dissociative symptoms and recognizing subtle clues of dissociation in the patient’s history and mental status.

The ISSTD Guidelines recommends the following:

At a minimum, the patient should be asked about episodes of amnesia, fugue, depersonalization, derealization, identity confusion, and identity alteration (Steinberg, 1995). Additional useful areas of inquiry include questions about spontaneous age regressions; autohypnotic experiences; hearing voices (Putnam, 1991a); passive-influence symptoms such as “made” thoughts, emotions, or behaviors (i.e., those that do not feel attributable to the self; Dell, 2009c; R. P. Kluft, 1987a); and somatoform dissociative symptoms such as bodily sensations related to strong emotions and past trauma (Nijenhuis, 1999). Clinicians should also be alert to behavioral manifestations of dissociation, such as posture, presentation of self, dress, fixed gaze, eye fluttering, fluctuations in style of speech, interpersonal relatedness, skill level, and sophistication of cognition (Armstrong, 1991, 2002; Loewenstein, 1991a). (ISSTD, 2011, p. 124)

Further, the guidelines also suggest that clinicians take the time to develop a supportive and trusting therapeutic alliance with patients in order to help them feel safe enough to disclose their symptoms.

On a broader level, the findings of this study highlight the importance of increasing awareness of dissociation, disseminating accurate knowledge about DID, and addressing sources
of stigma and misconceptions that may result in grave costs for patients with this disorder. While there is more work to be done by researchers and clinicians alike, the findings of this study suggest that there is also a great deal of hope for a brighter future. Many clinicians in this study demonstrated knowledge and experience related to DID, and others expressed increased interest in learning more about the condition. The resiliency of DID, so often mentioned by participants in this study, appears to be equally matched by the dedicated practitioners who find meaning in their work with patients with this disorder.
References


Somer, E. (2000). Israeli mental health professionals' attitudes towards dissociative disorders, reported incidence and alternative diagnoses considered. *Journal of Trauma & Dissociation, 1*(1), 21-44.


Table 1

Epidemiological Studies of DID and Dissociative Disorders Among Adults

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Country</th>
<th>Patients Completing the DES</th>
<th>Patients Completing a Structured Interview</th>
<th>Patients with a Dissociative Disorder</th>
<th>Patients with DID</th>
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<td>115</td>
<td>15</td>
<td>4-8%</td>
<td>1-2%</td>
</tr>
<tr>
<td>Foote et al. (2006)</td>
<td>Psychiatric outpatients</td>
<td>United States</td>
<td>231</td>
<td>82</td>
<td>24 of 82 (29%)</td>
<td>5 of 82 (6%)</td>
</tr>
<tr>
<td>Johnson et al. (2006)</td>
<td>Community</td>
<td>United States</td>
<td>658</td>
<td>658</td>
<td>60 (9.1%)</td>
<td>10 (1.5%)</td>
</tr>
<tr>
<td>Sar, Akyüz, &amp; Doğan (2007)$^1$</td>
<td>General population</td>
<td>Turkey</td>
<td>-</td>
<td>628</td>
<td>18.3%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Sar, Koyuncu, et al. (2007)</td>
<td>Psychiatric emergency ward</td>
<td>Turkey</td>
<td>43</td>
<td>17</td>
<td>15 of 43 (34.9%)</td>
<td>6 of 43 (14%)</td>
</tr>
<tr>
<td>Yu et al. (2010)</td>
<td>Psychiatric inpatients$^2$</td>
<td>China</td>
<td>569</td>
<td>96</td>
<td>15.3% after weighting</td>
<td>0.53% after weighting</td>
</tr>
</tbody>
</table>

Note. The DES is from Bernstein and Putnam (1986).

---

$^1$ Female patients only.

$^2$ 84.9% of patients in this sample had a clinical diagnosis of schizophrenia.
<table>
<thead>
<tr>
<th>Professional Organization</th>
<th>Permission</th>
<th>Advertisement</th>
</tr>
</thead>
<tbody>
<tr>
<td>APA Division 39 (Psychoanalysis)</td>
<td>Yes</td>
<td>Listserv email</td>
</tr>
<tr>
<td>APA Division 29 (Psychotherapy)</td>
<td>Yes</td>
<td>Listserv email</td>
</tr>
<tr>
<td>APA Division 56 (Trauma Psychology)</td>
<td>Yes</td>
<td>Listserv email</td>
</tr>
<tr>
<td>APA Division 55 (Pharmacotherapy)</td>
<td>Yes</td>
<td>Listserv email</td>
</tr>
<tr>
<td>APA Division 17 (Counseling Psychology)</td>
<td>Yes</td>
<td>Listserv email</td>
</tr>
<tr>
<td>SEPI</td>
<td>Yes</td>
<td>Listserv email</td>
</tr>
<tr>
<td>ISSTD</td>
<td>Yes</td>
<td>Listserv email</td>
</tr>
<tr>
<td>NASW</td>
<td>Yes</td>
<td>LinkedIn group post</td>
</tr>
<tr>
<td>APA Division 12 (Clinical Psychology)</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>AADPRT</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>ISTSS</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>ABCT</td>
<td>No response</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Note. APA = American Psychological Association; SEPI = Society for the Exploration of Psychotherapy Integration; ISSTD = International Society for the Study of Trauma and Dissociation; NASW = National Association of Social Workers; AADPRT = American Association of Directors of Psychiatric Residency Training; ISTSS = International Society for Traumatic Stress Studies; ABCT = Association for Behavioral and Cognitive Therapies.*
Table 3

Characteristics of Professional Organizations Involved in Recruitment

<table>
<thead>
<tr>
<th>Professional Organization</th>
<th>Targeted Professional Group</th>
<th>Theoretical Orientation</th>
<th>Trauma Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>APA Division 39 (Psychoanalysis)</td>
<td>Psychologists</td>
<td>Psychodynamic</td>
<td>No</td>
</tr>
<tr>
<td>APA Division 29 (Psychotherapy)</td>
<td>Psychologists</td>
<td>All</td>
<td>No</td>
</tr>
<tr>
<td>APA Division 56 (Trauma Psychology)</td>
<td>Psychologists</td>
<td>All</td>
<td>Yes</td>
</tr>
<tr>
<td>APA Division 55 (Pharmacotherapy)</td>
<td>Psychologists, Psychiatrists</td>
<td>All</td>
<td>No</td>
</tr>
<tr>
<td>APA Division 17 (Counseling Psychology)</td>
<td>Psychologists</td>
<td>All</td>
<td>No</td>
</tr>
<tr>
<td>SEPI</td>
<td>All</td>
<td>All</td>
<td>No</td>
</tr>
<tr>
<td>ISSTD</td>
<td>All</td>
<td>All</td>
<td>Yes</td>
</tr>
<tr>
<td>NASW</td>
<td>Social Workers</td>
<td>All</td>
<td>No</td>
</tr>
</tbody>
</table>

*Note. APA = American Psychological Association; SEPI = Society for the Exploration of Psychotherapy Integration; ISSTD = International Society for the Study of Trauma and Dissociation; NASW = National Association of Social Workers.*
Table 4

*Frequency Percentages of Other Theoretical Orientations*

<table>
<thead>
<tr>
<th>Other Theoretical Orientation</th>
<th>$(n = 11)$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attachment Informed CBT</td>
<td>1.2</td>
</tr>
<tr>
<td>Dynamical Systems and Psychodrama</td>
<td>1.2</td>
</tr>
<tr>
<td>EMDR Therapy</td>
<td>1.2</td>
</tr>
<tr>
<td>Feminist Multicultural</td>
<td>1.2</td>
</tr>
<tr>
<td>Gestalt</td>
<td>1.2</td>
</tr>
<tr>
<td>Integrative Trauma Theory</td>
<td>1.2</td>
</tr>
<tr>
<td>Neurodynamic</td>
<td>1.2</td>
</tr>
<tr>
<td>Person-Centered</td>
<td>1.2</td>
</tr>
<tr>
<td>Psychodynamic/Relational/Somatic</td>
<td>1.2</td>
</tr>
<tr>
<td>Structural Dissociation and EMDR</td>
<td>1.2</td>
</tr>
<tr>
<td>Trauma Theory</td>
<td>1.2</td>
</tr>
</tbody>
</table>

*Note.* $f\% = \text{frequency percentage}; \text{CBT} = \text{cognitive behavioral therapy}; \text{EMDR} = \text{eye-movement desensitization and reprocessing}.
Table 5

*Frequency Percentages of Other Current Practice Settings*

<table>
<thead>
<tr>
<th>Other Current Practice Setting</th>
<th>( f % )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community program</td>
<td>1.2</td>
</tr>
<tr>
<td>Crisis center</td>
<td>1.2</td>
</tr>
<tr>
<td>Home</td>
<td>1.2</td>
</tr>
<tr>
<td>Medical clinic</td>
<td>1.2</td>
</tr>
<tr>
<td>Military treatment facility</td>
<td>1.2</td>
</tr>
<tr>
<td>Nursing home and assisted living facility</td>
<td>1.2</td>
</tr>
<tr>
<td>PHP and ART</td>
<td>1.2</td>
</tr>
<tr>
<td>Residence</td>
<td>1.2</td>
</tr>
<tr>
<td>Retired</td>
<td>1.2</td>
</tr>
<tr>
<td>Community program</td>
<td>1.2</td>
</tr>
</tbody>
</table>

*Note.* \( f \% \) = frequency percentage; PHP = partial hospitalization program; ART = (adolescent) acute residential treatment.
<table>
<thead>
<tr>
<th>Specialty</th>
<th>(N = 83) f%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>66.3</td>
</tr>
<tr>
<td>ASD, developmental disorders, and learning disabilities</td>
<td>13.3</td>
</tr>
<tr>
<td>Child and adolescent externalizing disorders</td>
<td>9.6</td>
</tr>
<tr>
<td>Child and adolescent internalizing disorders</td>
<td>13.3</td>
</tr>
<tr>
<td>Chronic pain</td>
<td>14.5</td>
</tr>
<tr>
<td>Couples therapy/marriage counseling</td>
<td>19.3</td>
</tr>
<tr>
<td>Depression</td>
<td>65.1</td>
</tr>
<tr>
<td>Dementia</td>
<td>4.8</td>
</tr>
<tr>
<td>Dissociative disorders</td>
<td>43.4</td>
</tr>
<tr>
<td>Eating disorders and obesity</td>
<td>19.3</td>
</tr>
<tr>
<td>Family therapy</td>
<td>12.0</td>
</tr>
<tr>
<td>Generalist (adult)</td>
<td>42.2</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>7.2</td>
</tr>
<tr>
<td>LGBTQ issues</td>
<td>30.1</td>
</tr>
<tr>
<td>Men’s issues</td>
<td>14.5</td>
</tr>
<tr>
<td>Personality disorders</td>
<td>37.3</td>
</tr>
<tr>
<td>Serious mental illness, including bipolar and psychotic disorders</td>
<td>25.3</td>
</tr>
<tr>
<td>Substance and alcohol-related disorders</td>
<td>27.7</td>
</tr>
<tr>
<td>Trauma and PTSD</td>
<td>79.5</td>
</tr>
<tr>
<td>Grief/loss/bereavement</td>
<td>39.8</td>
</tr>
<tr>
<td>Women’s issues/feminist issues</td>
<td>39.8</td>
</tr>
<tr>
<td>*Other</td>
<td>10.8</td>
</tr>
</tbody>
</table>

Note. f% = frequency percentage; ASD = autism spectrum disorder; LGBTQ = lesbian, gay, bisexual, transgender, and queer; PTSD = posttraumatic stress disorder. *Other responses were: 1.2% issues faced by psychotherapists, 2.4% veteran issues, 1.2% shame, 1.2% non-suicidal self-injury, 1.2% attachment disorders, 2.4% ADHD, 2.4% cultural issues, and 1.2% human trafficking.
Table 7

*Frequency Percentages of Other Expertise/Training Modalities*

<table>
<thead>
<tr>
<th>Other Expertise/Training Modality</th>
<th>(n = 23) f %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychoanalysis</td>
<td>7.2</td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>1.2</td>
</tr>
<tr>
<td>Prolonged Exposure Therapy</td>
<td>1.2</td>
</tr>
<tr>
<td>Cognitive Processing Therapy</td>
<td>1.2</td>
</tr>
<tr>
<td>CBT or TF-CBT</td>
<td>3.6</td>
</tr>
<tr>
<td>Acceptance and Commitment Therapy</td>
<td>1.2</td>
</tr>
<tr>
<td>Somatic Experiencing</td>
<td>4.8</td>
</tr>
<tr>
<td>Coherence Therapy</td>
<td>1.2</td>
</tr>
<tr>
<td>Internal Family Systems</td>
<td>1.2</td>
</tr>
<tr>
<td>Developmental Needs Meeting Strategy</td>
<td>1.2</td>
</tr>
<tr>
<td>Hypnosis</td>
<td>6.0</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>1.2</td>
</tr>
<tr>
<td>Psychodrama</td>
<td>1.2</td>
</tr>
<tr>
<td>Imagery Rehearsal Therapy</td>
<td>1.2</td>
</tr>
</tbody>
</table>

*Note.* f% = frequency percentage; CBT = cognitive behavioral therapy; TF-CBT = trauma-focused CBT.
Table 8

*Frequency Percentages of Most Common Differential Diagnoses for DID*

<table>
<thead>
<tr>
<th>Differential Diagnosis</th>
<th>Choice 1 (n = 73)</th>
<th>Choice 2 (n = 73)</th>
<th>Choice 3 (n = 73)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety disorder</td>
<td>2.4 f%</td>
<td>6.0 f%</td>
<td>7.2 f%</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>3.6 f%</td>
<td>8.4 f%</td>
<td>8.4 f%</td>
</tr>
<tr>
<td>BPD</td>
<td>27.7 f%</td>
<td>20.5 f%</td>
<td>16.9 f%</td>
</tr>
<tr>
<td>Depressive disorder</td>
<td>-</td>
<td>3.6 f%</td>
<td>1.2 f%</td>
</tr>
<tr>
<td>Malingering</td>
<td>2.4 f%</td>
<td>2.4 f%</td>
<td>10.8 f%</td>
</tr>
<tr>
<td>PTSD</td>
<td>42.2 f%</td>
<td>18.1 f%</td>
<td>9.6 f%</td>
</tr>
<tr>
<td>Schizophrenia/psychotic disorder</td>
<td>8.4 f%</td>
<td>21.7 f%</td>
<td>16.9 f%</td>
</tr>
<tr>
<td>Somatic symptom disorder</td>
<td>1.2 f%</td>
<td>3.6 f%</td>
<td>12.0 f%</td>
</tr>
<tr>
<td>Substance-related disorder</td>
<td>-</td>
<td>3.6 f%</td>
<td>4.8 f%</td>
</tr>
</tbody>
</table>

*Note.* BPD = borderline personality disorder; PTSD = posttraumatic stress disorder.
Appendix A

Email Advertisement

From: jenna.n.blewis@gmail.com

Subject: Seeking Participants for a Doctoral Dissertation Study on Trauma

My name is Jenna Blewis, and I am a Clinical PsyD student at the Rutgers University, Graduate School of Applied and Professional Psychology. I am actively recruiting participants for my dissertation research project on trauma and dissociation (IRB #E17-214), pursued in collaboration with Drs. Monica J. Indart and Karen Skean.

Although there has been significant improvement in our understanding of traumatic and dissociative conditions, there is still not widespread agreement about the best practices for assessing, diagnosing, and treating these patients in practice. Empirical research is needed to investigate how practitioners approach trauma and dissociation in practice and what their beliefs are about the diagnoses themselves.

Participation involves completing a brief, anonymous online survey that will take approximately 30-40 minutes to complete. The survey is primarily comprised of multiple-choice questions, and you are free to withdraw at any time.

To participate, you must:

1. Be a licensed clinical psychologist, licensed clinical social worker, or board-certified psychiatrist.
2. Reside and practice in the United States.

To get started, please click this link: https://rutgers.qualtrics.com/jfe/form/SV_8HQZONPo4sgtoLH

Your input is extremely important and valuable to the research outcome. Please consider participating and supporting this project by forwarding this e-mail to interested parties.

Thank you for your time and consideration,

Jenna Blewis, PsyM
Monica J. Indart, PsyD
Karen Skean, PsyD

Contact Information:
Principal Investigator: Jenna Blewis, PsyM; Email: jenna.n.blewis@gmail.com or jenna16nicole@gmail.com
Appendix B

Recruitment Flyer

**Participate in a Study on Trauma**

Help us understand mental health professionals’ beliefs about **trauma and dissociation** and the ways they work therapeutically with these kinds of patients in practice.

If you live and work in the US and are a licensed psychologist, licensed clinical social worker, or board-certified psychiatrist, you may be eligible to participate.

The survey is completely anonymous and should take 30 to 40 minutes to complete.

Participants who complete the survey will help contribute to our knowledge about how mental health professionals think about and work with trauma and dissociation.

Questions? Contact Jenna Blewis, PsyM at jenna.n.blewis@gmail.com

**APPROVED**

**OCT 30 2016**

Approved by the Rutgers IRB
Appendix C

Survey Questions

Section 1: You and your practice

1. How did you hear about our study?
   a. APA Division 17 (Counseling Psychology)
   b. APA Division 29 (Psychotherapy)
   c. APA Division 39 (Psychoanalysis)
   d. APA Division 56 (Trauma Psychology)
   e. Society for the Exploration of Psychotherapy Integration (SEPI)
   f. International Society for the Study of Trauma and Dissociation (ISSTD)
   g. [LIST EACH ADDITIONAL ORGANIZATIONAL LISTSERV]
   h. Other (open text box)

2. Do you currently live and work in the United States of America?
   a. Yes
   b. No

3. How old are you (in years)?
   a. 20 – 29 years
   b. 30 – 39 years
   c. 40 – 49 years
   d. 50 – 59 years
   e. 60 – 69 years
   f. 70 – 79 years
   g. 80 – 89 years
   h. 90+ years

4. What is your gender?
   a. Male
   b. Female
   c. Transgender
   d. Other (open text box)

5. What is your racial/ethnic background?
   a. African-American / Black / African Origin
   b. Asian-American / Asian Origin / Pacific Islander
   c. Latino-a / Hispanic
   d. American Indian / Alaska Native / Aboriginal Canadian
   e. European Origin / White
   f. Bi-racial / Multi-racial
   g. Other (open text box)

6. What is your profession? (Select all that apply).
   a. Clinical psychologist (PhD)
   b. Clinical psychologist (PsyD)
   c. Board-certified psychiatrist (MD)
   d. Board-certified psychiatrist (DO)
e. Licensed clinical social worker (LCSW)  
f. Other (open text box)

7. How many years of post-graduate experience do you have?  
a. 0-5 years  
b. 6-10 years  
c. 11-15 years  
d. 16-20 years  
e. 21+ years

8. Where do you **currently** see patients? *(Select all settings that apply).*  
a. Community mental health center  
b. Forensic/ justice (jail)  
c. Hospital  
d. Inpatient psychiatric hospital  
e. Partial hospitalization/Intensive outpatient programs  
f. Outpatient psychiatric clinic/hospital (includes primary-care / family medicine)  
g. Private practice  
h. University counseling center  
i. VA medical center  
j. Other (open text box)

9. Where do you **primarily** see patients? *(Select only one setting).*  
a. Community mental health center  
b. Forensic/ justice (jail)  
c. Hospital  
d. Inpatient psychiatric hospital  
e. Partial hospitalization/Intensive outpatient programs  
f. Outpatient psychiatric clinic/hospital (includes primary-care / family medicine)  
g. Private practice  
h. University counseling center  
i. VA medical center  
j. Other (open text box)

10. What is your primary theoretical orientation? *(Select only one).*  
a. Behavioral/ cognitive-behavioral  
b. Dialectical behavioral therapy (DBT)  
c. Existential/humanistic  
d. Family/ systems  
e. Integrative/ eclectic  
f. Interpersonal therapy (IPT)  
g. Psychodynamic/psychoanalytic  
h. Other (open text box)

11. In which, if any, of the following modalities do you have expertise/training? *(Select all that apply).*  
a. Accelerated experiential dynamic psychotherapy (AEDP)  
b. Dialectical behavior therapy (DBT)  
c. Eye movement desensitization and reprocessing (EMDR)  
d. Mindfulness-based approaches  
e. Sensorimotor psychotherapy
f. Other (open text box)

12. What is the typical number of clients that you see each week?
   a. 1-5
   b. 6-10
   c. 11-15
   d. 16-20
   e. 21-25
   f. 26+

13. Which client group(s) do you currently work with? (Select all that apply).
   a. Children (3 – 12 years)
   b. Adolescents (13 – 17 years)
   c. Adults (18 – 64 years)
   d. Older adults (65+ years)
   e. Couples
   f. Families
   g. Other (open text box)

14. Which client group do you primarily work with? (Select one).
   a. Children/adolescents
   b. Adults/older adults
   c. Couples
   d. Families
   e. Other (open text box)

15. What (if any) specialties/areas of expertise do you have? (Select all that apply).
   a. Anxiety
   b. Autism spectrum, developmental disorders, and learning disabilities
   c. Child and adolescent externalizing disorders
   d. Child and adolescent internalizing disorders
   e. Chronic pain
   f. Couples therapy/marriage counseling
   g. Depression
   h. Dementia
   i. Dissociative disorders
   j. Eating disorders and obesity
   k. Family therapy
   l. Generalist (adult)
   m. Geriatrics
   n. LGBTQ issues
   o. Men’s issues
   p. Personality disorders
   q. Severe mental illness, including bipolar disorder and psychotic disorders
   r. Substance and alcohol-related disorders
   s. Trauma and PTSD
   t. Grief/loss/bereavement
   u. Women’s issues/feminist issues
   v. Other (please specify)
Section 2: Knowledge and beliefs about dissociative identity disorder (DID)

16. Please rate the extent to which you agree with the following statement: *DID is a valid, distinct clinical diagnosis.*
   1. Strongly disagree
   2. Disagree
   3. Neither agree nor disagree
   4. Agree
   5. Strongly agree

17. If you believe DID is a distinct, valid clinical disorder, what do you believe is the etiology of the disorder? (Open text box)

18. How familiar are you with the literature on DID?*
   1. Not at all familiar
   2. Slightly familiar
   3. Somewhat familiar
   4. Moderately familiar
   5. Extremely familiar

19. How have you learned about DID? *(Select all that apply)*
   a. First person accounts (e.g., memoir, documentary)
   b. Graduate school course(s)
   c. Continuing education (e.g., lecture, conference, or workshop)
   d. Multilevel professional certification in a specific approach (e.g., Internal Family Systems, etc).
   e. Media (e.g., fictional novel or film, non-professional articles)
   f. Professional literature
   g. Professional supervision
   h. Other (Open text box)

20. Please describe what you look for as red flags (e.g., clear signs and symptoms) to assess for DID (open text box)

21. How likely are you to believe a new patient that comes in and tells you that s/he has DID?*
   1. Extremely unlikely
   2. Unlikely
   3. Neutral
   4. Likely
   5. Extremely likely

22. Which of the following statements is most reflective of your beliefs about DID:
   i. DID is overdiagnosed in the US, despite little or no empirical support for its validity.
      i. If selected: What factors do you believe account for this phenomenon? (Open text box)
   j. DID is under- and misdiagnosed in the US, despite growing support for its validity.
      i. If selected: What factors do you believe account for this phenomenon? (Open text box)
   k. I don’t feel like I have enough knowledge or competence to make a determination.
   l. There is insufficient empirical research at present to make a determination about validity.
23. Are you aware of evidence-based treatments for DID?
   m. Yes
   n. No
   o. Not sure

Section 3: Working therapeutically with DID

24. What is your approach to the assessment of DID? (Open text box)
25. Which, if any, of the following have you used to assess for dissociative symptoms? (Select all that apply).
   a. Structured Clinical Interview for Dissociative Disorders (SCID-D/SCID-D-R)
   b. Dissociative Disorders Interview Schedule (DDIS)
   c. Dissociative Experiences Scale (DES)
   d. Multidimensional Inventory of Dissociation (MID)
   e. Questionnaire on Experiences of Dissociation (QED)
   f. Clinical interview
   g. Other (open text box)
26. Have you ever assigned a diagnosis of DID?
   h. Yes
   i. No
   j. Yes, but only as a rule-out or provisional diagnosis
27. Would you consider treating a patient with DID?
   k. No (would not consider) (open text box: why?)
   l. Maybe (might or might not consider) (open text box: why?)
   m. Yes (definitely consider) (open text box: why not?)
28. What do you think are the most common differential diagnoses for DID? Please rank your top three choices by moving those items into the box on the right and arranging them in order (box on the right displayed).
   n. Anxiety disorder
   o. Bipolar disorder
   p. Borderline personality disorder (BPD)
   q. Depressive disorder
   r. Malingering
   s. Posttraumatic stress disorder (PTSD)
   t. Schizophrenia/psychotic disorder
   u. Somatic symptom disorder
   v. Substance-related disorder
29. Have you worked therapeutically with one or more patients who had DID?
   w. Yes
      i. If Yes
         1. How many TOTAL patients have you treated with DID? (Open text box)
         2. How many patients are you CURRENTLY treating with DID? (Open text box)
   x. No
   y. Possibly but I didn’t realize they had DID at the time
30. Please describe your therapeutic modality/approach to treatment (open text box)
31. If you have worked with patient(s) with DID, please briefly describe your own reactions and experiences (open text box)

**Section 4: Training and supervision in DID**

32. Are you involved in individual supervision?
   a. Yes (open text box: please describe the nature of the supervision)
   b. No
33. Are you involved in an ongoing supervision group?
   c. Yes (open text box: please describe the nature of the supervision group)
   d. No
34. Have you received training and/or supervision that has been relevant to working with someone with DID? (This may be directly or indirectly relevant).
   e. Yes (open text box: please describe)
   f. No
35. Please describe anything else that has prepared you for working with people with DID (open text box)
36. Would you be interested in receiving further education on DID?
   g. Yes
   h. No
37. Would you be interested in receiving further training on assessing and treating DID?
   i. Yes
   j. No
38. What has been your reaction to participating in this study? (Open text box)

*Note:* * Denotes questions that will be rated on a 5-point Likert scale.
Appendix D

Online Consent Form and Survey

Introduction and Consent

ONLINE SURVEY
INFORMED CONSENT FORM

Rutgers, The State University of New Jersey
Graduate School of Applied and Professional Psychology

Title of Research Study: Mental health professionals’ beliefs and awareness about trauma and dissociation
Principal Investigator: Jenna Blewis, Psy.M., Doctoral Candidate
Faculty Investigators: Monica J. Indart, Psy.D., Visiting Assistant Professor
Karen Sken, Psy.D., Visiting Associate Professor

Purpose of the Study:
The purpose of this study is to investigate mental health professionals’ beliefs and awareness about trauma and dissociation. This study is part of a doctoral dissertation research project. You are being asked to participate because you are a licensed professional. You will be one of approximately 100 subjects.

Study procedures:
You will complete an online Qualtrics survey, which will take approximately 30-40 minutes to complete. The survey includes questions about demographic information, your beliefs about trauma and dissociation, and your experiences working therapeutically with these patients.

Participation in this study is voluntary. The only alternative to this study is not to participate.

Who can participate?
You are eligible to participate if you are a licensed psychologist, licensed clinical social worker, or board-certified psychiatrists working and residing in the United States.

Risks or discomforts:
Minimal risks are anticipated from taking part in this study. Responses to survey questions will be recorded anonymously and will not ask any sensitive questions. Because of the anonymity of the study, your honest responses about your professional beliefs will not pose the risk of damaging your professional reputation. If you feel uncomfortable with a question, you can skip that question or withdraw from the study altogether. If you decide to quit at any time before you have finished the questionnaire, your answers will NOT be recorded.

Potential benefits:
There is no direct benefit to you for participating in this study. You will be contributing to knowledge about how mental health professionals think about trauma and dissociation and work with these issues in practice. Current and future practitioners may benefit from what the researchers learn from this study.

Confidentiality:
Your responses will be kept completely anonymous. We will NOT know your IP address when you respond to the Internet survey. We will not ask for your name when you complete the Internet survey. Instead, you will be assigned a participant number. The researchers will see your individual survey responses and the results but no link between the survey data and identity will exist. All information you provide will be treated anonymously. There are no foreseeable risks to participation. The principal investigator has put in place adequate protections for your privacy in that all information provided
will be kept anonymous by using a randomly generated number code in place of your email address. This code will be kept securely by the research team only and will not be traced back to you.

**Compensation:**

You will not receive any payment for being in this study.

**Withdrawal:**

Your participation is voluntary; you are free to withdraw your participation from this study at any time. If you do not want to continue, you can simply leave this website. If you do not click on the "submit" button at the end of the survey, your answers and participation will not be recorded. You also may choose to skip any questions that you do not wish to answer.

**How will the findings be used?**

The results of the study will be used for the principal investigator’s doctoral dissertation research. The results from the study will be presented in for the requirements of the doctoral degree, and the results might be published in a peer-reviewed journal at a future date.

**Contact information:**

If you have concerns or questions about this research study, please contact the principal investigator, Jenna Blewis, Psy.M., at 410-409-0055 or jenna.n.blewis@gmail.com

If you have questions about your rights as a research subject, please contact the Arts and Sciences IRB director at:

Institutional Review Board
Rutgers University, the State University of New Jersey
Liberty Plaza / Suite 3200
335 George Street, 3rd Floor
New Brunswick, NJ 08901
Phone: 732-235-9806; Email: humansubjects@orsp.rutgers.edu

By beginning the survey, you acknowledge that you have read this information and agree to participate in this research, with the knowledge that you are free to withdraw your participation at any time without penalty.

**Signature of Investigator:**

---

*This informed consent form was approved by the Rutgers University Institutional Review Board for the Protection of Human Subjects on 10/30/2016. Currently, there is no expiration on the approval of this form.*

Please indicate if you consent to participate and would like to continue to the survey.

- Yes, I would like to continue to the survey.
- No, I would like to exit.

---

**Section 1: You and your practice**

How did you hear about our study?
| APA Division 17 (Counseling Psychology) |  
| APA Division 29 (Psychotherapy)       |  
| APA Division 39 (Psychoanalysis)      |  
| APA Division 56 (Trauma Psychology)   |  
| Society for the Exploration of Psychotherapy Integration (SEPI) |  
| International Society for the Study of Trauma and Dissociation (ISSTD) |  
| Other |  

Do you currently live and work in the United States of America?

| Yes |  
| No |  

How old are you (in years)?

| 20 - 29 |  
| 30 - 39 |  
| 40 - 49 |  
| 50 - 59 |  
| 60 - 69 |  
| 70 - 79 |  
| 80 - 89 |  
| 90+ years |  

What is your gender?

| Male |  
| Female |  
| Transgender |  
| Other |  


**What is your racial/ethnic background?**

- African-American / Black / African Origin
- Asian-American / Asian Origin / Pacific Islander
- Latino-a / Hispanic
- American Indian / Alaska Native / Aboriginal Canadian
- European Origin / White
- Bi-racial / Multi-racial
- Other  

**What is your profession? (Select all that apply).**

- Clinical psychologist (PhD)
- Clinical psychologist (PsyD)
- Board-certified psychiatrist (MD)
- Board-certified psychiatrist (DO)
- Licensed clinical social worker (LCSW)
- Other  

**How many years of post-graduate experience do you have?**

- 0-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 21+ years

**Where do you currently see patients? (Select all settings that apply).**

- Community mental health center
- Forensic/justice (jail or prison)
## Where do you primarily see patients? *(Select only one setting).*

- Community mental health center
- Forensic/justice (jail or prison)
- Hospital
- Inpatient psychiatric hospital
- Partial hospitalization/intensive outpatient program
- Outpatient psychiatric clinic/hospital (includes primary care/family medicine)
- Private practice
- University counseling center
- VA medical center
- Other

## What is your primary theoretical orientation? *(Select only one).*

- Behavioral/cognitive-behavioral
- Dialectical behavioral therapy (DBT)
- Existential/humanistic
- Family/systems
- Integrative/eclectic
- Interpersonal therapy (IPT)
- Psychodynamic/psychoanalytic
In which, if any, of the following modalities do you have expertise/training? *(Select all that apply).*

- [ ] Accelerated experiential dynamic psychotherapy (AEDP)
- [ ] Dialectical behavior therapy (DBT)
- [ ] Eye movement desensitization and reprocessing (EMDR)
- [ ] Mindfulness-based approaches
- [ ] Sensorimotor psychotherapy
- [ ] Other

What is the typical number of clients that you see each week?

- [ ] 1-5
- [ ] 6-10
- [ ] 11-15
- [ ] 16-20
- [ ] 21-25
- [ ] 26+

Which client group(s) do you currently work with? *(Select all that apply).*

- [ ] Children (3 - 12 years)
- [ ] Adolescents (13 - 17 years)
- [ ] Adults (18 - 64 years)
- [ ] Older adults (65+ years)
- [ ] Couples
- [ ] Families
- [ ] Other
Which client group do you **primarily** work with? *(Select one).*

- [ ] Children/adolescents
- [ ] Adults/older adults
- [ ] Couples
- [ ] Families
- [ ] Other

What (if any) specialties/areas of expertise do you have? *(Select all that apply).*

- [ ] Anxiety
- [ ] Autism spectrum, developmental disorders, and learning disabilities
- [ ] Child and adolescent externalizing disorders
- [ ] Child and adolescent internalizing disorders
- [ ] Chronic pain
- [ ] Couples therapy/marriage counseling
- [ ] Depression
- [ ] Dementia
- [ ] Dissociative disorders
- [ ] Eating disorders and obesity
- [ ] Family therapy
- [ ] Generalist (adult)
- [ ] Geriatrics
- [ ] LGBTQ issues
- [ ] Men's issues
- [ ] Personality disorders
- [ ] Severe mental illness, including bipolar disorder and psychotic disorders
- [ ] Substance and alcohol-related disorders
- [ ] Trauma and PTSD
- [ ] Grief/loss/bereavement
- [ ] Women's issues/feminist issues
- [ ] Other (please specify)
Section 2: Knowledge and beliefs about dissociative identity disorder

Please rate the extent to which you agree with the following statement:

*Dissociative identity disorder (DID) is a valid, distinct clinical diagnosis.*

- [ ] Strongly disagree
- [ ] Disagree
- [ ] Neither agree nor disagree
- [ ] Agree
- [ ] Strongly agree

If you believe DID is a distinct, valid clinical disorder, what do you believe is the etiology of the disorder?

[ ]

How familiar are you with the literature on DID?

- [ ] Not at all familiar
- [ ] Slightly familiar
- [ ] Somewhat familiar
- [ ] Moderately familiar
- [ ] Extremely familiar

How have you learned about DID? (Select all that apply).

- [ ] First person accounts (e.g., memoir, documentary)
- [ ] Graduate school course(s)
- [ ] Continuing education (e.g., lecture, conference, or workshop)
- [ ] Multilevel professional certification in a specific approach (e.g., Internal Family Systems, etc.).
Media (e.g., fictional novel or film, non-professional articles)
☐ Professional literature
☐ Professional supervision
☐ Other

Please describe what you look for as red flags (e.g., clear signs and symptoms) to assess for DID.

How likely are you to believe a new patient who comes in and tells you that s/he has DID?
☐ Extremely unlikely
☐ Unlikely
☐ Neutral
☐ Likely
☐ Extremely likely

Which of the following statements is most reflective of your beliefs about DID:
☐ DID is overdiagnosed in the US, despite little or no empirical support for its validity.
☐ DID is under- and misdiagnosed in the US, despite growing support for its validity.
☐ I don't feel like I have enough knowledge or competence to make a determination.
☐ There is insufficient empirical research at present to make a determination about validity.
☐ What factors do you believe account for this phenomenon?

Are you aware of evidence-based treatments for DID?
☐ Yes
☐ No
Section 3: Working therapeutically with DID

What is your approach to the assessment of DID?

Which, if any, of the following have you used to assess for dissociative symptoms? (Select all that apply).

- Structured Clinical Interview for Dissociative Disorders (SCID-D/SCID-D-R)
- Dissociative Disorders Interview Schedule (DDIS)
- Dissociative Experiences Scale (DES)
- Multidimensional Inventory of Dissociation (MID)
- Questionnaire on Experiences of Dissociation (QED)
- Clinical interview
- Other

Have you ever assigned a diagnosis of DID?

- Yes
- No
- Yes, but only as a rule-out or provisional diagnosis

Would you consider treating a patient with DID?

- No (would not consider)
- Maybe (might or might not consider)
- Yes (definitely consider)
What do you think are the most common differential diagnoses for DID? Please rank your top three choices by moving those items into the box on the right and arranging them in order.

<table>
<thead>
<tr>
<th>Items</th>
<th>Most Common Differential Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety disorder</td>
<td></td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td></td>
</tr>
<tr>
<td>Borderline personality disorder (BPD)</td>
<td></td>
</tr>
<tr>
<td>Depressive disorder</td>
<td></td>
</tr>
<tr>
<td>Malingering</td>
<td></td>
</tr>
<tr>
<td>Posttraumatic stress disorder (PTSD)</td>
<td></td>
</tr>
<tr>
<td>Schizophrenia/psychotic disorder</td>
<td></td>
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<tr>
<td>Somatic symptom disorder</td>
<td></td>
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<tr>
<td>Substance-related disorder</td>
<td></td>
</tr>
</tbody>
</table>

Have you worked therapeutically with one or more patients who has DID?

- Yes
- No
- Possibly, but I didn't realize they had DID at the time

- How many TOTAL patients have you treated with DID?

- How many patients are you CURRENTLY treating with DID?

Please describe your therapeutic modality/approach to treatment.
If you have worked with patient(s) with DID, please briefly describe your own reactions and experiences.

Section 4: Training and supervision in DID

Are you involved in individual supervision?

- Yes
- No
- Please describe the nature of the supervision

Are you involved in an ongoing supervision group?

- Yes
- No
- Please describe the nature of the supervision group

Have you received training and/or supervision that has been relevant to working with someone with DID? (This may be directly or indirectly relevant).

- Yes
- No
- Please describe
Please describe anything else that has prepared you for working with people with DID.

Would you be interested in receiving further education on DID?

- Yes
- No

Would you be interested in receiving further training on assessing and treating DID?

- Yes
- No

What has been your reaction to participating in this study?
### Appendix E
Data Extract with Focused Codes Applied

<table>
<thead>
<tr>
<th></th>
<th>Hard work, emotionally draining</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>when the patient told me about her diagnosis, I could see she was very gratified to have a framework for understanding herself that maintained the splitting she had developed. I validated and supported her working with a therapist who would help her using that framework.</td>
</tr>
<tr>
<td>4</td>
<td>Fascinated/curious. Concerned for pt's safety. Sometimes lost and incompetent</td>
</tr>
<tr>
<td>5</td>
<td>Challenged, challenging, and rewarding</td>
</tr>
<tr>
<td>6</td>
<td>It has been isolating at times as others deny or misunderstand the diagnosis and thus difficult to get supervision or consultation around DID issues. I have enjoyed working with clients with DID, am absolutely awed by their intelligence and ingenuity in adapting to impossibly traumatic childhoods and impressed by their courage and growth in recovery</td>
</tr>
<tr>
<td>8</td>
<td>I immediately got consultation in my first case because I wasn’t sure if this was DID or something else, and I continued consultation throughout treatment. I also always get consultation with a DID patient now as it helps me work through countertransference. Countertransference reactions have been strong at times - and initially confusing as I found myself in different “countertransference self-states” so to speak that sometimes rapidly changed within a session. Another example is of me feeling as though I’m in one of the persons’ self states and she is in another - this is usually behaviorally enacted and I would recognize it after the fact. When we could talk about this in the treatment, that was a significant milestone among the many others that preceded it.</td>
</tr>
<tr>
<td>10</td>
<td>Initially, questioned my competence. Quietly, tried to locate where she was and what she was feeling in her body.</td>
</tr>
</tbody>
</table>
## Developed Major Theme: Reactions to DID Work

<table>
<thead>
<tr>
<th>Major Theme</th>
<th>Theme</th>
<th>Sub-theme</th>
<th>Focused Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Therapy process and outcome</td>
<td>1a. Patient qualities and presentation</td>
<td>Symptom presentation (e.g., dissociation)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Strengths and resources</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>DID diagnosis</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Stereotypes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level of functioning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1b. Treatment progress and outcome</td>
<td>Treatment milestones</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Treatment failures</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Slow progress</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outside referral</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1c. Treatment challenges and concerns</td>
<td>Difficult to treat</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Therapist lack of expertise</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diagnostic issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Crises and safety concerns (e.g., suicidality, self-harm, aggression, hospitalization)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Comorbid psychiatric issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Challenging patients</td>
<td></td>
</tr>
<tr>
<td>2. Service and support considerations</td>
<td>2a. Professional support</td>
<td>Supervision and consultation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Group practice</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specialized training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2b. Controversy</td>
<td>Fear of not being believed</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Skepticism</td>
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<tr>
<td></td>
<td></td>
<td>Controversy</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Professional isolation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2c. Practice considerations</td>
<td>Caseload limits</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Session frequency</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prefer not to treat</td>
<td></td>
</tr>
<tr>
<td>3. Qualities and considerations for the therapist</td>
<td>3a. Therapist’s role and skills</td>
<td>Maintain clarity and balance</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Accept not knowing</td>
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<tr>
<td></td>
<td></td>
<td>Follow own instincts</td>
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<td></td>
<td></td>
<td>Supportive interventions (e.g., validation)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trauma work (e.g., tri-phasic treatment, parts)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Relational approach (e.g., work through counter-transference enactments)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3b. Therapist growth and fulfillment</td>
<td>Positive feelings (e.g., enjoyment, interest)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Witnessing change</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Growth and development</td>
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<tr>
<td></td>
<td></td>
<td>Compassion satisfaction (e.g., pleasure from rewarding or challenging work)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Meaningful experience</td>
<td></td>
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<tr>
<td></td>
<td>3c. Impact on the therapist</td>
<td>Strong counter-transference reactions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Signs of burnout (e.g., feeling drained, exhausted)</td>
<td></td>
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<td></td>
<td></td>
<td>Feeling lost or incompetent</td>
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<td></td>
<td></td>
<td>Self-care needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Risk of vicarious trauma or STS</td>
<td></td>
</tr>
</tbody>
</table>
Appendix G

Developed Major Theme: Red Flags for DID

<table>
<thead>
<tr>
<th>Major Theme</th>
<th>Theme</th>
<th>Sub-theme</th>
<th>Focused Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red flags to assess for DID</td>
<td>1. Dissociative features and symptom clusters</td>
<td>1a. Dissociative process</td>
<td>Dissociation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Depersonalization and/or derealization</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Amnesia or “lost time”</td>
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<td></td>
<td></td>
<td></td>
<td>Memory gaps or lapses</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Confusion or disorientation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1b. Identity alteration and fragmentation</td>
<td>Switching self-states</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Changes in personality, mood, affect, etc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Compartmentalization, passive influence</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Identity confusion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1c. Psychiatric comorbidity</td>
<td>Comorbid disorders</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Complex trauma symptoms (e.g., numbing, detachment, flashbacks, intrusions)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hearing (internal) voices</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>High-risk behaviors (e.g., suicidality, self-harm)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Acute somatic episodes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Acute psychotic episodes</td>
</tr>
<tr>
<td></td>
<td>2. Therapist’s subjective experience</td>
<td>2a. Observed shifts in presentation</td>
<td>Marked changes within or between sessions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fluctuations in mood or affect</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dissociation in session</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2b. Verbal and nonverbal indicators</td>
<td>Physiological/somatic indicators</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Bodily signs and indicators</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Verbal/language indicators</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nonverbal peculiarities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2c. Therapist reactions</td>
<td>Counter-transference reactions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>“Awakening”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Feel unprepared</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No experience</td>
</tr>
<tr>
<td></td>
<td>3. Objective reports and historical indicators</td>
<td>3a. Historical indicators</td>
<td>Trauma history</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unsuccessful past treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Medical records</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3b. Collateral and self-reports</td>
<td>Reports DID diagnosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>References self-states, parts, or different names</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reports evidence of dissociation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Collateral reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3c. DID assessment tools</td>
<td>Validated assessment instruments (e.g., DES, MID)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Assessment questions</td>
</tr>
<tr>
<td></td>
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<td>Associated impairment</td>
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</table>
### Appendix H

Developed Major Theme: Preparation for DID Work

<table>
<thead>
<tr>
<th>Major Theme for DID work</th>
<th>Theme</th>
<th>Sub-theme</th>
<th>Focused Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation for DID work</td>
<td>1. Personal and support factors</td>
<td>1a. Supervision and consultation</td>
<td>Individual and/or group supervision</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Consultation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Support groups (e.g., online, listserv)</td>
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<td></td>
<td></td>
<td></td>
<td>Advanced study groups</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Mentor experience</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Support from colleagues</td>
</tr>
<tr>
<td></td>
<td>1b. Barriers to accessing support</td>
<td></td>
<td>Lack training</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Skepticism</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Difficulty obtaining supervision</td>
</tr>
<tr>
<td></td>
<td>1c. Personal experiences</td>
<td></td>
<td>Personal trauma or family history</td>
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<tr>
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<td></td>
<td></td>
<td>Personal therapy</td>
</tr>
<tr>
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<td></td>
<td></td>
<td>Therapist’s capacity for dissociation</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Self-care practices (e.g., meditation, yoga)</td>
</tr>
<tr>
<td></td>
<td>2. Education and training</td>
<td>2a. Literature and broad education</td>
<td>Coursework or broad education</td>
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<tr>
<td></td>
<td></td>
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<td>Readings/literature</td>
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<tr>
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<td></td>
<td>Online resources</td>
</tr>
<tr>
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<td></td>
<td>Psychodynamic background</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2b. Advanced or specialized training</td>
<td>Conferences or meetings</td>
</tr>
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<td></td>
<td>Seminars, workshops, or training courses</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Training in trauma and/or dissociation</td>
</tr>
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<td></td>
<td></td>
<td>Training in specific therapies (e.g., EMDR, DBT)</td>
</tr>
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<td>Training with specific populations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2c. Clinical experiences</td>
<td>Trauma work</td>
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<tr>
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<td>Patients</td>
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<td>Experience</td>
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<td>Misunderstood diagnosis</td>
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### Developed Major Theme: Reactions to this Study

<table>
<thead>
<tr>
<th>Major Theme</th>
<th>Theme</th>
<th>Sub-theme</th>
<th>Focused Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reactions</td>
<td>1. Importance and value of the work</td>
<td>1a. Applications and contributions to the field</td>
<td>Important topic</td>
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<td>Glad research is being done</td>
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<td>study</td>
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<td>Much needed research</td>
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<td></td>
<td>Interested in findings</td>
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<td></td>
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<td></td>
<td>Addressing skepticism</td>
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<tr>
<td></td>
<td>1b. Concerns, critiques, and limitations</td>
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<td>Methodological concerns (e.g., study questions)</td>
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<td></td>
<td>Unsure how helpful</td>
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<tr>
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<td></td>
<td>Questioning study intent or value</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lacks relevance</td>
</tr>
<tr>
<td></td>
<td>2. Subjective experience and impact</td>
<td>2a. Increased awareness</td>
<td>Helped raise awareness</td>
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<td></td>
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<td>Realized lack of knowledge</td>
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<td></td>
<td></td>
<td></td>
<td>Want to learn more</td>
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<tr>
<td></td>
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<td></td>
<td>Feel unprepared to treat DID</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2b. Personal reflection and interest</td>
<td>Stimulated reflection</td>
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<td>Thought-provoking</td>
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<td>Positive emotions (e.g., interesting, curious, etc.)</td>
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<td>Feeling helpful</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Appreciative (e.g., thank you)</td>
</tr>
</tbody>
</table>