MULTIPLE PERSPECTIVES ON MULTIPLE SELVES: INVESTIGATING CLINICIANS'

KNOWLEDGE, BELIEFS, AND EXPERIENCES RELATED TO DISSOCIATIVE IDENTITY

DISORDER

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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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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

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.

― Elena Ferrante, *The Story of the Lost Child, 2014*

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, Horselenberg, 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 unfound. 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.

<p style="text-align:center">Objectives of the Current Study</p>

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

(ANOVAs) 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.

Chapter IV: Results

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, four (4.8%) disagreed, and six (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

3. Schizophrenia/psychotic disorder.

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

the therapist.

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 chucks 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 sever 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 asses 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

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 that 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 raised 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 strong 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

interested 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.

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Table 1

Epidemiological Studies of DID and Dissociative Disorders Among Adults

Study	Population	Country	Patients Completing the DES	Patients Completing a Structured Interview	Patients with a Dissociative Disorder	Patients with DID
Ross et al. (1991)	Psychiatric inpatients	Canada	299	80	21%	3-5%
Saxe et al. (1993)	Psychiatric inpatients	United States	110	20	13$	4$
Knudsen et al. (1995; as cited in Yu et al., 2010)	Psychiatric inpatients	Norway	85	23	8%	5%
Tutkun et al. (1998)	Psychiatric inpatients	Turkey	116	40	10%	5%
Friedl & Draijer (2000)	Psychiatric inpatients	Netherlands	122	56	8%	2%
Gast, Rodewald, Nickel, & Emrich (2001)	Psychiatric inpatients	Germany	115	15	4-8%	1-2%
Foote et al. (2006)	Psychiatric outpatients	United States	231	82	24 of 82 (29%)	5 of 82 (6%)
Johnson et al. (2006)	Community	United States	658	658	60 (9.1%)	10 (1.5%)
Sar, Akyüz, & Doğan (2007)[1]	General population	Turkey	-	628	18.3%	1.1%
Sar, Koyuncu, et al. (2007)	Psychiatric emergency ward	Turkey	43	17	15 of 43 (34.9%)	6 of 43 (14%)
Yu et al. (2010)	Psychiatric inpatients[2]	China	569	96	15.3% after weighting	0.53% after weighting

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

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[1] Female patients only.
[2] 84.9% of patients in this sample had a clinical diagnosis of schizophrenia.

Table 2

Professional Organizations Contacted for Recruitment

Professional Organization	Permission	Advertisement
APA Division 39 (Psychoanalysis)	Yes	Listserv email
APA Division 29 (Psychotherapy)	Yes	Listserv email
APA Division 56 (Trauma Psychology)	Yes	Listserv email
APA Division 55 (Pharmacotherapy)	Yes	Listserv email
APA Division 17 (Counseling Psychology)	Yes	Listserv email
SEPI	Yes	Listserv email
ISSTD	Yes	Listserv email
NASW	Yes	LinkedIn group post
APA Division 12 (Clinical Psychology)	No	N/A
AADPRT	No	N/A
ISTSS	No	N/A
ABCT	No response	N/A

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

Professional Organization	Targeted Professional Group	Theoretical Orientation	Trauma Focus
APA Division 39 (Psychoanalysis)	Psychologists	Psychodynamic	No
APA Division 29 (Psychotherapy)	Psychologists	All	No
APA Division 56 (Trauma Psychology)	Psychologists	All	Yes
APA Division 55 (Pharmacotherapy)	Psychologists, Psychiatrists	All	No
APA Division 17 (Counseling Psychology)	Psychologists	All	No
SEPI	All	All	No
ISSTD	All	All	Yes
NASW	Social Workers	All	No

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

Other Theoretical Orientation	(*n* = 11) *f* %
Attachment Informed CBT	1.2
Dynamical Systems and Psychodrama	1.2
EMDR Therapy	1.2
Feminist Multicultural	1.2
Gestalt	1.2
Integrative Trauma Theory	1.2
Neurodynamic	1.2
Person-Centered	1.2
Psychodynamic/Relational/Somatic	1.2
Structural Dissociation and EMDR	1.2
Trauma Theory	1.2

Note. f% = frequency percentage; CBT = cognitive behavioral therapy; EMDR = eye-movement desensitization and reprocessing.

Table 5

Frequency Percentages of Other Current Practice Settings

Other Current Practice Setting	$(n = 9)$ $f\%$
Community program	1.2
Crisis center	1.2
Home	1.2
Medical clinic	1.2
Military treatment facility	1.2
Nursing home and assisted living facility	1.2
PHP and ART	1.2
Residence	1.2
Retired	1.2
Community program	1.2

Note. $f\%$ = frequency percentage; PHP = partial hospitalization program; ART = (adolescent) acute residential treatment.

Table 6

Frequency Percentages of Specialties/Areas of Expertise

Specialty	(*N* = 83) *f* %
Anxiety	66.3
ASD, developmental disorders, and learning disabilities	13.3
Child and adolescent externalizing disorders	9.6
Child and adolescent internalizing disorders	13.3
Chronic pain	14.5
Couples therapy/marriage counseling	19.3
Depression	65.1
Dementia	4.8
Dissociative disorders	43.4
Eating disorders and obesity	19.3
Family therapy	12.0
Generalist (adult)	42.2
Geriatrics	7.2
LGBTQ issues	30.1
Men's issues	14.5
Personality disorders	37.3
Serious mental illness, including bipolar and psychotic disorders	25.3
Substance and alcohol-related disorders	27.7
Trauma and PTSD	79.5
Grief/loss/bereavement	39.8
Women's issues/feminist issues	39.8
*Other	10.8

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

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

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

Table 8

Frequency Percentages of Most Common Differential Diagnoses for DID

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

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.
3. Speak English.

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

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

Rutgers, Arts and Sciences IRB:
Institutional Review Board, Rutgers University, the State University of New Jersey
Liberty Plaza / Suite 3200, 335 George Street, 3rd Floor, New Brunswick, NJ 08901
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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

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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 3 0 2016

Approved by the
Rutgers IRB

Appendix C

Survey Questions

<u>Section 1: You and your practice</u>

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 Skean, 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 Services 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)

☐ 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

[   ]

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

○ Other

[　　　　　　]

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

○ Not sure

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)

○

Why?

[   ]

○ Why not?

[   ]

○ Why?

[   ]

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.*

Items

Anxiety disorder

Bipolar disorder

Borderline personality disorder (BPD)

Depressive disorder

Malingering

Posttraumatic stress disorder (PTSD)

Schizophrenia/psychotic disorder

Somatic symptom disorder

Substance-related disorder

Most Common Differential Diagnoses

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

[ ]
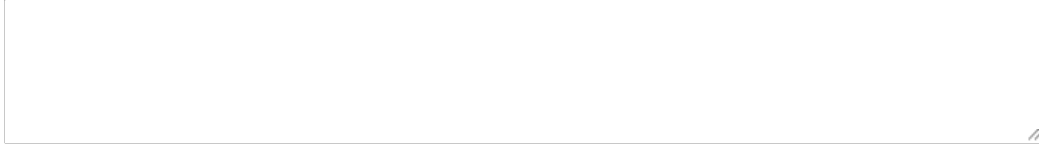
Are you involved in an ongoing supervision group?

○ 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

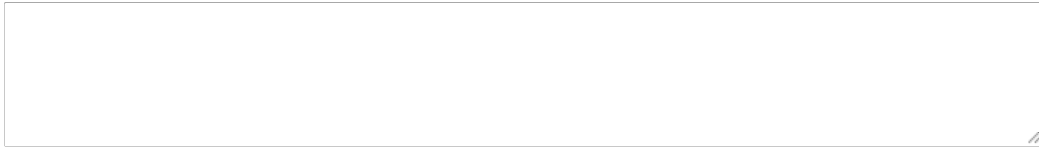| #	Text	Codes (handwritten)
1	Hard work, emotionally draining	emo draining (3c)
2		
3	when the patient told me about her diagnosis, I could see she was very gratified to have a framework for understanding herself that maintained the splitting she had developed. I validated and supported her working with a therapist who would help her using that framework.	DID dx disclosure (1a) / validate & support (3a)
4	Fascinated/curious. Concerned for pt's safety. Sometimes lost and incompetent	fascinated/curious (3b) lost, incompetent (3c) / safety concerns (1c)
5	Challenged, challenging, and rewarding	challenging & rewarding (3b)
6		
7	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	professional isolation (2b) / colleagues skeptical (2b) / need consultation/supervision (2a) / enjoy work (3b) / pt strengths (1a)
8		
9	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.	consultation (2a) / strong countertransference (3c) / recognize & work through self-state enactments (3a) / treatment milestone (1b)
10	Iinitially, questioned my competence. Quietly, tried to locate where she was and what she was feeling in her body.	questioned competence (3c) / supportive treatment (3a)

Appendix F

Developed Major Theme: Reactions to DID Work

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

Appendix G

Developed Major Theme: Red Flags for DID

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

Appendix H

Developed Major Theme: Preparation for DID Work

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

Appendix I

Developed Major Theme: Reactions to this Study

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