positive relationship from the start. Melissa was always quite likable and, further, seemed to appreciate the radically genuine stance of the DBT therapist.

Fruzzetti's commentary highlights some of the challenges, complexities, and decision-making points that we faced in treating this complicated case. Because few patients present with isolated problems, we expect that these challenges are universally experienced by clinicians within and outside the DBT modality.

References

Bedics, J. D., Atkins, D. C., Comtois, K. A., & Linehan, M. M. (2012). Treatment differences in the therapeutic relationship and introject during a 2-year randomized controlled trial of dialectical behavior therapy versus non-behavioral psychotherapy experts for borderline personality disorder. *Journal of Consulting and Clinical Psychology, 80, 66–77.*

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The Treatment of Dissociative Identity Disorder: Questions and Considerations

Steven Jay Lynn, Liam Condon, and Gep Colletti

Dissociative identity disorder (DID) is defined as the existence of at least two "distinct identities or personality states that recurrently take control of the individual's behavior" (p. 519) in conjunction with "an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness" (APA, 2000, p. 526). This disorder, formerly known as multiple personality disorder, purportedly reflects a "failure to integrate various aspects of identity, memory, and consciousness" (APA, 2000, p. 526), and is therefore better described as "identity fragmentation" than as the "proliferation of separate personalities."

Key Principles/Core Knowledge

In this chapter, we provide a case study of "Ms. M.," a 49-year-old Caucasian woman who presented with symptoms of DID and was successfully treated with a multifocal cognitive behavioral intervention that included methods derived from dialectical behavior therapy (Linehan, 1993) and acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 1999). We first present the posttraumatic model (PTM) of dissociation, which serves as a backdrop against which to view both the traditional treatment of DID and the controversies that have dogged DID from the time of Freud to the present. We present this introductory information to bring into relief the sharp contrasts between the conventional treatment of DID, which we eschew, and the empirically based approach that we adopt in the case at hand. More specifically, we propose that evidence-based methods can be implemented to treat the emotional dysregulation and manifold symptoms that accompany the typical presentation of DID. In contrast, we contend that treatments with a sole or major focus on trauma provide a cautionary example of how *not* to treat patients with DID, and that they serve as a counterpoint to empirically grounded treatments, which we favor and recommend to the reader.

The PTM (e.g., Gleaves, 1996; Gleaves, May, & Cardena, 2001; Ross, 1997) is commonly reflected in media portrayals of DID, such as the Academy Award–winning movie *The Three Faces of Eve* and the Emmy Award–winning movie *Sybil.* Proponents of the model posit that DID arises primarily from a history of severe childhood trauma, most notably physical abuse, sexual abuse, or both. Ross (1994) has gone so far as to claim that abuse is almost always required to cause DID. Individuals who undergo horrific trauma in early life are thought to compartmentalize their previously intact personalities into discrete multiple personalities—often called "alters"—as a means of coping with intense emotional pain. Although treatment varies somewhat among therapists who endorse the PTM, Putnam's (1989) now classic volume (896 citations, Google Scholar, December 10, 2012), *Diagnosis and Treatment of Multiple Personality Disorder,* both describes a trauma-based DID treatment approach and illustrates the outright suggestive and potentially harmful aspects of conventional DID treatment that we sought to avoid in our work with Ms. M. Putnam suggests that from the earliest meetings with the patient, in arriving at a diagnosis and in initial interventions, it is imperative that the therapist "meet and interact directly with alter personalities" (p. 90). To do so, the therapist asks highly leading and direct questions such as, "Do you ever feel as if there is some part (side, facet, etc.) of yourself that comes out and does or says things that you would not do or say?" and asks..."for a name or an attribute, function, or description that I can use as a label to elicit this other part directly" (p. 90). If the alter avoids giving a name, then the "therapist should make one up" and Putnam notes, "I will say something such as this: 'Since you are not willing to share your name with me at this time, I am going to refer to you as the one who covers her mouth with a hand when she talks'" (p. 142).

From this perspective, one of the therapist's pivotal tasks is to obtain a history for each alter, which often involves using potentially suggestive methods (e.g., journals, diaries) to recover memories, which research suggests are thought to be fraught with risk of creating, rather than uncovering, memories (Lynn, Fassler, Knox, & Lilienfeld, 2006). Putnam further notes, "In some cases... hypnosis or a drug-facilitated interview may be useful to facilitate the emergence of an alter" (p. 91). Notably, both hypnosis and drug-facilitated interviews are highly suggestive approaches that can increase the confidence in inaccurate memories (Lynn, Knox, Fassler, Lilienfeld, & Loftus, 2004). Indeed, Freud argued that most, if not all, cases of multiple personality resulted from the suggestive influence of therapists upon patients, an argument that presaged concerns expressed by modern critics of the posttraumatic model of DID (see Lynn et al., 2006).

Freud's concerns are probably not far off the mark. In all likelihood, therapists can concretize and reify the presence of alters with many of the following highly suggestive interventions that Putnam (1979) recommends. These interventions include (a) making contracts (e.g., "I will not hurt myself or kill myself") with different personalities (p. 144); (b) "filling in" the host personality regarding events for which she was purportedly amnesic when different alters were "in control" (p. 151); (c) treating people as if they were "multiples," despite their strongly expressed resistance to the diagnosis (p. 151); (d) "assembling whole memories from fragments" that are supposedly spread across several alters (pp. 198–199); (e) using dream material to "provide access to deeply hidden trauma" (p. 201); (f) mapping the purported personality system (pp. 210–211); (g) age regression for memory recovery (p. 228); (h) internal group therapy with different personalities (p. 261); and (i) "talking through," which involves exhorting the entire personality system to listen to a particular directive or communication (p. 227).

More recent DID treatment guidelines, developed by many leading exponents of the PTM and promulgated by the International Society for the Study of Dissociation (2005), repudiate the practice of the therapist "making up names" for supposed alters; however, the guidelines preserve many of Putnam's recommendations and explicitly endorse the practices of: (a) directly "accessing alters" (e.g., "I need to talk to the one(s) who went to Atlantic City last night and had unsafe sex," p. 97); (b) generating an "ongoing 'map' or 'roster' of the patients alternate identity system" (p. 98); and (c) conducting pharmacologically facilitated interviews for "emergency situations when other methods of assessment have failed, e.g., in a hospitalized patient who is engaging in high risk behavior in dissociated states, but who has been refractory to other methods of inquiry, including hypnosis" (p. 125).

DID is arguably among the most controversial disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (4th edition, text revision; *DSM-IV-TR*). For the past 25 years or so, debate has swirled around the genesis and treatment of DID. According to the rival sociocognitive model (SCM; Spanos, 1996; see also Aldridge-Morris, 1989; Lilienfeld et al., 1999; McHugh, 1993; Merskey, 1992; Sarbin, 1995), DID can result from the sorts of methods we reviewed, which include suggestive questioning regarding the existence of possible alters, hypnosis for memory recovery, and sodium amytal interviews, as well as media influences (e.g., television and film portrayals of DID) and sociocultural expectations regarding the presumed clinical features of DID. Interestingly, many DID patients show few or no clear-cut signs of this condition (e.g., alters) prior to psychotherapy (Kluft, 1984), raising the specter that alters are generated by treatment. Indeed, the number of alters per DID individual tends to increase substantially over the course of DID-oriented psychotherapy (Piper, 1997). Curiously, psychotherapists who use hypnosis tend to have more DID patients in their caseloads than do psychotherapists who do not use hypnosis (Powell & Gee, 1999), and most DID diagnoses derive from a small number of therapy specialists in DID (Mai, 1995), again suggesting that alters may be created rather than discovered in therapy.

Proponents of the SCM have also cited a number of reasons to question the widely received notion that childhood abuse causes dissociation. In most studies (e.g., Ross & Ness, 2010), objective corroboration of the abuse is lacking, and the overwhelming majority of studies of self-reported trauma and dissociation are based on cross-sectional designs that do not permit causal inferences. Prospective studies that circumvent the pitfalls of retrospective reporting often fail to substantiate a link between childhood abuse and dissociation in adulthood (Giesbrecht et al., 2008; but see Bremner, 2010). Moreover, the link between abuse and dissociative disorders may be due to (a) global familial maladjustment rather

than the abuse itself, or (b) other frequently overlapping conditions, such as anxiety, eating disorders, and personality disorders (Nash, Hulsey, Sexton, Haralson, & Lambert, 1993).

Conceptualization of Dissociation

Our treatment conceptualization centered on the idea that the core symptoms of DID (i.e., believed-in/imagined distinct personalities) can often be understood as manifestations of a dysfunctional avoidance-based coping strategy associated with (a) failure to acknowledge and/or take responsibility for puzzling and self-defeating behaviors, troubling cognitions, and negative feelings (e.g., guilt, anger, anxiety; see Colletti, Lynn, & Laurence, 2010; Lynn, Rhue, & Green, 1988), abetted by (b) the use of imagination and attention-regulating strategies to create a credible feeling of distance or separation from aversive personal or interpersonal events. Dissociative symptoms may be preceded or triggered by internal (e.g., memories, automatic cognitions) and external stimuli, including therapist suggestions or suggestive influences in everyday life (e.g., media). The avoidance-based nature of dissociative symptoms increases the likelihood that they will recur and even proliferate by means of negative reinforcement.

The diathesis for Ms. M.'s dissociative symptoms appeared to be a history of fantasy versus reality-based coping, which originated in childhood. She reported a history of childhood imaginary playmates and fantasy-proneness (e.g., profound involvements in fantasy and imaginal activities). When she was 5 years old, she experienced intense anger regarding her sister's death, accompanied by guilt at not being able to prevent it. She reported that shortly after this event, she experienced intense conflict and self-recrimination, as if she were split into angry and excessively protective aspects of herself. During adolescence, she imaginatively elaborated and segregated conflicting and chaotic emotions into different "parts" (e.g., childlike parts that required protection by an "adult protector," angry adult). These "parts" became crystallized in conjunction with her growing familiarity with DID through books and movies and early contacts with a therapist who reinforced her presentation of dissociative symptoms.

Ms. M.'s sensitivity to media and therapist cues was probably associated with her high suggestibility and fantasy-proneness, reflected not only by her long-standing history of fantasy involvements, but also by her excellent treatment response to hypnotic suggestions and her ability to use imaginative rehearsal interventions to advantage. Notably, at least 10 studies support at least a moderate association between dissociation and fantasy-proneness/imaginative abilities (Giesbrecht, Lynn, Lilienfeld, & Merckelbach, 2010). Interestingly, dissociative experiences can be predicted at least as accurately by absorption and fantasy-proneness abilities as by the report of trauma (Pekala, Angelini, & Kumar, 2001). Moreover, patients with dissociative disorders (e.g., DID and dissociative disorder not otherwise specified) score higher on measures of hypnotic suggestibility than do patients with schizophrenia, anxiety disorder, mood disorder, and college student control participants (Frischholz, Lipman, Braum, & Scahs, 1992). Interestingly, higher levels of hypnotic suggestibility are associated with PTSD avoidance symptoms (Bryant, Guthrie, Moulds, Nixon, & Felmingham, 2003).

Late in treatment, it became apparent that Ms. M's dissociative symptoms, including depersonalization, were exacerbated by poor sleep, including terrifying sleep paralysis symptoms, which often left her feeling depleted, mildly disoriented, and dysphoric the following day. Ms. M.'s experiences of sleep paralysis and fragmented sleep, caused by the medical conditions described below, were in conformance with the findings of 19 studies that report a link between dissociation and sleep problems (van der Kloet, Giesbrecht, Merckelbach, & deZutter, 2012).

In short, Ms. M. moved, psychologically speaking, from feeling "as if" she were composed of different parts and mentally elaborating such parts, to reifying her purportedly separate parts and using their imagined presence as a way to comprehend puzzling thoughts, emotions, and behaviors, further reinforcing her sense of personality fragmentation. Increasingly coordinated and frequent avoidance-based responding to aversive events and internal experiences through dissociation became steadily more maladaptive, rigid, and stimulus-bound, thereby precluding more adaptive and situationally appropriate coping. We have termed this state of affairs the *dissociative trap* (Colletti et al., 2010).

Our treatment of Ms. M. was guided by the fact that researchers have failed to find support for the idea that alters or "parts," as Ms. M. described them, are psychologically distinct entities. When scientists present certain information to one alter, objective measures of memory (e.g., behavioral tasks or event-related potentials) reveal that the information is typically accessible to another (Allen & Movius, 2000; Huntjens et al., 2006). Accordingly, clinicians should be skeptical about claims that patients somehow house independent personalities with separate streams of memories and histories. In fact, we repeatedly shared with Ms. M. the idea that although she might have felt at times that she housed distinct personalities, she truly embodied only one personality.

We also shared with Ms. M. that her "dissociative coping style" was, in fact, not successful in defending her against anxiety and dysphoria, and that it was therefore imperative that we work together to help her find more adaptive ways of coping. In fact, researchers have found that patients with DID and others with high levels of dissociation display *better* memory for to-be-forgotten sexual words in directed forgetting tasks (Elzinga, deBeurs, Sergeant, Van Dyck, & Phaf, 2000). This finding is strikingly discrepant with the presumed defensive function of dissociation. Studies of cognitive inhibition in high dissociative clinical and nonclinical samples typically find a breakdown in such inhibition, challenging the widespread idea that amnesia (i.e., extreme inhibition) is a core feature of dissociation (Giesbrecht et al., 2008, 2010). Ms. M. exhibited little inhibition: She startled easily, and on occasion she displayed exaggerated and histrionic reactions to interpretive statements made in therapy, especially when they challenged well-ingrained self-perceptions. (e.g., she did not have to "automatically" help anyone who sought her help or support, especially at expense to herself).

Epidemiological Considerations

Population prevalence estimates of DID vary widely, from extremely rare (e.g., Piper, 1997; Rifkin, Ghisalbert, Dimatou, Jin, & Sethi, 1998) to rates approximating that of schizophrenia (1–2%; Coons, 1998; Ross, 1997). Estimates of DID in inpatient settings range from 1–9.6% (Rifkin et al., 1998; Ross, Duffy, & Ellason, 2002). In addition to the dramatic increase in DID's prevalence since the mid-1970s, which parallels extensive media coverage of the disorder, there has been an increase in the number of "alters" reported, from only two or three separate identities to an average of approximately 16 (interestingly, the exact number reported by Sybil; see below) by 1990. This dramatic increase has provoked considerable controversy as to whether the rise in DID cases is attributable to sociocognitive influences (e.g., media coverage, labeling of puzzling symptoms as DID, suggestive methods in psychotherapy) or increased awareness of DID in the patient population and more accurate diagnosis of the condition.

DID is reported to be between three and nine times more common in women than men, and women also tend to have more identities (an average of 15, as compared with the male average of eight; APA, 2000). However, this imbalanced sex ratio may be an artifact of selection and referral biases (Lynn, Fassler, Knox, & Lilienfeld, 2006). In particular, a large proportion of males with DID may end up in prisons (or other forensic settings), rather than in clinical settings (Putnam & Loewenstein, 2000).

Diagnosis, Comorbidity, and Assessment

To meet criteria for DID, an individual's symptoms cannot be attributable to substance use or to a medical condition. Ms. M's medical history was remarkable: She had surgery for cervical cancer, repeated kidney stones and infections, peripheral muscle weakness and sometimes severe chronic pain, chronically abnormal blood values (i.e., erythrocyte sedimentation rate), cysts on her bladder, ovarian cysts, and lupus, all of which were documented in writing and in conversations with a number of her physicians. Ms. M. often experienced dissociative reactions in response to medical procedures. In fact, she first presented for treatment at a university psychological clinic at the suggestion of her physician, who was alarmed by her startling and disturbing behavioral changes during a pelvic examination in his office. During the examination, she vacillated repeatedly from being scared and vulnerable one moment, to being angry and aggressive the next.

DID typically is manifested against a backdrop of substantial preexisting psychopathology, a fact that applies to the case of Ms. M. Ellason, Ross, and Fuchs (1996) reported that DID patients meet criteria for an average of 8 Axis I disorders and 4.5 Axis II disorders. One-half to two-thirds of patients with DID meet diagnostic criteria for borderline personality disorder (Coons et al., 1988; Horevitz & Braun, 1984). Kemp, Gilbertson, and Torem (1988) reported no significant differences between BPD and DID patients on measures of personality traits,

cognitive and adaptive functioning, and clinician ratings, suggesting noteworthy commonalities between the two conditions. Importantly, Ms. M. met at least five diagnostic criteria for borderline personality disorder (i.e., identity disturbance; inappropriate, intense anger, or difficulty controlling anger; severe dissociative symptoms; and affective instability, unstable and intense interpersonal relationships), which provided warrant to use tactics (e.g., cognitive behavioral therapy, mindfulness training, affect management techniques) in treatment found to be effective with patients with borderline personality disorder (Linehan, 1993).

Posttraumatic stress disorder (PTSD) is commonly comorbid with DID (Loewenstein, 1991). In a study (Ellason, Ross, & Fuchs, 1996) of 135 patients with DID, 79.2% were diagnosed with PTSD. Ms. M. related a history replete with highly aversive events. For example, she reported experiencing the death of her sibling at around age 5, being sexually molested by her treating optometrist during the same time period, an abortion while in college, being raped prior to the start of treatment, and the experience of the death of a neonate under her care as a nurse in the context of a live abortion incident. Ms. M. met all diagnostic criteria for PTSD, including highly disturbing flashbacks triggered by seemingly innocuous statements by the therapist, emotional numbing, and startle responses, as noted above. Although patients with DID also often meet criteria for major depression, schizotypal personality disorder, substance abuse or dependence, sexual and eating disorders, schizoaffective disorder, and schizophrenia (Fullerton, Ursano, Epstein, Crowley, Vance, Kao, & Baum, 2000; North et al., 1993; Lauer et al., 1993; Ross & Norton, 1988), Ms. M. did not qualify for any of these diagnoses.

Assessment Strategy

Ms. M. was assessed for dissociative experiences and symptoms with the 28-item Dissociative Experiences Scale (DES-II; Bernstein-Carlson & Putnam, 1993), the most frequently used self-report measure of dissociation (Brand, Armstrong, & Loewenstein, 2006). The DES possesses adequate test-retest reliability (r =.84 over a period of 4 to 8 weeks) and validity, with the ability to differentiate participants with DID from those without a dissociative disorder (e.g., normal adults, college students, alcoholics, phobics). A cutoff of 30 correctly identified 74% of patients with DID and 80% of subjects without DID in a multicenter study (Carlson, Putnam, Ross, Torem, Coons, Bowman, et al., 1993): Ms. M. scored 39 on the DES.

Ms. M. met diagnostic criteria for DID based on the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D; Steinberg, 1994). The 250-item SCID-D incorporates *DSM-IV* criteria for dissociative disorders, and assesses five core symptoms: amnesia, depersonalization, derealization, identity confusion, and identity alteration. Ms. M. achieved a high score on all five dimensions. The SCID-D possesses good interrater agreement (r = .72–.86), very good-to-excellent temporal reliability (weighted kappa .77–.86), and good convergent

validity (e.g., DES; see, Lynn, Berg, Lilienfeld, Merckelbach, Giesbrecht, Accardi, & Cleere, 2012). To avoid the appearance of a sole emphasis on dissociative symptoms and to glean information across multiple domains of both abnormal and normal-range personality, we recommend also administering the Minnesota Multiphasic Personality Inventory-2 (Butcher, Graham, Ben-Porath, Tellegen, Dahlstrom, & Kaemmer, 2001) and the NEO-PI-3 (McCrae, Costa, & Martin, 2005).

In short, Ms. M. met all of the diagnostic criteria for DID, based both on formal assessment and her enacting distinct "parts" during sessions and reporting such alterations outside sessions. She also reported amnesia associated with dissociative episodes and was troubled by her failure to recall key interpersonal interactions that others remembered well.

Several points are noteworthy in evaluating DID, which apply to the case of Ms. M. as well. First, individuals with high levels of dissociation may be more prone than are other individuals to develop false memories of emotional childhood events (e.g., a severe animal attack; Porter, Birt, Yuille, & Lehman, 2000). Moreover, dissociation increases the risk of commission errors (e.g., confabulations/false positives, problems in discriminating perception from vivid imagery, errors in response to leading questions) (Giesbrecht et al., 2008; Holmes et al., 2005). Given the propensity for pseudomemory formation in highly dissociative individuals, it is important to secure objective confirmation of childhood abuse and other highly aversive events. Unfortunately, we were not able to obtain such confirmation in the case of Ms. M., with the exception that we did corroborate key aspects of her medical history. Notably, the treatment recounted below pointedly did not focus on past traumas or historical events as much as on enhanced coping, affect management, and problem solving in everyday life.

Second, clinicians should not assume that patients who present with symptoms of DID have necessarily endured childhood abuse; however, it is appropriate for clinicians to routinely assess for a history of such events. Moreover, clinicians should avoid repeated questioning about historical events, as it can lead patients to mistakenly believe that they have significant gaps (e.g., amnesia) in their autobiographical memories of childhood (Belli, Winkielman, Read, Schwartz, & Lynn, 1998) and possibly infer that these normal gaps in memory are caused by dissociation or repression of traumatic events, engendering false memories.

Third, clinicians should not use hypnosis to recover allegedly dissociated or repressed memories: Hypnosis does not enhance the overall accuracy of memories and is associated with a heightened risk for confabulation (Lynn, Knox, Fassler, Lilienfeld, & Loftus, 2004). However, it is often perfectly appropriate for practitioners to use hypnosis for other purposes, such as relaxation and affect management, as hypnosis appears to enhance positive treatment expectancies and can serve as a catalyst to cognitive behavioral interventions (see Lynn, Rhue, & Kirsch, 2010; Kirsch, Montgomery, & Sapirstein, 1995).

Fourth, given the probable importance of sociocultural influences in the presentation of DID, clinicians should assess patients' exposure to information about

DID conveyed by movies, books, magazines, the Internet, and, often most important, previous therapists. The use of suggestive procedures (e.g., dream interpretation, guided imagery, journaling incidents of abuse) should be noted as well.

Initial Case Formulation

The treatment of Ms. M. can be divided into three phases, which we will discuss in turn: (1) treatment with the initial therapist, (2) treatment with Gep Colletti (GC), and (3) conjoint treatment with Gep Colletti and Steven Jay Lynn (SJL). When the patient initiated treatment with a psychotherapist, she insisted that her problems were the product of stress at work, related to the serious medical concerns we described above. Nevertheless, the therapist, a graduate student at a local clinic, noted that her mood and behavior fluctuated dramatically and sometimes unpredictably both within and between sessions, with episodes of anger and anxiety flaring up frequently within sessions. Over the next two years, the patient recounted many traumatic experiences, as described above. Emotional outbursts during sessions escalated; seemingly innocuous statements by the therapist could trigger memories of highly aversive events, impeding progress and often stymieing the behaviorally oriented problem-solving approach that the therapist adopted. The patient became frustrated with the fact that therapy did not provide a "quick fix" for her problems with her job, setbacks with physical ailments, and problems interacting with her family. Ms. M. began to experience more frequent crises both in and out of sessions, with increasing emotional lability and crisis phone contacts between sessions. In session, Ms. M. more frequently alternated between speaking in a childlike voice and like an angry adult, only to later apologize and express deep regret, prior to yet another angry outburst or childlike presentation. Her memory for what transpired when she appeared to be enacting different "identities" was spotty and at times devoid of meaningful content. The therapy was, not surprisingly, frequently disrupted and did not proceed in a linear course, as it became increasingly apparent that the patient met criteria for DID.

After more than two years of treatment, the graduate student completed his graduate studies and transferred the case to his supervisor, GC, one of the authors of this chapter, who fully appreciated that this was a complex case that required intensive psychotherapy. GC witnessed increased irritability, vitriolic anger, and cue-triggered flashback-like experiences in session that were followed by amnesia, depersonalization, derealization, and problems in focusing attention. The patient reported feeling "spaced out" in session, reported that she often was aware of "missing time" at home, and experienced difficulties recalling anything beyond the gist of the previous session. At the start of treatment with her second therapist, she met the criteria for borderline personality disorder, and DID was considered a rule-out diagnosis. She reported hearing "voices in my head" and experienced herself as "splitting off" into an angry "adult protector" or defender of others and childlike aspects of herself that required protection. As therapy

progressed, so did manifestations of her dissociative symptomatology, with more frequent episodes of depersonalization and disturbing episodes of amnesia, as well as disorientation at times of high stress. She also reported more incidents of abuse during childhood, and her therapist concluded that her presentation now met criteria for DID.

Treatment Strategy

Unfortunately, there were few guideposts in the empirical literature to steer the therapy of a patient with DID. The literature on the pharmacological treatment of DID is scant, and studies of depersonalization disorder have found little or no evidence of efficacy for such pharmacological treatment (Simeon, 2009). Although case studies of the treatment of DID, from a variety of psychotherapeutic perspectives ranging from logotherapy and mutual storytelling to cognitive analytic therapy have been reported (Brandsma & Ludwig, 1974; Gold, Elhai, Rea, Weiss, Masino, Morris, & McIninch, 2001; Hutzell & Eggert-Jenkins, 1990; Kellett, 2005; Rosenstein, 1994), the empirical literature on such approaches is slim. Brand, Classen, McNary, & Zaveri, (2009) were able to identify only eight studies that examined treatment outcomes for DID and other dissociative disorders, and randomized controlled trials are nonexistent. Extant studies do not permit an evaluation of the extent to which symptom reduction in dissociative patients is due to regression to the mean, the passage of time, placebo effects, or other artifacts.

Given this state of affairs, GC instituted empirically supported cognitive behavioral approaches to treat different aspects of the symptom picture, including activity scheduling (i.e., monitoring mood and daily activities, increasing pleasant activities and interactions; Cuijpers, van Straten, & Warmerdam, 2007) for depressed mood, applied relaxation and progressive muscle relaxation to reduce anxiety and psychophysiological reactivity (Carlson & Hoyle, 1993; Ost, 1998), and rational disputation of thoughts (see David, Lynn, & Ellis, 2010), as well as other approaches described below. Recurrent maladaptive thoughts and core beliefs that were addressed included (a) "Someone will learn I feel weak and afraid"; (b) "It is dangerous to trust others and let them see your vulnerability because you will most certainly be hurt"; (c) "To be weak or incapable of doing something is unacceptable"; (d) "No matter what I do to help myself I will never get well"; (e) "I must protect those I love, but I am mentally, or physically, unable to do it"; and (f) "If I get angry, I will lose control." Notably, some of these thoughts related directly to the putative role of different "parts." Additionally, role-playing and rehearsal, including imaginal rehearsal (Hackman & Bennett-Levy, 2011) of situations in which the patient modeled appropriate assertive responses in the context of family demands, were implemented.

Over the next few years, the patient's day-to-day functioning improved significantly, yet ranged from competent to impaired, with fluctuation between these two extremes, mostly as a function of whether or not she experienced a crisis.

Effective parenting was perhaps the only area of functioning that consistently remained unimpaired and preserved throughout crises. Serious medical problems persisted, often resulting in severe and chronic pain, frequent hospitalizations, and demoralization due to her inability to pursue fulfilling activities, including her full-time career of nursing, which was scaled down to part-time.

Dissociation persisted in session and out of session. For example, the patient continued to report hearing "voices in her head" and experiencing herself as "splitting off" into an angry and aggressive adult "protector" or defender of others and childlike aspects of herself that required protection. She also reported considerable confusion and disorientation at times of high stress, emotional numbing, and an urge to retreat by way of not concentrating on ongoing activities and situations. Not surprisingly, she reported disturbing periods of amnesia. Dissociative episodes were likely to occur before or during the many medical procedures she endured. At this time, she met the formal criteria for DID, and it became increasingly obvious that it was necessary to more directly confront her dissociative symptoms.

CO-THERAPY

In 1999, GC began to attend weekly clinical hypnosis seminars in which the first author (SJL) presented an approach to dissociation that was based on combining empirically supported techniques to treat specific symptoms and problems in living. During this time period, SJL provided emergency coverage for GC and conducted a phone session with the patient who "hit if off" with SJL. At the invitation of GC, and with the patient's agreement, SJL became a co-therapist. SJL attended sessions two to three times a month, while individual sessions occurred four to six times a month.

The Treatment Agenda

GC and SJL (see Colletti et al., 2010) proceeded to create an agenda, with the patient's input, that included the following goals, geared to (1) provide education regarding her long-standing pattern of using dissociation as an avoidance maneuver; (2) develop a unified positive sense of identity; (3) validate feelings and the idea that conflict is inevitable and can be managed; (4) assist her in accepting responsibility for her behavior to minimize the need to resort to different "parts" to mitigate responsibility; (5) facilitate positive treatment expectancies, self-control abilities, and her ability to accept positive feedback; (6) increase assertiveness and improve social interactions with a focus on respect for others and reciprocity in relationships; (7) restructure maladaptive thinking patterns, attitudes, and beliefs; (8) enhance decision-making skills; (9) deepen her capacity to experience and accept the gamut of emotions in the here and now without engaging in experiential avoidance; (10) assist her in working through grief and loss issues, including the death of her father; (11) experience and accept expressions of care and

concern extended by others to her; and (12) help her cope with medical evaluations and treatment procedures. As the interventions described below often relate to multiple aspects of the treatment agenda, we will not key the interventions to the specific goals presented above.

Our treatment was guided by the belief that if we attended to her experiential avoidance and the anxiety-reducing function that animated it, we would help reduce, if not eliminate, her dissociative responses and obviate her need to conceptualize her experiences in terms of "parts." We continued many of the interventions first instituted in GC's treatment of Ms. M., including rational disputation, activity scheduling and behavioral activation, and imaginal rehearsal. We also added a number of interventions with an evidence base that supports their use: stress-inoculation training (Foa, Dancu, Hembree, Jaycox, Meadows, & Street, 1999; Meichenbaum, 1985, 2003; Saunders, Driskell, Hall, & Salas, 1996), mindfulness/attention training (Baer, 2003), exposure therapy (Rothbaum, Olasov, & Schwartz, 2002), problem-solving therapy (D'Zurilla & Nezu, 2007), and self-hypnosis (see Lynn et al., 2010). A number of the evidence-based interventions we employed, with evidence of treatment efficacy, were adapted from those used commonly in two so-called "third wave" cognitive behavioral therapies: dialectical behavior therapy (DBT; Ost, 2008; Dimeff, Koerner, & Linehan, 2007; Linehan et al., 2006) and acceptance and commitment therapy (ACT; Hayes, Luoma, Bond, Masuda, & Lillis, 2006). The interventions that emphasized mindful awareness, tolerance, and acceptance to promote emotional regulation are allied with both DBT and ACT. Consistent with the practice of DBT, we encouraged and/or taught Ms. M. to (a) use assertiveness skills, (b) identify and label emotions, (c) seek out positive emotional experiences, (d) do "the next right thing," and (e) develop distress tolerance. Consistent with ACT, we encouraged Ms. M. to practice cognitive defusion (e.g., to regard a thought simply as a thought, rather than a fact) and to calibrate her actions to her values.

When the authors began to collaborate, we agreed that consistent reference to a unitary self would be paramount in treatment, and that education regarding the function of her dissociative responses was prerequisite to Ms. M. developing a unified positive sense of identity. We spoke with her about the origins of her dissociative tendencies, the fact that conflict and strong feelings are a normal and often healthy aspect of everyday life, and emphasized that she could accept and tolerate a gamut of feelings and thoughts and be able to accommodate a sense of unity of self and purpose, even when she experienced emotional duress and conflict.

We also talked about what we called "AC/DC," control via acceptance (AC) versus control via dissociation (DC), and noted that AC was advantageous, as "it is reliable, and always available at full strength." DC, while highly portable and applicable in a broad number of situations, is "like battery power, variable and limited in duration." Moreover, we explained that relying on DC does not permit Ms. M. to learn that many of her fears are unfounded, and that she is able to cope in the absence of DC. As we implemented educational tactics—deliberately designed to modify her self-conceptualization and, simultaneously, not reward

a dissociative presentation—Ms. M. spoke less about her parts and increasingly referred more to herself as a whole person. In keeping with these developments, unpredictable outbursts, disorientation, and amnesic episodes decreased in therapy session.

We also assisted Ms. M in identifying, labeling, and nonjudgmentally accepting her feelings, and encouraged her to become mindfully attuned to her moment-to-moment experience and to develop a nonjudgmental stance toward the stream of experiences in her field of awareness. We also assisted her in recognizing that her "thoughts were thoughts" that had no power to hurt anyone, and that the flotsam and jetsam of cognitive activity neither invariably reflected on her personhood nor qualified as "facts" about herself or others. We consistently reinforced her ability to observe her thoughts and feelings without the imperative to take action, unless such action was carefully conceived and deemed to be congruent with her values and her best interests. We also suggested that Ms. M. practice nonjudgmental awareness and what we called "attention training" by focusing on her breathing and counting breaths in cycles of 1–10 breaths. When Ms. M. experienced flashbacks, she was instructed to focus on her breaths and to alternate her attention between different stimuli in her immediate field of awareness. These distracting activities often succeeded in reorienting her attention to the present and diminishing anxiety and dissociation.

To facilitate problem solving and impulse control, to decrease avoidance, and to increase assertiveness, we invited Ms. M. to participate in role-plays in which she "interacted" with people at work and with family members, including her daughter, to resolve conflicting feelings and to gain confidence in her ability to encounter others appropriately and in a measured way. We encouraged her to embrace a problem-solving approach in which she assesses and evaluates different possible outcomes of decisions and imagines herself responding in appropriately assertive ways in a variety of scenarios, all the while maintaining contact with her feelings. When she became anxious or disoriented in session, SJL taught her to take diaphragmatic breaths, contact her "moment-to-moment experience," make reassuring self-statements, and engage in productive "self-talk" to foster calm problem solving and the ability to pursue her objectives as she delineated them. In this way, we fostered assertiveness in everyday life, and she began to feel more comfortable in an expanding circle of situations and more confident in her ability to modulate her anger.

We helped Ms. M. to identify a number of circumstances that were reliably associated with anxiety, concerns about losing control, and dissociation. These circumstances included invasive medical procedures in which she became concerned about her physical integrity, ruminating about her daughter's safety and security and the death of her father, and situations in which she felt her personal autonomy was undermined by individuals in authority with whom she dealt concerning disability issues. We conducted imaginal exposure sessions in relation to each of these areas of concern, and after each 50-minute exposure, we discussed how Ms. M. could better cope in target situations (e.g., asserting her needs for privacy while undergoing certain medical procedures), using problem-solving

techniques as well as cue-controlled relaxation (e.g., bringing her thumb and forefinger together to anchor feelings of being more calm, at ease, and accepting). To further facilitate a sense of grounding in the present, we taught Ms. M. to perform a rapid body scan to not only identify loci of physical tension and to begin to "release and relax," but also to "get in touch with and connect" with different parts of her body, and say to herself, "that was then, this is now; I am a whole person in the present."

We attempted to foster behavioral activation by encouraging Ms. M. to be involved in as many enjoyable activities (e.g., writing, craft work) as her physical limitations allowed. We also practiced with Ms. M. skills related to limit setting with her family members, who often made unrealistic and excessive demands on her time, and we continued to dispute evidence of negative cognitions and all-or-none thinking (e.g., "I must be a perfect mother"; "I must never say 'no' to my own mother"; "If someone needs me, I must be there for them, no matter what"; "I must have a full-time job or I am worthless") using the Socratic method.

Hypnosis, couched as self-hypnosis, played an important part in the treatment of Ms. M. (see Colletti et al., 2010, for a more complete discussion of the use of hypnosis in this case). Ms. M. proved to be highly responsive to hypnotic suggestions, first administered by SJL, and subsequently self-administered. Ms. M. was able to control episodes of mental confusion and "feelings of overwhelm" with self-administered suggestions to feel calm and relaxed and view herself walking 10 steps down a staircase, with each step promoting progressive calm and ease, "with nothing to bother, nothing to disturb." Hypnosis was used to promote (a) equanimity after exposure sessions, (b) imaginative rehearsal with suggestions for vivid imagery and suggestions to maintain a coherent sense of self, (c) a measured approach to problem solving and role-played interactions, and (d) nonjudgmental attention to moment-to-moment experiences. Post-hypnotic suggestions (i.e., suggestions for specific responses following hypnosis) were used to generalize treatment gains by encouraging Ms. M. to be aware of "moments of optimism" and positive accomplishments in everyday life; to be more accepting of positive feedback from others; and to enhance self-soothing/relaxation, problem-solving skills, and mindfulness practice on a daily basis. Importantly, hypnosis was never used to retrieve or refresh past memories or to call up purported alters.

Late in therapy, Ms. M. noted that the quality of her sleep was generally very poor, with numerous nighttime "wake-ups" due to severe chronic pain. However, she also disclosed, with some embarrassment, that she experienced terribly upsetting "nightmares" that paralyzed her and were accompanied by the sense of a "presence," like "the boogey man" under her bed. SJL explained that she was probably experiencing sleep paralysis, a not uncommon sleep problem reported by one estimate to be 7.6% of the general population, 28.3% of students, and 31.9% of psychiatric patients (lifetime prevalence; Sharpless & Barber, 2011). It became apparent that these episodes of sleep paralysis, which occurred three to five times a month, often were followed by fatigue and disorientation during the daytime. More specifically, Ms. M. reported that after a night of fragmented sleep, she felt much more "spaced out" and vulnerable to emotional upset.

Coincidentally, around the time that Ms. M. first reported these problems, SJL was exploring the relation between sleep problems and dissociation with his colleagues Harald Merckelbach, Timo Giesbrecht, Scott Lilienfeld, and Dalena van der Kloet (Giesbrecht et al., 2010; Lynn et al., in press; van der Kloet et al., 2012). Interestingly, we found that dissociative experiences were more reliably associated with sleep paralysis and narcolepsy than with insomnia (see also Koffel & Watson, 2009). By this time in the therapy, Ms. M. rarely experienced dissociative symptoms in session; yet, on occasion, she still was plagued with feelings of depersonalization during the day and night. Ms. M. expressed relief at knowing that these residual symptoms might be related to sleep difficulties.

Ms. M. noted that after she experienced nightmares and sleep paralysis, she often would get out of her bed and be awake for hours afterward. We noted that her leaving the bed, in this instance, was reinforcing sleep difficulties, and we encouraged her to do the following: (a) remain in bed (contrary to recommendations for treating insomnia, but appropriate for her terrifying experiences); (b) immediately reassure herself that the experience of the presence was a manifestation of sleep paralysis; (c) reassure herself that her fears are unfounded; (d) if (c) does not prove reassuring, look under the bed; and (e) use the self-hypnotic relaxation and self-soothing and breathing techniques that she had used to advantage in other contexts in order to resume sleeping. After two weeks, Ms. M. was instructed to not look under the bed, because excessive reassurance seeking could maintain sleep problems. The patient achieved considerable success with this approach, which reduced fatigue, tiredness, and depersonalization during the day.

We strongly recommend that clinicians who treat patients with symptoms of DID assess for sleep-related problems. If such problems are evident, we suggest that practitioners implement the above steps to treat sleep paralysis, along with sleep hygiene and cognitive behavioral treatments for insomnia (see Bootzin & Epstein, 2011 for a review), if indicated. Notably, medications can be used to treat sleep-paralysis (e.g., sodium oxybate/Xyrem) if psychological interventions are not sufficient to normalize sleep.

Outcome

The treatment was almost entirely successful in eliminating startle reactions, flashbacks, and dissociative responses, including amnesia and disorientation, in response to aversive stimuli. In session, she rarely speaks in a different voice or behaves as if she were a person of a different developmental level; this reportedly occurs only rarely outside session, and only during a crisis. Additionally, the patient exhibits improved anger management, impulse control, and the ability to evaluate alternative behaviors in situations that require problem solving. She practices mindfulness on a regular basis, reminds herself to use self-hypnosis and other extra-session coping skills in trigger situations, and takes considerable pride in doing so. Importantly, she can now better tolerate negative affect and is

more accepting of herself even when she displays anger. The frequency of crises is dramatically reduced, as is the need for intersession contact with GC. She has succeeded in raising a child who is now employed full-time and in a gratifying relationship.

Unfortunately, serious medical problems persist, and the patient is often unable to pursue pleasurable activities due to severe chronic pain and infrequent yet highly disturbing hospitalizations, as a result. We now talk about her engaging in "adaptive dissociation" in which she can experience a sense of detachment from aversive medical procedures, without experiencing amnesia or a fragmentation of self. Although day-to-day functioning has clearly improved in most areas, her physical disabilities, chronic pain, and interactions with the medical community suggest the need for ongoing treatment. Nevertheless, as the patient's confidence has blossomed over the past few years, her sense of neediness and dependency has diminished, and SJL is less involved in treatment, participating in fewer sessions per month.

Relapse Prevention

Importantly, much of our treatment has been geared toward Ms. M. exporting what she has learned in therapy to the real world and maintaining treatment gains. More specifically, Ms. M. employs problem-solving, activity scheduling, mindfulness, and self-hypnosis on a regular basis, anticipates potential anxiety and dissociation triggers, and uses self-talk and rational disputation, as well as self-soothing techniques, to mitigate adverse consequences of stressful life events.

Nonspecific Factors and Therapy Dynamics

The therapy arrangement was unconventional and noteworthy. The dual therapist approach provided enhanced opportunities to (a) share expertise and provide consultation and emergency coverage; (b) improve treatment planning; (c) better identify exaggerated transference reactions in response to one or both therapists; and (d) dialogue in front of the patient to discuss different viewpoints and possibilities, thereby alleviating or "loosening" dichotomous thinking. The attention lavished on Ms. M. was considerable and, in all likelihood, strengthened the alliance with Ms. M. in relation to both therapists, who were unstinting in the optimism they expressed that change was possible.

If there was "art" in treating this case, it was evident in the way that the therapists managed the treatment. For example, when the patient expressed anger directed at one therapist, the other therapist often would say something to diffuse tension in the relationship and point out that Ms. M.'s reaction was often (but certainly not always) exaggerated or based on a misunderstanding of the intent of the therapist. When the therapist and patient were following a meandering

course, the co-therapist was often able to redirect the conversation to the topic or treatment objective at hand. Moreover, when one therapist was unclear or obtuse, the other was often able to remedy the situation and foster better communication. At times when it appeared that therapy was "not working," it was typically evident to one therapist before the other, making it possible to determine whether it was resistance/avoidance on the part of the patient, or therapist insensitivity. Finally, it bears mention that the therapist's styles were highly compatible, and humor was used to advantage to defuse the tensions that inevitably arose in therapy and to solidify the therapeutic relations.

Ethical Considerations

No major ethical considerations came into play. There are no empirically supported treatments for DID, necessarily forcing therapists to extrapolate/generalize from allied literatures, as we did in the case of Ms. M. We recommend that clinicians conduct a careful assessment and functional analysis of problems and implement established evidence-based treatments to treat relevant symptoms and problems in living. Under these circumstances, it is wise for therapists to adopt a flexible approach that takes into account the somewhat experimental interventions implemented.

Common Mistakes to Avoid

The approach we used was sharply at variance with the traditional treatment of DID, which we believe holds the potential to produce iatrogenic effects. In keeping with our intent to avoid such potentially damaging effects, we carefully avoided reinforcing or reifying Ms. M.'s presentation of "multiple personalities." We did not use hypnosis for memory recovery, nor did we use any special memory recovery procedures. We also were sensitive to the language that we used in therapy, and we did our level best to not ask leading questions. Our approach was not designed to uncover instances of sexual or childhood abuse, although Ms. M. appeared to feel entirely comfortable sharing pertinent life experiences with us.

Conclusions

The case of Ms. M. illustrates how a present-centered, forward-looking cognitive behavioral treatment, which encompasses elements of so-called third wave therapies, can be used to alleviate symptoms of dissociation and the presentation of multiple selves. We believe that many of the interventions we used will eventually be found to be helpful in treating people with symptoms of DID. However, at the present time, well-controlled research is lacking to support any treatment of

DID, much less specific or tailored interventions. We conclude our chapter with a call for researchers to develop empirically supported multicomponent treatments for DID and to identify the relative efficacy of specific interventions that make up such multifocal treatments.

References

Aldridge-Morris, R. (1989). *Multiple personality disorder. An exercise in deception.* London: Lawrence Erlbaum Associates.

Allen, J. J. B., & Movius, H. L. (2000). The objective assessment of amnesia in dissociative identity disorder using event-related potentials. *International Journal of Psychophysiology, 38*(1), 21–41. doi:10.1016/S0167-8760(00)00128 8

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (DSM-IV-TR).* Washington, DC: Author.

Baer, R. A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. *Clinical Psychology: Science and Practice, 10*(2), 125–143. doi:10.1093/clipsy/bpg015

Belli, R. F., Winkielman, P., Read, J. D., Schwarz, N., & Lynn, S. J. (1998). Recalling more childhood events leads to judgments of poorer memory: Implications for the recovered/false memory debate. *Psychonomic Bulletin & Review, 5,* 318-323.

Bernstein-Carlson, E., & Putnam, F. W. (1993). An update on the Dissociative Experiences Scale. *Dissociation, 6,* 19–27.

Bootzin, R. R., & Epstein, D. R. (2011). Understanding and treating insomnia. *Annual Review of Clinical Psychology. 7,* 435–458. DOI: 10.1146/annurev.clinpsy.3.022806.091516.

Brand, B. L., Armstrong, J. G., & Loewenstein, R. J. (2006). Psychological assessment of patients with dissociative identity disorder. *Psychiatric Clinics of North America, 29,* 145-168.

Brand, B. L., Classen, C. C., McNary, S. W., & Zaveri, P. (2009). A review of dissociative disorders treatment studies. *Journal of Nervous and Mental Disease, 197*(9), 646–654. doi:10.1097/NMD.0b013e3181b3afaa

Brandsma, J. M., & Ludwig, A. M. (1974). A case of multiple personality: Diagnosis and therapy. *International Journal of Clinical and Experimental Hypnosis, 22*(3), 216–233. doi:10.1080/00207147408413001

Bremner, J. D. (2010). Cognitive processes in dissociation: Comment on Giesbrecht et al. (2008). *Psychological Bulletin, 136*(1), 1–6. doi:10.1037/a0018021

Bryant, R. A., Guthrie, R. M., Moulds, M. L., Nixon, R. D. V., & Felmingham, K. (2003). Hypnotizability and posttraumatic stress disorder: A prospective study. *International Journal of Clinical and Experimental Hypnosis, 51*(4), 382–389. doi:10.1076/iceh.51.4.382.16407

Butcher, J. N., Grahan, J. R., Ben-Porath, Y. S., Tellegen, A., Dahlstrom, W. G., & Kaemmer, B. (2001). *Minnesota Multiphasic Personality Inventory-2 (MMPI-2) Manual.* Boston: Pearson.

Carlson, E. B., Putnam, F. W., Ross, C. A., Torem, M., Coons, P., Bowman, E. S. et al. (1993). Validity of the Dissociative Experiences Scale in screening for multiple personality disorder: A multicenter study. *American Journal of Psychiatry, 150*(7), 1030–1036.

Carlson, R. C., & Hoyle, R. H. (1993). Efficacy of abbreviated progressive muscle relaxation training: A quantitative review of behavioral medicine resarch, *Journal of Consulting and Clinical Psychology, 61*(6), 1059–1067.

Colletti, G., Lynn, S. J., & Laurence, J. (2010). *Hypnosis and the treatment of dissociative identity disorder.* Washington, DC: American Psychological Association.

Coons, P. M. (1998). The dissociative disorders: Rarely considered and underdiagnosed. *Psychiatric Clinics of North America, 21*(3), 637–648. doi:10.1016/S0193-953X(05)70028-9

Coons, P. M., Bowman, E. S., & Milstein, V. (1988). Multiple personality disorder: A clinical investigation of 50 cases. *Journal of Nervous and Mental Disease, 176*(9), 519–527. doi:10.1097/00005053-198809000-00001

Cuijpers, van Straten, A., & Warmerdam, L. (2007). Behavioral activation treatments of depression A meta-analysis. *Clinical Psychology Review, 27*(3), 318–326.

D'Zurilla, T. J., & Nezu, A. M. (2007). *Problem-solving therapy: A positive approach to clinical intervention* (3rd ed.). New York: Springer Publishing.

David, D., Lynn, S. J., & Ellis, A. (Eds). (2010). *Rational and irrational beliefs: Research, theory, and clinical practice.* New York: Oxford University Press.

Dimeff, L. A., & Koerner, K. (eds.). (2007). *Dialectical behavior therapy in clinical practice: Applications across disorders and settings.* New York: Guilford Press.

Ellason, J. W., Ross, C. A., & Fuchs, D. L. (1996). Lifetime axis I and II comorbidity and childhood trauma history in dissociative identity disorder. *Psychiatry: Interpersonal and Biological Processes, 59*(3), 255–266.

Elzinga, B. M., de Beurs, E., Sergeant, J. A., Van Dyck, R., & Phaf, R. H. (2000). Dissociative style and directed forgetting. *Cognitive Therapy and Research, 24,* 279–295.

Foa, E. B., Dancu, C. V., Hembree, E. A., Jaycox, L. H., Meadows, E. A., & Street, G. P. (1999). A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology, 67*(2), 194–200. doi:10.1037/0022-006X.67.2.194

Frischholz, E. J., Lipman, L. S., Braun, B. G., & Sachs, R. G. (1992). Psychopathology, hypnotizability, and dissociation. *The American Journal of Psychiatry, 149*(11), 1521–1525.

Fullerton, C. S., Ursano, R. J., Epstein, R. S., Crowley, B., Vance, K. L., Kao, T., & Baum, A. (2000). Peritraumatic dissociation following motor vehicle accidents: Relationship to prior trauma and prior major depression. *Journal of Nervous and Mental Disease, 188*(5), 267–272. doi:10.1097/00005053-200005000-00003

Giesbrecht, T., Lynn, S. J., Lilienfeld, S. O., & Merckelbach, H. (2008). Cognitive processes in dissociation: An analysis of core theoretical assumptions. *Psychological Bulletin, 134*(5), 617–647. doi:10.1037/0033-2909.134.5.617

Giesbrecht, T., Lynn, S. J., Lilienfeld, S. O., & Merckelbach, H. (2010). Cognitive processes, trauma, and dissociation—Misconceptions and misrepresentations: Reply to Bremner (2010). *Psychological Bulletin, 136*(1), 7–11. doi:10.1037/a0018068

Gleaves, D. H. (1996). The sociocognitive model of dissociative identity disorder: A reexamination of the evidence. *Psychological Bulletin, 120,* 142–159.

Gleaves, D. H., May, M. C., & Cardeña, E. (2001). An examination of the diagnostic validity of dissociative identity disorder. *Clinical Psychology Review, 21*, 577–608.

Gold, S. N., Elhai, J. D., Rea, B. D., Weiss, D., Masino, T., Morris, S. L., & McIninch, J. (2001). Contextual treatment of dissociative identity disorder: Three case studies. *Journal of Trauma & Dissociation, 2*(4), 5–36. doi:10.1300/J229v02n04_02

Hayes, S. C., Luoma, J., Bond, F., Masuda, A., & Lillis, J. (2006). Acceptance and Commitment Therapy: Model, processes, and outcomes. *Behaviour Research and Therapy, 44*(1), 1–25.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change.* New York: Guilford Press.

Holmes, E. A., Brown, R. J., Mansell, W., Fearon, R., Hunter, E. C. M., Frasquilho, F., et al. (2005). Are there two qualitatively distinct forms of dissociation? A review and some clinical implications. *Clinical Psychology Review, 25*, 1–23.

Horevitz, R. P., & Braun, B. G. (1984). Are multiple personalities borderline? An analysis of 33 cases. *Psychiatric Clinics of North America, 7*(1), 69–87.

Huntjens, R. J. C., Peters, M. L., Woertman, L., Bovenschen, L. M., Martin, R. C., & Postma, A. (2006). Inter-identity amnesia in dissociative identity disorder: A simulated memory impairment? *Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences, 36*(6), 857–863. doi:10.1017/S0033291706007100

Hutzell, R. R., & Jerkins, M. E. (1990). The use of a logotherapy technique in the treatment of multiple personality disorder. *Dissociation: Progress in the Dissociative Disorders, 3*(2), 88–93.

International Society for the Study of Dissociation. (2005). [Chu, J. A., Loewenstein, R., Dell, P. F., Barach, P. M., Somer, E., Kluft, R. P., Gelinas, D. J., Van der Hart, O., Dalenberg, C. J., Nijenhuis, E. R. S., Bowman, E. S., Boon, S., Goodwin, J., Jacobson, M., Ross, C. A., Sar, V., Fine, C. G., Frankel, A. S., Coons, P. M., Courtois, C. A., Gold, S. N., & Howell, E.]. Guidelines for treating dissociative identity disorder in adults. *Journal of Trauma & Dissociation, 6*(4), 69–149.

Kellett, S. (2005). The treatment of dissociative identity disorder with cognitive analytic therapy: Experimental evidence of sudden gains. *Journal of Trauma & Dissociation, 6*(3), 55–81. doi:10.1300/J229v06n03_03

Kemp, K., Gilbertson, A. D., & Torem, M. S. (1988). The differential diagnosis of multiple personality disorder from borderline personality disorder. *Dissociation: Progress in the Dissociative Disorders, 1*(4), 41–46.

Kirsch, I., Montgomery, G., & Sapirstein, G. (1995). Hypnosis as an adjunct to cognitive-behavioral psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology, 63*(2), 214–220. doi:10.1037/0022-006X.63.2.214

Kluft, R. P. (1984). Treatment of multiple personality disorders: A study of 33 cases. *Psychiatric Clinics of North America, 7*, 9–29.

Koffel, E., & Watson, D. (2009). Unusual sleep experiences, dissociation, and schizotypy: Evidence for a common domain. *Clinical Psychology Review, 29*(6), 548–559. doi:10.1016/j.cpr.2009.06.004

Lauer, J., Black, D.W., & Keen, P. (1993). Multiple personality disorder and borderline personality disorder: Distinct entities or variations on a common theme. *Annals of Clinical Psychiatry, 5*, 129–134.

Lilienfeld, S. O., Lynn, S. J., Kirsch, I., Chaves, J. F., Sarbin, T. R., Ganaway, G. K., & Powell, R. A. (1999). Dissociative identity disorder and the sociocognitive model: Recalling the lessons of the past. *Psychological Bulletin, 125*(5), 507–523.

Linehan, M.M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* New York: Guilford Press.

Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., et al. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry, 63*(7), 757–766. doi:10.1001/archpsyc.63.7.757

Loewenstein, R. J. (1991). An office mental status examination for complex chronic dissociative symptoms and multiple personality disorder. *Psychiatric Clinics of North America, 14*(3), 567–604.

Loewenstein, R. J. (1991). Rational psychopharmacology in the treatment of multiple personality disorder. *Psychiatric Clinics of North America, 14*(3), 721–740.

Lynn, S. J., Berg, J., Lilienfeld, S. O., Merckelbach, H., Giesbrecht, T., Accardi, M., & Cleere, C. (2012). Dissociative disorders. In M. Hersen & D. C. Beidel. *Adult psychopathology and diagnosis* (pp. 497–538). New York: John Wiley.

Lynn, S. J., Fassler, O., Knox, J., & Lilienfeld, S.O. (2006). Dissociation and dissociative identity disorder: Treatment guidelines and cautions. In J. Fisher, & W. O'Donohue (Eds.), *Practitioner's guide to evidence based psychotherapy* (pp. 248–257). New York: Springer Publishing.

Lynn, S. J., Knox, J., Fassler, O., Lilienfeld, S. O., & Loftus, E. (2004). Trauma, dissociation, and memory. In J. Rosen (Ed.), *Posttraumatic stress disorder: Issues and controversies.* New York: Wiley.

Lynn, S. J., Rhue, J. W., & Green, J. P. (1988). Multiple personality and fantasy proneness: Is there an association or dissociation? *British Journal of Experimental & Clinical Hypnosis, 5*(3), 138–142.

Lynn S. J., Rhue, J. W., & Kirsch, I. (2010). *Handbook of clinical hypnosis* (2nd ed). Washington, DC: American Psychological Association.

Mai, F. M. (1995). Psychiatrists' attitudes to multiple personality disorder: A questionnaire study. *The Canadian Journal of Psychiatry / La Revue Canadienne De Psychiatrie, 40*(3), 154–157.

McCrae, R. R., Costa, P. T., & Martin, T. A. (2005). The NEO-PI-3: A more readable revised NEO personality inventory. *Journal of Personality Assessment, 84*(3), 261–270.

McHugh, P. R. (1993). Multiple personality disorder. *Harvard Mental Health Newsletter, 10*(3), 4–6. Meichenbaum, D. (1985). *Stress inoculation training.* Elmsford, NY: Pergamon Press.

Meichenbaum, D. (2003). Stress inoculation training. In W. O'Donohue, J. Fisher, & S. C. Hayes (Eds.). *Cognitive behavior therapy: Applying empirically supported techniques in your practice* (pp. 407–410). New York: Wiley.

Merskey, H. (1992). The manufacture of personalities: The production of multiple personality disorder. *British Journal of Psychiatry, 160*, 327–340.

Nash, M. R., Hulsey, T. L., Sexton, M. C., Harralson, T. L., & Lambert, W. (1993). Long-term sequelae of childhood sexual abuse: Perceived family environment,

psychopathology, and dissociation. *Journal of Consulting and Clinical Psychology, 61*(2), 276–283. doi:10.1037/0022-006X.61.2.276

North, C. S., Ryall, J. M.., Ricci, D. A., & Wetzel, R. D. (1993). Multiple personalities, multiple disorders: Psychiatric classification and media influence. Oxford: Oxford University Press.

Öst, L. (1988). Applied relaxation vs progressive relaxation in the treatment of panic disorder. *Behaviour Research and Therapy, 26*, 13–22.

Öst, L. G. (2008). Efficacy of the third wave of behavioral therapies: A systematic review and meta-analysis. *Behaviour Research and Therapy, 46*, 296–321.

Pekala, R. J., Angelini, F., & Kumar, V. K. (2001). The importance of fantasy-proneness in disassociation: A replication. *Contemporary Hypnosis, 18*(4), 204–214. doi:10.1002/ch.231

Piper, A. (1997). *Hoax and reality: The bizarre world of multiple personality disorder.* Northvale, NJ: Jason Aronson.

Porter, S., Birt, A. R., Yuille, J. C., & Lehman, D. R. (2000). Negotiating false memories: Interviewer and remember characteristics relate to memory distortion. *Psychological Science, 11*(6), 507–510. doi:10.1111/1467–9280.00297

Powell, R. A., & Gee, T. L. (1999). The effects of hypnosis on dissociative identity disorder: A reexamination of the evidence. *The Canadian Journal of Psychiatry, 44*(9), 914–916.

Putnam, F. W. (1989). Diagnosis and treatment of multiple personality disorder. New York: Guilford Press.

Putnam, F. W., & Loewenstein, R. J. (2000). Dissociative identity disorder. In B. J. Sadock & V. A. Sadock (Eds.), *Kaplan and Sadockis comprehensive textbook of psychiatry* (7th ed., Vol. 1, pp. 1552–1564). Philadelphia: Lippincott, Williams, & Wilkins.

Rifkin, A., Ghisalbert, D., Dimatou, S., Jin, C., & Sethi, M. (1998). Dissociative identity disorder in psychiatric inpatients. *The American Journal of Psychiatry, 155*(6), 844–845.

Rosenstein, L.D. (1994). Potential neuropsychologic and neurophysiologic correlates of multiple personality disorder: Literature review and two case studies. *Neuropsychiatry, Neuropsychology, and Behavioral Neurology. 7*(3), 215–229.

Ross, C. A. (1994) *The Osiris complex: Case-studies in multiple personality disorder.* Toronto, ON: University of Toronto Press.

Ross, C. A. (1997). *Dissociative identity disorder: Diagnosis, clinical features, and treatment of multiple personality.* New York: Wiley.

Ross, C. A., Duffy, C. M. M., & Ellason, J. W. (2002). Prevalence, reliability and validity of dissociative disorders in an inpatient setting. *Journal of Trauma & Dissociation, 3*(1), 7–17. doi:10.1300/J229v03n01_02

Ross, C. A., & Ness, L. (2010). Symptom patterns in dissociative identity disorder patients and the general population. *Journal of Trauma & Dissociation, 11*(4), 458–468. doi:10.1080/15299732.2010.495939

Ross, C. A., & Norton, G. R. (1988). Multiple personality patients with a past diagnosis of schizophrenia. *Dissociation, 1*(2), 39–42.

Rothbaum, B. O., & Schwartz, A. C. (2002). Exposure therapy for posttraumatic stress disorder. *American Journal of Psychotherapy, 56*(1), 59–75.

Sarbin, T. R. (1995). On the belief that one body may be host to two or more personalities. *International Journal of Clinical and Experimental Hypnosis, 43*, 163–183.

Saunders, T., Driskell, J.E., Hall, J., Salas, E. (1996). The effect of stress inoculation training on anxiety and performance. *Journal of Occupational Health Psychology 1*, 170–186.

Sharpless, B. A., & Barber, J. P. (2011). Lifetime prevalence rates of sleep paralysis: A systematic review. *Sleep Medicine Review, 15*(5), 311–315.

Simeon, D. (2009). Neurobiology of depersonalization disorder. In P. F. Dell, & J. A. O'Neil (Eds.), *Dissociation and dissociative disorders: DSM-5 and beyond* (pp. 367–372). New York: Routledge/Taylor & Francis.

Spanos, N. P. (1996). *Multiple identities & false memories: A sociocognitive perspective.* Washington, DC: American Psychological Association.

Steinberg, M. (1994). *Structured clinical interview for DSM-IV dissociative disorders revised (SCID-D-R).* Washington, DC: American Psychiatric Press.

van der Kloet, D., Merckelbach, H., Giesbrecht, T., & Lynn, S. J. (2012). Fragmented sleep, fragmented mind: The role of sleep in dissociative symptoms. *Perspectives on Psychological Science, 7*, 159–175.

COMMENTARY

Harald Merckelbach

Is there evidence-based physics? If you would ask a scientist, he or she would probably burst into laughter. It is like talking about black darkness or four-legged horses. Why, then, do we speak of evidence-based treatments in psychopathology? The answer is, of course, that few treatments in that domain are backed by a solid corpus of knowledge derived from research. Such state of affairs is not unique for psychopathology. Consider the example of spinal fusion that Groopman (2007) describes in his *How Doctors Think*. Spinal fusion is a surgical intervention that is performed on a wide scale to alleviate chronic low back pain. Yet prospective trials have not shown it to be more effective than noninvasive treatments, like physical therapy. Part of the problem here is that chronic low back pain is not a well-circumscribed diagnostic entity. Things are much the same for patients who have been given a diagnosis of dissociative identity disorder (DID). Although the diagnostic label suggests otherwise, dissociative symptoms comprise an extremely heterogeneous class of experiences and complaints.

Some authors have argued that, in the 1990s, DID was a fashionable diagnosis but that it has declined in recent years (Pope, Barry, Bodkin, & Hudson, 2006). I doubt whether that conclusion is justified. For example, Foote and coworkers (2006) employed a structured interview for dissociative disorders in their sample of inner-city psychiatric outpatients and reported a prevalence rate of 29% for all dissociative disorders and a prevalence rate of 6% for DID specifically. The authors also administered a trauma self-report scale to their patients and found that 74% of the dissociative patients said that they had a traumatic background, whereas this was true for 29% of the patients without dissociative symptomatology. The authors concluded that "our findings add to the growing amount of data concerning both the association between childhood trauma and adult dissociative psychopathology and the surprisingly high prevalence of dissociative disorders in the clinical population" (Foote, Smolin, Kaplan, Legatt, & Lipschitz, 2006, p. 627). At minimum, the study illustrates that some clinicians still use the diagnostic category of DID. More important, its findings seem to underpin the trauma-focused treatment of dissociative symptoms propagated by some clinicians (e.g., Sinason, 2011).

But, as Lynn and colleagues make clear in their chapter, this trauma-focused approach has a poor track record. Evidence for its efficacy is largely lacking (but see Ellason & Ross, 1997). Even worse is that it may produce iatrogenic exacerbation of symptoms (Lilienfeld, 2007). Many clinicians treating patients with dissociative symptoms seem to be ignorant of this risk. A case in point is drug treatment for dissociative amnesia. In 2003, a group of clinicians published an enthusiastic report about the apparent safety and efficacy of intravenous diazepam (Valium) for facilitating memory retrieval in dissociative patients (Ballew, Morgan, & Lippmann, 2003). The basic assumption of the authors was that dissociative symptoms reflect a primitive defense against traumatic stress and that diazepam may help to overcome this defense maneuver. Clearly, the authors either did not read or ignored the critical literature on narco-analysis and the risks that this method conveys in terms of false memories (e.g., Kihlstrom, 1998).

With these considerations in mind, Lynn and colleagues are to be commended for their detailed description of how cognitive behavioral interventions can help to treat the emotional dysregulation that is typical for patients who have been given a diagnosis of DID. Interestingly, their approach has an historical antecedent, namely, the fascinating paper by Robert Kohlenberg (1973). Kohlenberg demonstrated how instrumental conditioning can be used to reduce the behavioral manifestations of DID, such as alter switching.

Strictly speaking, Kohlenberg's and Lynn et al.'s approaches are not evidence-based. The cognitive behavioral interventions that they employed to treat DID patients have demonstrated their efficacy in a different context, notably that of the anxiety and mood disorders. As Lynn and associates themselves acknowledge, "at the present time, well-controlled research is lacking to support any treatment of DID, much less specific or tailored interventions." Nevertheless, for clinicians, the authors' case description provides a valuable catalogue of treatment options. Having said this, four points remain to be discussed.

The first concerns Lynn et al.'s recommendation that clinicians should assess their patients' previous exposure to DID movies, DID books, and DID therapists, because—as the sociocognitive model emphasizes—these sources may have conveyed suggestive misinformation that helped to create typical DID features. That suggestive misinformation may encourage the development of DID symptoms is a recurring theme in many critical papers on DID (e.g., Piper, 1995; Simpson, 1995). One remarkable aspect of Lynn et al.'s case vignette is that the DID symptoms of their patient became stronger over time, while the patient was in therapy. In fact, it was only after a series of treatment sessions that she began to meet the criteria for DID. Assuming that the authors went to great lengths to avoid the suggestive shaping of DID symptoms in their patient, the question rises whether their patient is a straightforward example of "spontaneous developing" DID—an example that would provide a falsification of the sociocognitive model.

The second point has to do with the nosologic status of DID. What is it, anyway? Lynn and coworkers argue that the DID symptoms of their patient can be

understood as a self-defeating repertoire to cope with guilt, anger, and anxiety. Does that imply that DID is a complex mood disorder? The idea is attractive and reminds us of North, Ryall, Ricci, and Wetzel (1993) who presented an in-depth analysis of the extensive comorbidity that is characteristic of DID, raising the distinct possibility that DID is a severity marker rather than a nosologic entity per se. Since North et al. (1993) wrote their text, little progress has been made in determining whether DID is sufficiently different from other conditions to afford it its own *DSM-5* entry. For example, we know near to nothing about the natural course of DID and its precise relationship to Briquet's syndrome (a condition similar to somatization disorder in *DSM-IV*) is still ill-understood. What would Lynn and coworkers advise clinicians to do? To treat DID as a mood disorder complicated by Briquet's syndrome and other comorbid symptoms? The obvious advantage of this view would be that it opens a rich literature on cognitive behavioral treatment interventions, arguably the strongest quarter of clinical psychology (see also Hunter, Phillips, Chalder, Sierra, & David, 2003).

The third question concerns the diagnostic assessment of DID patients. In their section on assessment strategy, Lynn and colleagues focus on the systematic evaluation of dissociative symptoms. Would they agree that if DID is a severity marker of a polysymptomatic condition, it would be wise to carry out a more thorough evaluation of the totality of signs and symptoms? For example, clinicians might administer a battery of well-validated tests (e.g., MMPI, depression scales, sleep disorder scales), and this might inform the treatment plan. A related issue, but slightly taboo, is the phenomenon of symptom exaggeration. In one of our own studies, we found a correlation of $r = 0.51$ between dissociative symptoms as measured by the Dissociative Experiences Scale (DES) and symptom exaggeration as indexed by the Structured Inventory of Malingered Symptomatology (SIMS) in a sample of undergraduates (Giesbrecht & Merckelbach, 2006). Patients with DID are known to have elevated scores on the validity scales of the MMPI, suggesting the possibility of symptom exaggeration and confabulation (e.g., Simpson, 1995). Symptom fluctuations are also a hallmark feature of Briquet's syndrome (North et al., 1993). The point that I want to make is this: there are good reasons to assume that patients with DID perform poorly when it comes to providing their therapists with consistent reports about their symptoms. This being the case, one wonders why Lynn and coworkers apparently did not rely on progress and outcome data independent of their patient's self-reports (e.g., collateral information from others).

The fourth issue pertains to the treatment strategy of Lynn and coworkers. It capitalized on interventions that require the imaginative involvement of the patient, such as imaginal rehearsal, role-playing, metaphors like "AC/DC" control, and hypnosis. Such interventions have also often been criticized for their potential to cause artifactual symptoms and false memories (e.g., Piper, 1995). When are these interventions encouraging regressive behavior and when can they applied successfully? Articulating this demarcation line more precisely will assist clinicians in their efforts to help patients who have been given a diagnosis of DID.

References

Ballew, L., Morgan, Y. & Lippmann, S. (2003). Intravenous diazepam for dissociative disorder. Memory lost and found. *Psychosomatics, 44*, 346–347.

Ellason, J. W., & Ross, C. A. (1997). Two-year follow-up of inpatients with dissociative identity disorder. *American Journal of Psychiatry, 154*, 832–834.

Foote, B., Smolin, Y., Kaplan, M., Legatt, M. E., & Lipschitz, D. (2006). Prevalence of dissociative disorders in psychiatric outpatients. *American Journal of Psychiatry, 163*, 623–629.

Giesbrecht, T., & Merckelbach, H. (2006). Dissociatieve symptomen en slaap [Dissociative symptoms and sleep]. *Tijdschrift voor Psychiatrie* [Dutch Journal of Psychiatry], 3, 207–215.

Groopman, J. (2007). *How doctors think*. New York: Houghton Mifflin.

Hunter, E. C. M., Phillips, M. L., Chalder, T., Sierra, M., & David, A. S. (2003). Depersonalization disorder: A cognitive behavioral conceptualisation. *Behaviour Research and Therapy, 41*, 1451–1467.

Kihlstrom, J. F. (1998). Exhumed memory. In S. J. Lynn & K. M. McConkey (Eds.). *Truth in memory* (pp. 3–31). New York: Guilford Press.

Kohlenberg, R. J. (1973). Behavioristic approach to multiple personality: A case study. *Behavior Therapy, 4*, 137–140.

Lilienfeld, S. O. (2007). Psychological treatments that can cause harm. *Perspectives on Psychological Science, 2*, 53–70.

North, C. S., Ryall, J. M., Ricci, D. A., & Wetzel, R. D. (1993). *Multiple personalities, multiple disorders: Psychiatric classification and media influence*. Oxford: Oxford University Press.

Pope, H. G., Barry, S., Bodkin, A., & Hudson, J. I. (2006). Tracking scientific interest in the dissociative disorders: A study of scientific publication output 1984–2003. *Psychotherapy & Psychosomatics, 75*, 19–24.

Piper, A. (1995). A skeptical look at multiple personality disorder. In L. Cohen, J. Berzoff, & M. Elin (Eds.). *Dissociative identity disorder* (pp. 135–174). Northvale, NJ: Jason Aronson.

Sinason, V. (2011). *Attachment, trauma, and multiplicity: Working with dissociative identity disorder* (2nd ed.). London: Routledge.

Simpson, M. A. (1995). Gullible's travels or the importance of being multiple. In L. Cohen, J. Berzoff & M. Elin (Eds.). *Dissociative identity disorder* (pp. 87–134). Northvale, NJ: Jason Aronson.

RESPONSE

Steven Jay Lynn, Liam Condon, and Gep Colletti

We thank Professor Merckelbach for his thoughtful commentary, which raises important questions about the treatment of DID and is replete with interesting observations (e.g., DID may represent a complex mood disorder, DID is a severity marker of a polysymptomatic condition, the need to take symptom exaggeration into account in a complete evaluation of DID). For example, Merckelbach questions whether our patient's DID symptoms could be an example of "spontaneous developing DID, and thereby provide a falsification of the sociocognitive model," as he presumed we "went to great lengths to avoid the suggestive shaping of DID symptoms." Shaping influences on patients may be subtle (e.g., exposure to movies, books, magazine misinformation about DID), and symptoms may appear to arise "spontaneously." Yet in the case of Ms. M., potentially suggestive influences were less than subtle, if not blatant. Indeed, she was not only an avid consumer of media with trauma-based depictions of multiple personalities, but relatively early in her treatment (before SJL came on board), her previous therapist at some point began to interact with supposedly separate personalities, potentially reifying them and rewarding their manifestation.

Merckelbach understandably wonders why we did not rely on collateral information from others. The answer is simple. The patient did not want her parents and friends to know that she was participating in psychotherapy. Still, we agree that such information can be invaluable (e.g., we were able to obtain medical information that confirmed her self-reports), especially in cases in which patients relate highly improbable stories about extreme abuse (e.g., satanic ritual abuse).

We agree with Merckelbach that it is important to demarcate the line between interventions that encourage regressive behavior and false memories and interventions that promote adaptive coping. He singles out the techniques of hypnosis, the AC/DC metaphor, imaginal rehearsal, and role-playing as potentially problematic. In the case of Ms. M. we used hypnosis, imaginal rehearsal, and role-playing to facilitate affect management and problem solving, never to recover memories. Similarly, we used the AC/DC metaphor to highlight the problems with "dissociative coping" and to tout the benefits of acceptance and engagement with anxiety-eliciting situations, rather than experiential avoidance. We recommend that therapists scrupulously monitor the effects of any intervention, even

those not presumed to be at high risk for producing false memories or "regressive reactions."

It is right for Merckelbach to question whether our therapy with Ms. M. is truly "evidence-based." Unfortunately, no single protocol for DID can claim convincing empirical support. Accordingly, we were careful to call attention to the "somewhat experimental" nature of the interventions we employed. Our definition of "evidence-based" was admittedly liberal. More specifically, our therapy proceeded with a keen recognition that evidence-based practice related to DID must, of necessity, involve a creative synthesis of information derived from limited systematically collected data, as well as scientifically informed decisions based on theoretical formulations and empirically supported treatments originally developed for other disorders. Regrettably, that is sometimes the best that a scientifically minded clinician can do when rigorously evaluated treatments for the disorder at hand are nonexistent.