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ARTICLE

## Evidence for phase-based psychotherapy as a treatment for dissociative identity disorder comorbid with major depressive disorder and alcohol dependence

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### ABSTRACT

We report on the treatment and successful outcome of a 58-year-old Native American male with a history of complex trauma presenting with dissociative identity disorder (DID) and major depressive disorder. The treatment included a trauma-informed phase-based psychotherapy as recommended by the International Society for the Study of Trauma and Dissociation for treating DID. We assessed symptoms at baseline and at three additional time points over the course of 14 months. We utilized the Reliable Change Index to examine statistically significant change in symptoms over the course of treatment. Significant symptom improvements were realized posttreatment across all measured domains of functioning, including dissociative symptoms, alcohol abuse, depression, anxiety, and emotion regulation skills. Moreover, the client no longer met criteria for DID, major depressive disorder, or alcohol abuse. Results are discussed in terms of the effectiveness of trauma-focused, phase-based treatment for DID for cases of complex trauma with comorbid disorders.

### ARTICLE HISTORY

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### KEYWORDS

Clinical work; dissociation; dissociative identity disorder; trauma-focused CBT; treatment effectiveness

Treatment outcome research on individuals with dissociative identity disorder (DID) has largely been explored through case studies and naturalistic outcome studies. Several case studies have revealed positive self-reported outcomes when transference-focused therapy (Draijer & Van Zon, 2013) and nonspecified, trauma-informed long-term psychotherapy (Şar, Ozturk, & Kundakci, 2002) have been applied as treatment for DID. The majority of case studies, however, have relied on subjective observations from the treating clinician or a review of medical records to assess benefits of treatment rather than on client-reported data on symptom change that are subjected to statistical analysis (for a review, see Brand, Classen, McNary, & Zaveri, 2009). The aim of the current study was to report the history, intervention approach, and treatment outcomes for a 58-year-old Native American male with DID, co-occurring major depressive disorder, and substance abuse disorder. Client progress was

examined using a systematic approach to data collection coupled with the client's narrative reports.

Research has shown that phasic trauma treatment focused on dissociation and dissociative identities is effective for individuals with DID and is consequently recommended for treatment (Brand & Loewenstein, 2014). The International Society for the Study of Trauma and Dissociation's (ISSTD) revised guidelines for the treatment of DID support the use of a phase-oriented treatment approach by planning treatment in sequenced stages (ISSTD, 2011). Treatment is tailored in a way that considers a client's individual differences and developmental history. However, no study to date has utilized the new comprehensive ISSTD guidelines in conjunction with a skills training manual for an individual with DID.

An important issue when working with individuals with DID is treating the high rates of comorbid disorders. Specifically, there are high rates of comorbidity among DID, mood disorders (Johnson, Cohen, Kasen, & Brook, 2006), and substance abuse (Karadag et al., 2005). Indeed, approximately 55% of individuals diagnosed with a dissociative disorder dropped out of treatment early because of substance abuse (Tamar-Gurol, Sar, Karadag, Evren, & Karagoz, 2008). The current study applied a phasic trauma-informed intervention to address co-occurring DID, substance abuse disorder, and major depressive disorder. Statistical analyses were performed to examine the effect of the phasic trauma-informed intervention on the client's self-reported symptoms and categorical *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, diagnoses.

## Case introduction

### *Presenting complaints*

"M" was a married 58-year-old Native American male who lived with his wife of 13 years and was employed in the hospitality industry. M sought therapy over concern over an escalation of physical conflicts with his wife and dissociative episodes, depressive symptoms, and substance abuse. His dissociative symptoms included long periods of what he referred to as "blackouts" or dissociative episodes lasting from several minutes to several hours or, less often, several days. M stated that these episodes had occurred since childhood but had increased in frequency and duration in the past several years. M presented with disruptions of identity, first presenting as episodes of depersonalization (e.g., feeling as if he were an outside observer of his actions), and a disruption of identity including what he experienced as overwhelming "blackouts" in which "others" would take over his actions. These episodes were often triggered by emotional encounters and included a child-like state and a persecutory, angry state. M reported an extensive

trauma history, including childhood sexual and physical abuse and months in solitary confinement while incarcerated as an adult.

### **History**

M reported the following details on his history. He was born to a single mother, who relinquished custody to the state when M was 4 years old. As an adult, he learned that his conception was the product of his mother's rape at the age of 14 by her biological brother. M resided in a residential institution as a ward of the state from 4 to 8 years old. During this time, he was sexually abused by an older boy living in the institution. M was adopted at age 8 into the strict, religious home of a first-generation immigrant couple. His adoptive parents were verbally and physically abusive, which M believed stemmed in part from their derogation of his Native American heritage. M's adoptive grandmother and parents called him a "wild beast" and other insults because of his sociocultural identity. He was seen by psychologists at age 12 for behavioral problems. M began to defend himself against his adoptive father's physical abuse as a teenager. He had difficulty controlling his anger and at times felt as though he were an outside observer during physical altercations with his adoptive father. M joined the army after graduating high school but went absent without official leave after having dissociative experiences that impaired his ability to do his duties and led to his subsequent admittance to a psychiatric hospital.

M married at the age of 22 and remained married for 9 years. He described his relationship as unhealthy because of dynamic intimate partner violence (i.e., the perpetration of violence by both partners), substance abuse, and financial hardship. M was incarcerated several times for physical altercations and driving while intoxicated. During a period of incarceration while M was in his 30s, he was placed in solitary confinement (e.g., no social interaction, no windows, mostly dark) before he was tried in court, was forgotten, and was mistakenly left there for 9 months. During his time in solitary confinement, M was consciously aware of dissociative experiences such as leaving his body and losing time, voices in his head that he did not believe to be his own, and frequent memories of the childhood abuse. M remarried in 2000 to his current wife. He described his wife as very dependent on him and his relationship with her as volatile, oscillating between periods of intense conflict and happiness and support.

M reported a history of alcohol and substance abuse from his 20s to 40s. He pursued counseling on occasion, but episodes of treatment were short lived, lasting no more than a few sessions. In his 20s, M experienced a concussion when he fell out of a construction truck at work. He also presented with arthritis, migraines, and gastrointestinal problems. M was

not taking medication at the time of treatment and reported a history of severe side effects from past medication use.

M reported ongoing passive suicidal ideation at the time of treatment and a history of previous suicide attempts, including an attempted overdose on prescription pain medication and natural gas inhalation between his 20s and 40s. M denied any homicidal ideation but was concerned about his level of violence reported by his wife during periods of “blackouts” and depersonalization. M also endorsed episodes of auditory and command hallucinations.

### **Assessment and diagnoses**

An unstructured clinical interview was completed to assess *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, symptoms of trauma-related, dissociative, anxiety, and mood disorders. Information collected from intake, client self-report measures, collateral information from M’s wife, and observations of the treating clinician indicated that M met criteria for DID, major depressive disorder (recurring, severe), and alcohol dependence (American Psychiatric Association, 2000). During the intake process, consent to treatment and to collect data and information to be included in a case study about the course and outcome of treatment was obtained. M completed baseline self-report measures prior to the first therapy session and on three additional occasions separated by 4–5 months.

### **Substance abuse**

Alcohol consumed over the past week was assessed via self-report at each session. Measurement occasions approximately coincided with the end of each treatment phase. The final assessment was collected one session prior to termination.

### **Depression**

The Beck Depression Inventory–II (BDI-II; Beck, Steer, & Brown, 1996), a 21-item self-report measure, was utilized to assess overall depression symptoms.

### **Anxiety**

The Beck Anxiety Inventory (BAI; Beck & Steer, 1993), a 21-item self-report measure, was utilized to assess overall anxiety symptoms.

### **Dissociation**

The Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986), a 28-item self-report measure, was utilized to assess dissociative symptoms.

### **Emotion regulation**

The Emotion-Regulation Skills Questionnaire (ERSQ; Berking & Znoj, 2008) is a 27-item self-report measure that assesses emotion regulation skills. The average score is 2.70 for the general population and 2.03 for a clinical sample (Berking et al., 2008).

### **Case conceptualization**

M was prone to posttraumatic hypervigilance and a detached attachment style in interpersonal relationships. He was cautious around threats to his safety and security in relationships. M had only one close relationship in his life—his wife—and often did not share with her his internal experiences. He avoided self-focus and discussed himself in a manner similar to that described in introjective depression (Blatt, 2004), often viewing himself as the source of his depression, as “evil,” “not good enough,” and “flawed.” M attributed these negative qualities to his identity as a Native American, for which he felt shame and resentment. Theory and research have shown that individuals with severe traumatization frequently experience shame (Dorahy et al., 2015; Kluft, 2007). M lacked a consistent and effective coping style and responded unpredictably to stressors. Often he would vacillate between coping strategies, at times expressively acting out (e.g., increased suicidality, alcohol abuse) or experiencing dissociative episodes with alternate personality states, including protective, but outwardly aggressive, or very withdrawn, child-like states. M had difficulty with reality testing, often misperceiving others’ actions and intentions, prompting intense anger and withdrawal.

M’s severe trauma and abuse history throughout his childhood and adolescence significantly impacted his relationships and ability to cope with negative affect or stressful situations. He demonstrated a tendency to repeat maladaptive patterns of relating to others throughout his adulthood, often by engaging in physical altercations resulting in incarceration. M’s “blackouts” were clinically defined as dissociative episodes with instances of other emotional states and identities assuming control, amnesia for the time, or feeling distant from his physical body. However, given his level of alcohol use, a diagnosis of DID was specified with the understanding that the alcohol abuse could function as a trigger or coping response for his dissociative episodes. Research has shown that inpatients with alcohol dependency are not at higher risk for comorbid dissociative disorder, and the majority of inpatients with comorbid alcohol dependence and a dissociative disorder reported that their dissociative symptoms occurred prior to their alcohol use (Evren, Sar, Karadag, Gurol, & Karagoz, 2007). Therefore, M’s alcohol abuse was conceptualized as a form of self-medication or escapism from the symptoms of

both depression and DID. Yet his alcohol abuse appeared to only intensify those symptoms.

### **Course of treatment and assessment**

Based on International Society for the Study of Trauma and Dissociation (ISSTD; Cloitre et al., 2012) treatment guidelines and the case conceptualization of M, treatment utilized a multiphase model. Phase 1 included supportive and directive psychotherapy focused on stabilizing M's alcohol abuse, reducing suicidal ideation, and improving emotion regulation abilities. Phase 2 focused on processing past traumatic experiences and coping with current triggers utilizing trauma-focused skills training as presented in *Coping With Trauma-Related Dissociation* (Boon, Steele, & van der Hart, 2011). The goal of Phase 3 was to continue to work on Phase 2 goals, with an emphasis on integration of memories, identities, and stability when under stress.

### **Overview**

M participated once a week or every other week in individual psychotherapy for 30 sessions over 14 months of treatment. M had difficulty attending sessions regularly during the initial phase of treatment, often canceling a few hours prior to the scheduled session. M cited difficulties with transportation, work, and health problems as reasons for his inconsistent attendance.

### **Phase 1**

Treatment Phase 1 lasted approximately 11 sessions over the course of 5 months. M's difficulty forming relationships was addressed first through a focus on the therapeutic alliance and rapport building. The treatment approach emphasized supportive and directive psychotherapy coupled with psychoeducation around his diagnoses and symptom presentation. The etiology of DID, dissociation, and different self-states (i.e., child-like self; angry, protecting self) was discussed, as was the utility of dissociative states (e.g., an adaptive coping mechanism that has developed into a maladaptive response to stress or threat). Several sessions and after-hour phone calls during Phase 1 addressed high levels of suicidal ideation, including one suicide attempt in the middle of Phase 1 in which M attempted suicide by police gunfire. The client experienced the care he received following his suicide attempt as evidence that he was cared for by his wife and the therapist, a belief not previously held by him. After this experience, the patient reported feeling recommitted to living and to therapy, resulting in a steady increase in rate of attendance.

Phase 1 focused on self-care, symptom reduction, the client's sense of safety and stability, and the reduction of violence in the home. This phase deemphasized trauma in order to focus on M's self-care, including alcohol abuse, sleep, physical health, and relaxation as a method of coping. In addition, brief interventions of behavioral activation and reward planning were utilized to further address depressive symptoms (Hopko, Lejuez, Leage, Hopko, & McNeil, 2003). Skills training with between-session practice was used to address self-care, sleep, physical health, and psychoeducation (Boon et al., 2011).

A critical component of the ISSTD protocol during Treatment Phase 1 is the reduction of self-destructive behaviors (e.g., substance abuse). Alcohol use was addressed using the harm reduction method as opposed to abstinence programs. *Harm reduction* generally refers to interventions aimed at reducing the problematic effects of behaviors, frequently substance use (Marlatt, Larimer, & Witkiewitz, 2011); research suggests that the efficacy of harm reduction for reducing substance use is similar to that of abstinence-only programs (for a review, see Logan & Marlatt, 2010). Positive coping and emotion regulation skills, as outlined in *Coping With Trauma-Related Dissociation*, were emphasized in treatment as a way to replace alcohol use as a primary coping response for emotional distress (Boon et al., 2011). M decreased his alcohol use from a half to 1 pints of brandy per day 4–5 times a week to a half pint of brandy per week by the end of Phase 1. The client's treatment progress and readiness to examine traumatic events were discussed before progressing to Treatment Phase 2.

## **Phase 2**

The second phase of treatment applied trauma-informed psychotherapy to address symptoms stemming from the client's experiences with trauma. The intervention approach concentrated on the client's memories and perceptions of the trauma and the integration of these experiences into his identity and lasted 12 sessions over the course of 4 months. In general, the first half of each session began with processing traumatic material, followed by an examination of the client's functioning in the domain of coping, romantic relationships, and occupational stress. In each session, M confronted traumatic memories, triggers, and accompanying emotional experiences based on a hierarchical list while continuing to utilize the emotion regulation coping skills discussed in Phase 1. Treatment created opportunities for him to revisit traumatic memories in a manualized exposure format and to revisit relaxation skills to help him cope with the negative emotions resulting from trauma exposures. Frequent exposure to the traumatic material while working to reassess the trauma and reframe the experience has been suggested as an important mechanism of change during Phase 2 (ISSTD, 2011).

M would indirectly express self-loathing, shame, and feelings of responsibility for the abuse. He often attributed these feelings to his general identity, particularly his identity as a Native American. This presentation is consistent with those who have experienced trauma and an introjective depressive personality, both of which are indicated as a focus of treatment by ISSTD (2011). M's experience of guilt and shame around his trauma required several sessions of processing and active cognitive restructuring. M also recognized that feeling deserving of abuse gave him a sense of control in the world; lacking this sense of control would have forced him to confront his lack of agency as a child and as an adult when he dissociated.

Following these insights, the therapy addressed M's sense of agency, control, and capacity to regulate his environment (e.g., becoming engaged in the household chores and decorating). M also began to explore his anger toward his adoptive parents but also his affection for them. During several sessions, M discussed the death of his adoptive parents and the then inexplicable sadness and longing he felt when his adoptive siblings were selling off his parents' belongings and he was not given the chance to keep anything. M would have liked to have kept tools that he had been taught to use by his father, which facilitated his exploration of positive memories of his adoptive father. Sessions then directly addressed the dissociative self-states that would resume control and the function, needs, and triggers associated with them.

In Phase 2 M moved toward integration, which is theorized to be the key outcome in psychotherapy for individuals with DID (Kluft, 1993). Specifically, integration is conceptualized as a structural change within an individual such that there is a reduction in dissociative identity states followed by fusion and maintenance of a single identity (Kluft, 1993). M historically actively attempted to avoid or deny, through either substance abuse or dissociating, the experience of his separate identities' attempts to communicate. He would often experience those other self-states as overwhelming voices in his mind issuing commands or incomprehensible noise. During this phase, M was able to tolerate the internal experience of the voices he perceived as "other" without alcohol abuse or dissociation, and he began to understand those internal experiences as his own self attempting to communicate unmet needs or perceived sources of threat or fears.

Prior to Phase 2, M displayed extreme anger in dissociative episodes but had little to no recollection afterward other than a vague memory and was unable to describe the feeling of "being angry" in session. After considerable exploration around anger at past trauma, M began to express anger to the therapist and his wife without having violent and dissociative episodes. M also became aware of his child-like self and the needs that child represented that were never met, such as emotional closeness, safety, and attachment. A focus on integration was continued during Phase 3.

### Phase 3

Phase 3 focused on M continuing integration and maintaining a sense of secure identity while relearning how to relate to his wife and others, tolerate stress and conflict without dissociation and withdrawal, and explore new personal goals previously thought impossible. M embraced and integrated his identity as a Native American; he explored his heritage and ancestry. This phase occurred over seven sessions, and M and the therapist met approximately two times a month for 5 months. This phase focused on increasing the patient's sense of fulfillment in his relationship with his wife, who was diagnosed with an early stage of treatable cancer. M worked to develop a closer tie with his community by joining alcohol abuse support groups in the area. At the end of Phase 3 M had decreased his alcohol use from a half pint of brandy per week to three to six light beers per week.

M requested termination several sessions into Phase 3. He cited a sense of stability and increased ability to pick up more hours at work as reasons for discontinuing treatment. At the end of Phase 3 M denied any ongoing experiences of dissociative episodes and intimate partner violence within the past several months. He also reported increased awareness of his emotional experiences and ability to cope with stress and triggers in the environment. The treating clinician expressed the opinion that continued therapy could be warranted given M's slightly elevated rates of depression, anxiety, and dissociative experiences (see "Assessment of Progress"), but ultimately M reported feeling stable and requested termination.

### Assessment of progress

Clinically significant symptom change was assessed through computation of the Reliable Change Index (RCI; Jacobson & Truax, 1991). The RCI was used to assess change in depression, anxiety, dissociation, and emotion regulation ability. The RCI defines clinically significant change as a client achieving a level of functioning closer to that of the functional population than the mean of the dysfunctional population posttreatment (Jacobson & Truax, 1991). Specifically, statistical significance ( $p < .05$ ) is calculated by dividing the standard error of the measure by the RCI needed to exceed the  $z$  score for the 97th percentile ( $-1.96$  or  $1.96$ ). We obtained general and clinical reference group data and test-retest reliabilities for the BDI-II (Beck et al., 1996; Dozois, Dobson, & Ahnberg, 1998), BAI (Beck, Epstein, Brown, & Steer, 1988; Osman, Kopper, Barrios, Osman, & Wade, 1997), DES (van IJzendoorn & Schuengel, 1996), and ERSQ (Berking et al., 2008) prior to performing analyses (see Table 1). RCI analyses were conducted between each assessment time point, including baseline, Time 1 (T1; 4.5 months after baseline), Time 2 (T2; 9 months after baseline), and Time 3 or termination (T3; 14.5 months after baseline, just prior to termination; see Table 2).

**Table 1.** Clinical and general population descriptive statistics used for Reliable Change Index calculations.

Instrument	Clinical population mean		General population mean		Cutoff threshold
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
BDI-II	22.36	11.92	9.11	7.57	15.74
BAI	18.84	11.81	10.75	9.12	14.80
DES	14.27	11.54	11.75	10.63	13.01
ERSQ	2.03	0.71	2.70	0.52	2.37

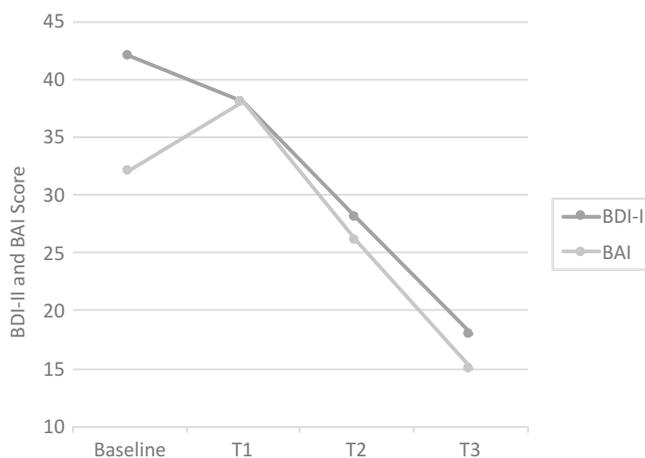
Notes: BDI-II = Beck Depression Inventory–II; BAI = Beck Anxiety Inventory; DES = Dissociative Experiences Scale; ERSQ = Emotion-Regulation Skills Questionnaire.

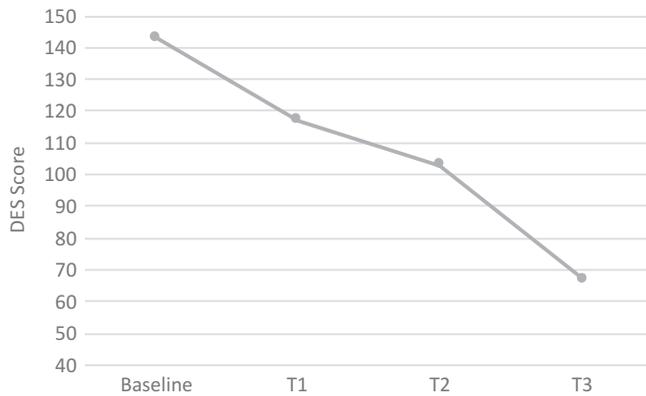
**Table 2.** Monthly symptom ratings during baseline and treatment phases.

Instrument	Baseline score	Treatment phase		
		1	2	3
BDI-II	42	38	28	18
BAI	32	38	26	15
DES	143	117	103	67
ERSQ	1.11	1.48	1.58	1.77

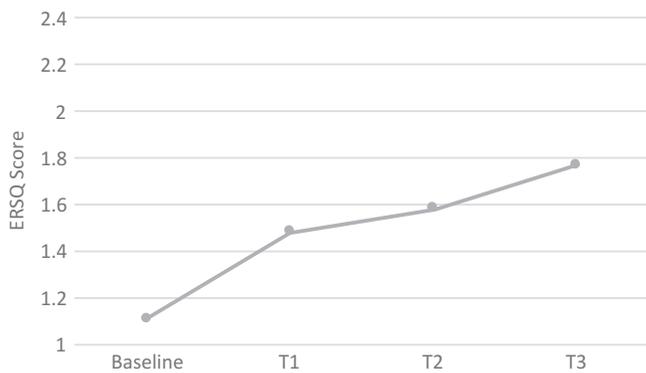
Notes: BDI-II = Beck Depression Inventory–II; BAI = Beck Anxiety Inventory; DES = Dissociative Experiences Scale; ERSQ = Emotion-Regulation Skills Questionnaire.

In depressive symptoms as measured by the BDI-II, M evidenced statistically significant improvements across all time point comparisons, except from baseline to T1, with the largest reduction in BDI-II score found from baseline to T3 (Figure 1;  $RCI = -8.47, p < .05$ ). M experienced a nonsignificant increase in anxiety from baseline to T1 but achieved statistically significant symptom reduction on the BAI from baseline to T3 ( $RCI = -2.68, p < .05$ ) and from T1 to T3 ( $RCI = -3.63, p < .05$ ). On the DES, M experienced statistically significant improvement in

**Figure 1.** Change over four time points on the Beck Depression Inventory–II (BDI-II) and Beck Anxiety Inventory (BAI). T1 = Time 1; T2 = Time 2; T3 = Time 3.



**Figure 2.** Change over four time points on the Dissociative Experiences Scale (DES). T1 = Time 1; T2 = Time 2; T3 = Time 3.



**Figure 3.** Change over four time points on the Emotion-Regulation Skills Questionnaire (ERSQ). T1 = Time 1; T2 = Time 2; T3 = Time 3.

dissociation across all time points, with the highest RCI score again from baseline to T3 (Figure 2;  $RCI = -17.6, p < .05$ ). Overall, M had significant symptom reduction in depression, anxiety, and dissociation. Finally, on the ERSQ, M also achieved a statistically significant reliable change from baseline to T3 only (Figure 3;  $RCI = 2.31, p < .05$ ), suggesting an increase in emotion regulation skills.

### Treatment implications of the case

A phase-oriented treatment approach is recommended and effective for the treatment of DID (Brand & Loewenstein, 2014; ISSTD, 2011). The multiphase treatment model implemented with the current client focused on (a) stabilization through supportive and directive psychotherapy with a focus on improving emotion regulation; (b) utilization of trauma-focused skills training to allow for processing and coping with traumatic events and triggers (Boon et al., 2011);

and (c) integration of memories and identities, and emotional stability under stressful conditions. No case study to date has utilized trauma-informed, phasic treatment as recommended by the ISSTD guidelines with a male with DID. Evidence from the present study provides support for the use of a multiphase treatment approach when working with individuals with DID comorbid with major depression and alcohol dependence.

M experienced statistically significant improvements in depression, anxiety, dissociation, and emotion regulation over the course of treatment. Moreover, M's alcohol use decreased substantially as treatment progressed: M's self-reported alcohol use decreased from 42.66 drinks per week (1 pint of brandy 4 days per week) to six drinks (six light beers) per week. The pattern of symptom change suggests that treatment gains were steady across treatment phases and targeted outcomes, rather than gains aligning with only a single treatment phase. The one exception to this pattern was M's level of anxiety, which evidenced a slight, nonsignificant elevation from baseline to T1 followed by a significant decline over the remaining phases of treatment. It is possible that M's slight increase in anxiety can be attributed to the fact that a discussion of the Phase 2 goal of processing traumatic experiences coincided with the T1 measurement occasion. Phase 2 often elicits an increase in symptoms while processing traumatic experiences (ISSTD, 2011). It is noteworthy that M's level of emotion regulation increased steadily over the course of treatment; his final score on the ESRQ ( $M = 1.77$ ) was only slightly worse than that of individuals in both clinical ( $M = 2.03$ ) and community ( $M = 2.70$ ) samples. The progression of change across treatment phases points to the clinical utility of a phase-based approach to treatment, particularly one in which goals (e.g., self-care) and skills (e.g., emotion regulation) established early in treatment are integrated into and practiced during later treatment phases.

Although M improved across multiple areas of functioning, he was not symptom free at the time of treatment termination. His depression and anxiety were in the mild range at the end of treatment, indicating that he was still experiencing some disturbance in mood. M continued to endorse symptoms such as little interest in sex, tiredness, loss of energy, and difficulty with sleep. In addition, despite significant decreases in dissociative symptoms over the course of treatment, M's score at discharge on the DES ( $M = 67$ ) was still slightly above the mean for the DID population ( $M = 48$ ), indicating that he still experienced symptoms of dissociation. Specifically, he still experienced difficulty with absorption (e.g., becoming absorbed in TV shows or daydreams), forgetfulness, and memory (e.g., difficulty remembering if one has done something or just thought about doing it). Given M's age (60 at treatment termination) and history of drug and alcohol abuse, some level of forgetfulness and absorption might be expected. Indeed, research has shown that these items are often endorsed by individuals in the general population

who do not meet criteria for DID (Ross, Joshi, & Currie, 1990). It is also important to note that M denied both during sessions and on the DES having many dissociative experiences, such as feeling as though his body were not his own, experiencing derealization/depersonalization, having significant memory lapses, or hearing voices in his head that were not his own. Although M's DES score was elevated at treatment termination, his self-reported symptoms during the treatment termination session indicated that he no longer met criteria for DID given the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, definition of the disorder. M denied any disruptions of identity, sense of self, or agency in his behavior and no longer experienced recurrent gaps in memory or lack of awareness about past traumatic experiences. Overall, M made significant progress over the course of treatment, in part because of his commitment to treatment and to utilizing coping skills outside of treatment, social support from his wife, and a high level of insight. M's progress may not be indicative of most individuals with DID, whose individual differences may necessitate more sessions and whose level of progress may vary.

Limitations of the current study include the single-participant case study design. Future treatment outcome studies should use larger sample sizes to gather further evidence of the efficacy of phase-based treatment. Also, the current study utilized short-term behavioral activation and harm reduction treatments to address the client's depression and substance abuse, respectively. The ISSTD guidelines highlight the need to directly address the client's self-harming and destructive behaviors, such as substance abuse, but the guidelines do not cover recommended treatment approaches for attending to those issues. Thus, the current study utilized alternative treatments such as behavioral activation and harm reduction. Future studies will need to control for the effects of other treatments incorporated into Phase 1 on the final treatment outcome data and identify which forms of treatment for related destructive and self-harm behaviors are most efficacious.

In summary, M no longer met criteria for diagnoses of depression, alcohol dependence, or DID at treatment termination. His significant improvement on targeted outcomes during Phase 1 of treatment supports the value of focusing on symptom stabilization, building the therapeutic alliance, and increasing emotion regulation skills. It is possible that a treatment approach that moved too quickly into processing trauma could have significantly damaged the therapeutic relationship or further exacerbated M's symptoms. The second and third treatment phases allowed M to work through his trauma history and begin to integrate those experiences into a solidified sense of identity. The insights made during therapy allowed M to begin to build meaningful relationships with others and to increase satisfaction in his marriage. In processing his traumatic history, M addressed long-standing issues of mistrust and violent defensiveness with women who resembled his adoptive mother, including his wife. Furthermore, the insights and skills gained

during therapy allowed M to understand and forgive himself for a long-held belief that he was responsible for his abuse as a child. Indeed, M overcame the shame he had held since childhood around his sociocultural identity, and he was able to explore and engage positively with his ethnic identity as a Native American at the time of termination. Overall, the current case study finds the utilization of trauma-focused, phase-based treatment for DID effective and warranted for cases of complex trauma with comorbid disorders.

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