UNIVERSITY OF SOUTHAMPTON

FACULTY OF HUMAN AND SOCIAL SCIENCES

School of Psychology

Volume 1 of 1

Formulating Dissociative Identity Disorder in Clinical Practice: A Q-study

by

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Thesis for the degree of Doctor of Clinical Psychology

Word count:

Literature Review: 9845 (without tables)

Empirical Paper: 9968 (without tables)

Total: 19813

March 2016

UNIVERSITY OF SOUTHAMPTON

ABSTRACT

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FORMULATING DISSOCIATIVE IDENTITY DISORDER IN CLINICAL PRACTICE: A Q-STUDY

Laura Louise Davis

Dissociative Identity Disorder (DID) is a complex and often poorly understood dissociative disorder, characterised by disruption of identity with the presence of two or more distinct personality states (APA, 2013). Several theoretical models have been proposed to provide a framework within which to understand this client group. However, little is known about the conceptualisation of this presentation by therapists working clinically with this population. The current study aimed to explore the subjective opinions of therapists regarding the conceptualisation of DID in clinical practice. Q-methodology was used in order to operationalise and analyse these subjective beliefs. A Q set of 54 statements was created from previously reported interview data (Stokoe, 2014) with clinicians who had significant experience in working with clients with DID. The Q set was then administered to 18 therapist participants, who were asked to Q sort the statements in relation to how essential the items were conceptualising or 'formulating' DID. Factor analysis identified three factors, suggesting the presence of three differing perspectives regarding the 'essential' features of the formulation of DID. Factor A focused on "Trauma, attachment and the internal system", whilst Factor B, "The conscious experience of DID", prioritised the everyday experience of DID and Factor C emphasised the "Helpful aspects of DID: Compartmentalising emotions to enable functioning". There was consensus across all three factors regarding the 'least essential' items to include in their formulations. However, the identification of three statistically distinct factors indicates the existence of differing viewpoints amongst the therapist participants.

Table of Contents

List of Figures

List of Tables

DECLARATION OF AUTHORSHIP

I, LAURA LOUISE DAVIS

declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

FORMULATING DISSOCIATIVE IDENTITY DISORDER IN CLINICAL PRACTICE: A Q-STUDY

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission

Signed:

Date:

Acknowledgements

I would like to thank the therapists who so kindly donated their time and expertise to participate in my study. This was no small undertaking and I am immensely grateful.

Thank you to my supervisors, Drs. Lusia Stopa, Tess Maguire and Nicole Stokoe. I have really appreciated your support, guidance and patience throughout this marathon of a project!

I would also like to thank my manager, Dr. Alison Pearce. Your empathy, flexibility and pragmatism have made juggling everything that little bit easier.

To my family and friends: Thanks for waiting for me! I've missed you.

Finally, to Damo, I couldn't have done it without you. Words don't cut it, but thank you.

Chapter 1: Systematic Literature Review

The effectiveness of psychotherapeutic treatment of Dissociative Identity Disorder

1.1 Introduction

1.1.1 Dissociative Identity Disorder

Dissociative Identity Disorder (DID) is a polysymptomatic disorder, which is characterised by affective, somatoform and post-traumatic symptoms as well as dissociative symptoms (Coons, 1998). Individuals with DID, also frequently present with a range of Axis-I and Axis-II comorbidities. DID was initially introduced into diagnostic criteria under the label of Multiple Personality Disorder in the DSM-III (APA, 1980). The term DID was introduced in the DSM-IV (APA, 1994) and has been carried through into the DSM-5 (APA, 2013), where it is defined as

> Disruption of identity characterized by two or more distinct personality states…The disruption of marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual. (APA, 2013, p. 292).

In the ICD-10 (WHO, 1991), it is classified under the dissociative disorders but is still referred to as Multiple Personality Disorder where it is defined as the:

> Apparent existence of two or more distinct personalities within an individual, with only one of them being evident at a time. Each personality is

> complete with its own memories, behaviour, and preferences; these may be in marked contrast to the single premorbid personality. (p. 160).

For an outline of the diagnostic criteria, see appendix A.

The prevalence rate of DID has been estimated as .01 to 5% in the general population (Ross, 1997; Johnson, Cohen, Kaen & Brook, 2006), between 1-21% in the psychiatric inpatient population (e.g. Foote, Smolin, Kaplan, Legatt & Lipschitz, 2006; Sar, Koyuncu, Ozturk et al, 2007) and 12-38% among outpatients (e.g. Foote et al, 2006). However, despite significant prevalence rates, evidence suggests that DID is often misdiagnosed and as such may in fact be underrepresented within services.

1.1.2 Dissociative Disorder Not Otherwise Specified

In the (now obsolete) DSM-IV and DSM-IV-TR criteria, DDNOS was outlined as category for the small number of people who have a dissociative condition, which does not fulfil the criteria for any specific dissociative disorder (APA, 1994; APA, 2000). However, research suggests that rather than being a category with which to diagnose a limited number of outliers, it is in fact consistently one of the most prevalent dissociative disorders. An American longitudinal study reported the prevalence of DDNOS was 5.5% in the general population compared to 1.5% for DID (Johnson, Cohen, Kasen & Brook, 2006) and in a Turkish study the prevalence of DDNOS was 8.3% in females in the general population as opposed to 1.1% for DID in the same population (Şar, Akyüz & Doğan, 2007).

1.1.3 Limitations of Diagnostic Criteria

Critics argue that the monothetic DSM criteria overlooked the complexity and polysymptomatic nature of DID (Dell, 2001; Spiegel et al., 2011). They suggest that the criteria give rise to high levels of false negatives, which results in a reduced baseline for DID as well as an unacceptably high number of diagnosed cases of DDNOS (Spiegel, 2011). There is evidence of significant overlap in symptomatology for DID and DDNOS (ISSTD, 2011). The majority of DDNOS diagnoses represent cases who fulfil partial criteria for DID (Dell, 2001).

In response to concerns regarding the overuse of DDNOS as a diagnosis, the current diagnostic criteria (DSM-5; APA, 2013) have broadened the criteria for DID. Amongst the changes made was the inclusion of self-reported symptoms (the previous criteria required the clinician to observe signs and symptoms of DID). This will likely reduce the number of case of DID that are misdiagnosed as DDNOS due to clinicians not having observed the signs and symptoms of DID, which often are not obvious to the onlooker.

1.1.4 Psychological models of DID

A number of psychological models attempt to make sense of DID. Broadly, these models can be understood as Trauma Models (e.g. Ross, 2000), which postulate that DID develops as a defense against severe and enduring trauma, and Sociocognitive Models (e.g. Spanos, 1994), which argue that DID is a socially constructed condition, which is selectively reinforced by social and cultural influences. There is an ongoing debate in the literature regarding the utility of different models of DID and a consensus has yet to be reached.

1.1.5 Treatment Guidelines

The International Society for the Study of Trauma and Dissociation (ISSTD) have published guidelines for the treatment of DID, which are currently on their third revision (2011). The guidelines identify a number of goals for treatment, highlighting the importance of building awareness of and sharing responsibility between different identities in order to achieve integrated functioning. They also identify that the “most stable treatment outcome is final fusion – complete integration, merger, and loss of separateness – of all identity states” (p. 195). However, they also acknowledge that this level of integration may not be achievable or desirable for a considerable number of DID patients.

The ISSTD guidelines propose a phase-oriented, sequenced approach to treatment: Stabilising, building safety and reducing symptoms (phase one); trauma focused work (phase two); and integration and rehabilitation (phase three). They advise that individual outpatient psychotherapy is the primary treatment modality for clients with DID, and that such treatment frequently requires long-term input over several years. Inpatient treatment however, can also be necessary for brief crisis management, when clients are experiencing overwhelming symptoms or are at risk of harming themselves or other people.

1.1.6 Previous Reviews

Two existing reviews have considered the treatment of DID, however, both included single case studies and one included cost effectiveness studies as well as treatment guidelines. In their review of the literature, Brand, Classen, McNary and Zaveri (2009) specifically examined treatment outcomes across a range of dissociative disorders. They identified a number of case studies, case series and empirical studies reporting systematic outcome data relating to DID, DDNOS, DPD and dissociative seizures. However, their conclusions were not specific to DID and the review was limited by the researcher's lack of systematic, and therefore replicable, methodology.

In a more recent review, Brand and colleagues (2014) examined evidence for and against the claim that DID treatment causes harm; reviewing treatment guidelines, and treatment studies. However, they did not report the full process for retrieving articles (for example, omitting information regarding their exclusion and inclusion criteria). Furthermore, whilst the focus was on DID, the review examined a range of articles and was not limited to outcome studies.

Despite the presence of review articles which consider outcome studies for DID, there is a lack of systematic and thus replicable methodology. Neither article focused specifically on treatment studies of DID reporting systematic data, nor did they highlight the evidence for variables, which may influence treatment outcome. The existing articles review a broad range of papers and as such it is beyond their scope to critically evaluate the methods used in any depth. There is a need for an up to date review of the literature in order to better understand the effectiveness of treatment outcomes in this complex patient group.

1.1.7 Aim of the Current Review

The aim of the current systematic review is to provide a comprehensive synthesis of the available psychotherapeutic treatment studies reporting systematic outcome data. It will also consider the evidence for variables that may influence treatment outcomes. DID is often poorly understood and despite significant prevalence rates, research suggests that only just over half of clinical psychologists in the UK have identified seeing patients with the diagnosis (Ost, Wright, Easton, Hope & French, 2011). The current review will bring together and critique the empirical evidence in order to extend clinicians' knowledge and inform their treatment of DID.

1.1.7.1 Review objectives

1. To review articles reporting psychotherapy outcome data using standardised measures for DID and DDNOS in a systematic and thus replicable way
2. To review the variables that may influence treatment outcome
3. To critically evaluate the empirical findings
4. To consider the clinical implications of these findings

Due to the significant overlap in symptoms between DID and DDNOS and given that the majority of papers included in this review report outcome data for participants who received a diagnosis prior to the publication of the DSM-5, the current review includes patients with diagnoses of both DID and DDNOS.

1.2 Method

1.2.1 Search Strategy

Electronic bibliographic databases (MEDLINE, PsycINFO) were searched for peer-reviewed, empirical studies published in English between the years 1994 and 2014. The search terms used for this review were adapted from those used by Brand and colleagues (2009) in their review of dissociative disorders treatment studies. Unlike the previous review however, the present review focused only on papers where data was reported for participants with a diagnosis of DID or DDNOS. As such, the key search terms used were: *dissociative identity disorder, dissociative disorder not otherwise specified, complex dissociative disorder* and *multiple personality disorder c*ombined with *treatment, therapy, psychotherapy and intervention*.

1.2.2 Inclusion and Exclusion Criteria

Papers were included if they conformed to the following requirements: treatment outcome papers; written in English; published in an academic journal; published between 1994 and 2015; which report systematic data. Criteria were initially intentionally liberal in order to maximise the number of papers identified from this developing research topic. Methodological quality criteria were then considered; case studies or self-reports, commentaries or correspondence, and studies focused on child samples were excluded from the review.

1.2.3 Information Extracted

For each study, the researcher extracted data relating to: (a) study design; (b) sample characteristics, including sample size and range diagnoses within the sample; (c) intervention characteristics, including the duration and modality of treatment; (d) instruments used to measure outcomes; (e) overall conclusions; (f) limitations of the study, including sources of bias (e.g. selection bias or attrition). The quality of studies was assessed using the Grades of Recommendation, Assessment, Development and Evaluation (Oxman & GRADE Working Group, 2004): The methodology, design and results of studies as well as sources of bias were all considered when grading the quality of studies.

1.3.1 Overview

Excluding duplicates, 212 studies were identified with the initial search, which was reduced to 21 articles following screening of titles. Abstracts were then checked in order to apply inclusion and exclusion criteria, which resulted in 21 studies. The full text articles were subsequently scrutinised according to the same criteria, which resulted in 14 articles. Finally, the references of these articles were reviewed, generating a further 5 full-text articles for inclusion in the review. Thus 19 articles were included in the final review. Studies were excluded if full text articles were unobtainable; the sample did not include participants with a diagnosis of DID; the paper used a child sample; or if there were no quantitative pre- and post-treatment outcome measures used.

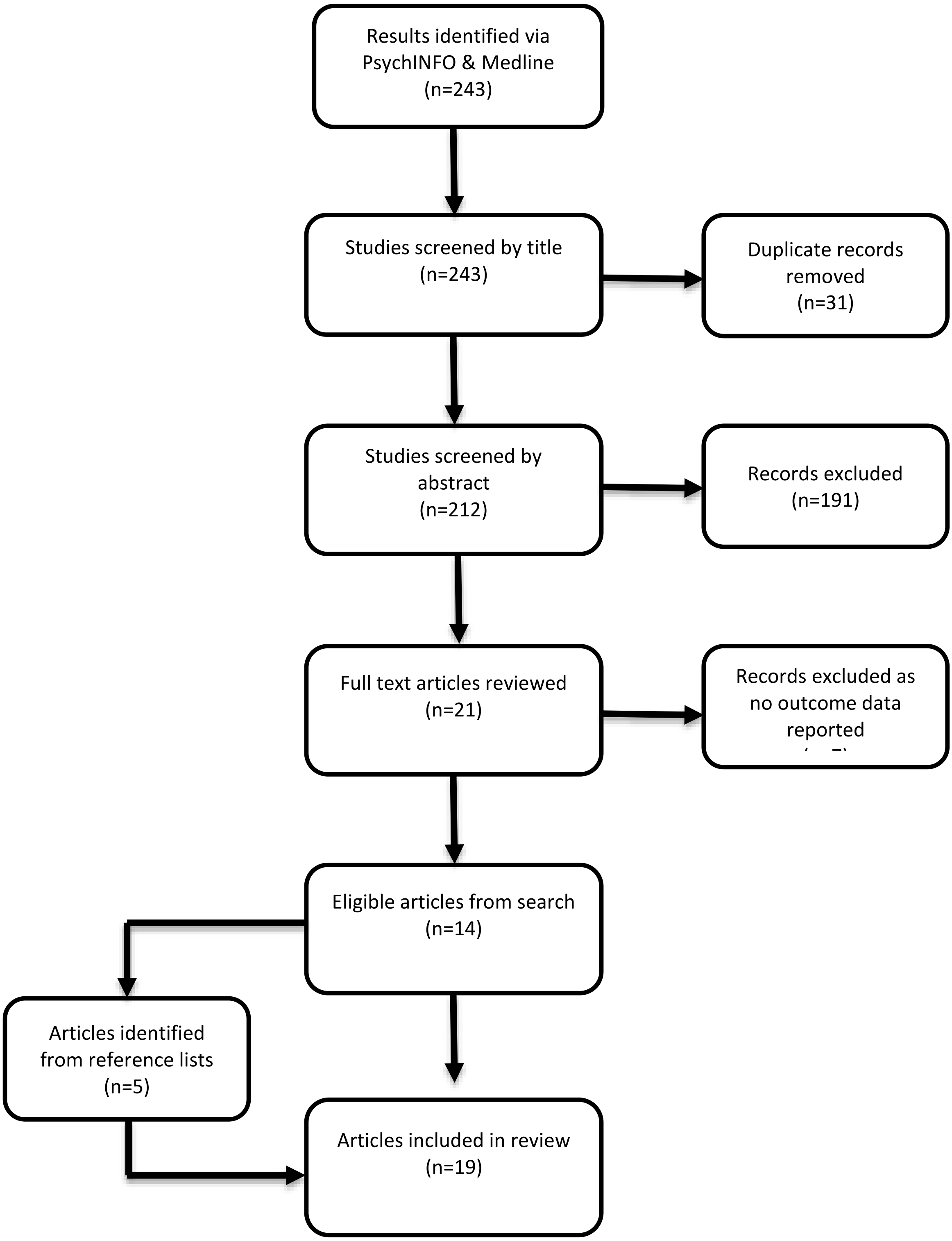

Figure 1. Systematic literature search flow diagram.

1.4 Overview of Results

1.4.1.1 Descriptive Summary of Studies

The 19 articles reported data from eight outcome studies. Of these, eight articles reported outcomes from participants from the USA; three from Norway; and eight utilised an international sample of therapists and patients from 21 different countries across North America, Europe, Asia, and South America. Sample sizes ranged from 12 to 280 patients. Where provided, the mean age of participants ranged from 25.6 – 45.5 years. The overall mean age was 39.9 years. All of the papers included in this review reported a majority of female participants, with the proportion of female participants ranging from 77% - 100%. Across all articles that reported the gender of participants, there was an average of 93.31% female participants.

All 19 papers reported observational designs: one case series; four cross-sectional and 14 longitudinal naturalistic designs. Nine papers examined inpatient treatment and 10 looked at outpatient treatment of DID and DDNOS. A range of psychometric outcome measures were used: 11 articles used patient self-report measures only and eight used a combination of patient and therapist self-report measures. A total of 20 standardised measures were used across all studies, reflecting seven constructs (see table 1). Sixteen articles used measures of dissociation; 14 looked at general distress; 13 measured PTSD symptomatology; 10 measured depression; 4 measured interpersonal problems; 4 measured integration; 3 measured suicidal ideation; 3 measured behavioural problems; 3 measured adaptive function; 2 measured hopelessness; and 1 measured alexithymia.

Table 1. Validated Measures used for each construct in the review.

Construct	Sub-construct		Instrument
Psychiatric Distress	General Distress		Symptom Check List 90 –Revised (SCL-90-R;Derogatis, 1992)
			Symptom Check List -45 (SCL-45; Alvir, Schooler, Borenstein, Woerner, & Kane, 1987)
			Minnesota Multiphasic Personality Inventory (MMPI-I; Dahlstrom, Welsh & Dahlstrom, 1972)
			Millon Clinical Multiaxial Inventory-II (MCMI-II; Millon, 1987)
		Depression	Beck Depression Inventory (BDI; Beck, A. T., Steer, R. A., & Brown, G. K. (1996)
			Hamilton Depression Rating Scale (HRDS; Rehm & O'Hara, 1985)
		Hopelessness	Beck Hopelessness Scale (BHS; Beck & Steer, 1988)
		Alexithymia	Toronto Alexithymia Scale (TAS; Taylor et al., 1988)
		Suicidal Ideation	Beck Scale for Suicidal Ideation (BSSI; Beck & Steer, 1991)
	Dissociation		Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986)
			Dissociative Experiences Scale –II (DES-II; Bernstein & Putnam, 1986)
			Dissociative Experiences Scale – Taxonomic (DES-T; Waller SC Ross, 1997)
			Somatoform Dissociation Questionnaire-20 (SDQ-20; Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden, 1996)
	Interpersonal difficulties		Inventory of Interpersonal Problems-Circumplex (IIP-C; Pederson, 2002) Norwegian version
	Post-traumatic Stress		PTSD Checklist – Civilian Version (PCL-C; Weathers, Litz, Huska, & Keane, 1994)
			Impact of Events Scale (IES; Horowitz, Wilner, & Alvarez, 1979)
			Mississippi PTSD Scale – Civilian Version (Vreven, Gudanowski, King & King, 1995)
	General Functioning		Global Assessment of Functioning (GAF; American Psychological Association, 2000)
			Life Experiences Survey (LES; Sarason, Johnson, Seigel, 1978)
	Therapeutic alliance		Working Alliance Inventory – Therapist form (WAI-T; Horvath & Greenberg, 1989; Hatcher, 1999)
			Combined Alliance Short Form – Patient Version (CASF-P; Hatcher, 1999; Hatcher & Barends, 1996; Hatcher, Barends, Hansell, & Gutfreund, 1995).

1.5 Results

Results are presented in narrative form, supplemented with tabulated information where necessary. Effect sizes are reported for inpatient and outpatient studies (tables 4 and 6 respectively) where stated or where the appropriate data was provided with which to calculate them. The reviewer used the Hedges' *g*[1] statistic because it adjusts for biases due to small sample sizes and is therefore more conservative. The ISSTD guidelines recommend outpatient psychotherapy for patients with DID and suggest that inpatient treatment is best used for stabilization and crisis management. As such the articles are categorised into inpatient (table 2) and outpatient (table 3) studies to investigate the outcomes of each treatment approach and to enable the clear synthesis of results. Nine papers reported the outcomes of inpatient treatment of DID and 10 reported outcomes of outpatient treatment. Many studies assess multiple outcomes, (e.g. nine articles measure symptoms of both dissociation and depression), thus to avoid repetition, descriptions of the studies' designs are reported on the first reference to the article only.

1.5.1 Inpatient Studies

Nine articles reported the effectiveness of nonrandomised inpatient treatment for patients with DID. The proportion of participants with diagnoses of DID or DDNOS ranged from 41.1% – 100% across the 19 studies. Only three articles reported data from a comparison group and none used a control group. Five papers focused specifically on acute stabilisation and building safety during inpatient admissions and reported data from the same group of researchers, across three different samples in the USA (Ellason & Ross, 1996; Ellason & Ross, 1997; Ellason & Ross, 2004; Ross & Ellason, 2001; Ross & Haley, 2004). Four papers focused on inpatient treatment which specifically targeted DID symptomatology: Three of the four papers reported data from one outcome study from Norway (Jepsen, Langeland & Heir, 2013; Jepsen, Langeland, & Heir, 2014a; Jepsen, Langeland, Sexton & Heir, 2014) and one reported pilot data from a study in the USA (Choe & Kluft, 1995). All nine inpatient studies included a combination of individual psychotherapy and group therapy with admissions ranging from an average of 18.2 days

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[1] $g = \frac{\bar{x}_1 - \bar{x}_2}{s*}$, where s* is pooled variance

– three months.

1.5.1.1 Measures of Psychiatric Distress

For the purpose of this review, the term psychiatric distress includes measures of general distress, depression, PTSD, hopelessness and suicidal ideation. Six inpatient studies measured psychiatric distress (Ellason & Ross, 2004; Ross & Ellason, 2001; Ross & Haley, 2004; Jepsen, Langeland & Heir, 2013; Jepsen, Langeland & Heir, 2014; Jepsen, Langeland, Sexton & Heir, 2014). All six studies reported a measure of general psychiatric distress (SCL-90-R); five also used a measure of depression (BDI; HDRS); two measured suicidal ideation (BSSI); two measured hopelessness (BHI) and one measure PTSD (IES). All six papers reported that inpatient treatment was associated with reductions across all measures of distress.

Ross and Ellason (2001) reported preliminary data for 50 patients (74% DID, 8% DDNOS) undergoing acute stabilisation treatment in an American inpatient trauma program. The average length of stay for the program was 19.2 days. Treatment was associated with significant reductions in symptoms of general distress, depression, hopelessness and suicidal ideation, with large effect sizes. Despite these promising results, using well validated measures, there are a number of reasons why it is hard to make firm conclusions from this study. Firstly, the lack of comparison or control group means that it is not possible to attribute causality. Participants recruited to the study were not consecutive admissions, but rather were the first 50 to complete all measures at both admission and discharge. As such, the sample is small in comparison to the overall number of patients admitted during the time period of the study (391), moreover it is non- random and therefore likely biased. Finally, the authors provided very little information regarding the specific treatment program, and as such it is hard to establish what exactly the treatment was.

Ross and Haley (2004) extended this methodology, for a second sample of 60 consecutive admissions, 46 (52% DID, 28% DDNOS) of whom completed follow-up measures three months post-discharge. Patients were admitted to the hospital-based trauma program for acute stabilisation over an average stay of 18.2 days. Treatment was based on the trauma model (Ross, 2000) and specifically targeted depression, suicidal ideation and hopelessness. Cognitive behavioural and experiential therapies were delivered via a combination of group and individual therapy. Significant reductions were reported from admission to discharge on measures of general psychiatric distress, depression, hopelessness and suicidal ideation, all of which were sustained at three-month follow-up. Large effect sizes were reported on all measures from admission to both discharge and follow-up. This study improved upon the methodology of Ross and Ellason (2001), by reducing possible selection bias and including follow-up data. It also provided information regarding the treatment protocol. However, as with the previous study, it is not possible to attribute causality.

Significant reductions in the symptoms of general psychiatric distress were replicated in a third sample of patients participating in a two-year follow-up study (Ellason & Ross, 2004). Patients were initially admitted for acute inpatient treatment and subsequently treated as outpatients in the community. The authors compared the follow-up results to those of the previous two studies and found similar scores on the SCL-90-R across the three samples, both at baseline and post- treatment whether at discharge, three-month follow-up or two-year follow-up. They concluded that this is a replicable result. However, it is important to note that this conclusion was based upon descriptive rather than statistical analysis of the data and therefore further statistical data is required in order to enable meaningful comparisons between groups.

A Norwegian study investigating the outcomes of a three-month inpatient treatment program for early sexually abused adults (Jepsen, Langeland & Heir, 2013; Jepsen, Langeland & Heir, 2014; Jepsen, Langeland, Sexton & Heir, 2014) also demonstrated significant reductions in the symptoms of general psychiatric distress, depression and PTSD. The sample for this study consisted of 56 consecutive admissions, who were assigned to one of two mutually exclusive diagnostic subgroups: 23 (41%) comprised the complex dissociative disorder (CDD) group having received a diagnosis of DID or DDNOS-1 (DDNOS, which closely resembles DID); and 33 (59%) comprised the non-CDD group. Treatment was based on Herman's (1992) first-phase trauma program, which targeted trauma-related symptoms and included psychodynamic and cognitive behavioural individual and group therapy and supportive interventions. There was also an emphasis on relational work within the treatment program. Importantly, treatment did not provide acute stabilisation for psychiatric emergencies; instead it offered a planned admission, with an average period of 11.2 months from initial assessment to hospital admission. Outcome data was collected at four time-points: pre-admission, admission, discharge and one-year follow- up.

Patients with a CDD consistently demonstrated higher symptom levels than their non-CDD counterparts, across all measures of distress and all time points. At follow-up, although patients with a CDD were significantly more symptomatic than those without a CDD, both groups demonstrated parallel improvement. Effect sizes for the CDD group were small and medium for general distress and PTSD respectively and were medium for both from admission to follow-up. The effect size for depression was negligible from admission to discharge and small from admission to follow-up. In contrast, the non-CDD group demonstrated medium to large effect sizes across all measures of distress from both admission to discharge and to follow-up, suggesting that patients with DID or DDNOS require more time to make treatment gains. This study has several methodological strengths including the presence of a comparison group, the collection of pre-care data, a low drop-out rate from pre-care to admission and the fact that initial diagnosis of a CDD was given at entry to the study. However, the sample size is small, particularly when considering the subgroups and may have resulted in underpowered analyses. Furthermore, whilst the comparison group does enable the authors to assess the treatment progress of patients with DID and DDNOS against those without, the attribution of causality is precluded by the lack of a control group.

Whilst there is compelling evidence that inpatient treatment of DID is associated with reductions in symptoms of psychiatric distress, there are a number of methodological issues that confound these findings. Three of the six inpatient studies reported data from acute inpatient stabilization programs and as such do not include any pre-treatment outcome measures. It may be that at the point of admission, patients are experiencing heightened symptomatology and therefore reported reductions in symptoms of distress may represent regression to the mean as opposed to treatment gains per se. Furthermore, none of the studies were randomised or controlled, thus limiting the conclusions that can be drawn from the results. However, given that symptom reductions are consistently reported across a range of samples, time-points and designs, this association appears to be replicable and certainly warrants further attention.

1.5.1.2 Dissociative symptomatology

Six of the nine inpatient studies measured dissociation. Of these, three described inpatient treatments for acute stabilisation, and three described planned hospital admissions, which were not for emergency admissions. Only one intervention reported specifically targeting dissociation (Choe & Kluft, 1995). Four studies reported significant reductions in dissociative symptoms, whereas one failed to find such a reduction, and one reported improvement but at significantly lower level for patients with CDD than those without CDD.

In a study of acute inpatient stabilisation, significant reductions in dissociative symptoms were recorded both at discharge and two-year follow-up (Ellason & Ross, 1997). This finding was replicated by Ross and Haley (2004), in their study of 46 patients (52% DID, 28% DDNOS) admitted to an inpatient trauma program for an average stay of 18.2 days. The program offered acute stabilisation treatment and did not specifically target dissociative symptomatology, although it did work directly with different self-states of patients with DID. This study reported significant reductions in dissociative symptoms, with a large effect size

demonstrated from admission to discharge. These reductions were also sustained at three-month follow-up.

A further study of acute inpatient stabilisation (Ross & Ellason, 2001) failed to confirm these results, reporting no significant reduction in dissociative symptomatology as measured by the DES. Whilst the samples in Ross and Ellason (2001) and Ross and Haley's (2004) inpatient studies are similar in size, mean age and mean inpatient stay, they differ in respect of the clinical diagnoses of the patients in each: Ross & Ellason (2001) reported that their sample consisted of 74% DID, 8% DDNOS and 18% major depressive disorder with psychotic features whereas the sample utilised by Ross & Haley (2004) reported 52% had a diagnosis of DID, 28% DDNOS and 30% other dissociative disorders. It is not possible to say whether this difference accounts for the variance in dissociation outcomes, however, it does highlight the need for additional studies to further elucidate this relationship.

Three papers focused on the outcome of non-emergency inpatient treatment for DID (Choe & Kluft, 1995; Jepsen, Langeland & Heir, 2014; Jepsen, Langeland, Sexton & Heir, 2014). Two papers reported outcomes from one sample of patients attending a three-month inpatient program for early sexually abused adults. Jepsen and colleagues (Jepsen, Langeland & Heir, 2014) studied the treatment outcomes of a three-month program of inpatient trauma therapy for a group of 56 early sexually abused adults, of whom 41% had a complex dissociative disorder (CDD: a diagnosis of DID or DDNOS). Whilst the treatment program specifically targeted dissociation, it did not address severe dissociative pathology involving memory or identity alteration, nor did it target somatoform dissociation. Of the whole sample, 14.5% demonstrated reliable change at discharge and 25.5% showed reliable change at 12-month follow-up. However, when analysed separately, fewer CDD patients demonstrated reliable change in dissociative symptoms than did their non-CDD counterparts (Jepsen, Langeland, Sexton & Heir, 2014).

Only one inpatient study specifically targeted the dissociative pathology of DID (Choe & Kluft, 1995). In this pilot study, dissociative symptoms were examined in 21 of 66 female DID patients consecutively admitted to an inpatient trauma program. Patients were selected for inclusion in the study if they had been treated in the program for at least four weeks; a cut-off chosen so as to exclude those patients who were admitted for assessment only or for acute stabilisation. Treatment included attendance at a number of groups as well as individual inpatient psychotherapy, which was usually facilitated with hypnosis. The researchers administered the DES within 48 hours of admission and again at discharge from the treatment program. They reported significant overall reductions on the DES, as well as on the individual subscale scores for absorption factor and depersonalisation/derealisation factor, however there was also a significant increase on the amnesia factor score from admission to discharge. The study was a pilot and as such was limited by the small, non-random sample. The authors failed to report the time at which outcomes measures were administered during treatment, thus limiting conclusions that can be drawn from the results. However, a notable strength of the study was in its confirmation of diagnoses using the SCID-D-R and the specific targeting of dissociative pathology in DID.

1.5.1.3 Interpersonal problems

Three articles reporting data from one study measured changes in interpersonal functioning following inpatient trauma treatment (Jepsen, Langeland & Heir, 2013; Jepsen, Langeland & Heir, 2014; Jepsen, Langeland, Sexton & Heir, 2014). A group of 48 adults with a history of CSA (46% CDD) attending an inpatient trauma program showed significant improvement in interpersonal problems from admission to discharge and these improvements were maintained at one-year follow-up (Jepsen, Langeland & Heir, 2013). At discharge 29.1% patients demonstrated reliable change and this increased to 36.4% at follow-up. However, when the data was analysed according to subgroup membership, fewer patients with a CDD demonstrated reliable change in interpersonal problems than those without (Jepsen, Langeland, Sexton & Heir, 2014). These results suggest that inpatient treatment that emphasises relational work, may be associated with improvements in interpersonal problems. However, given that these results are derived from only one sample of participants, further research is needed to ascertain if this finding is replicated.

1.5.1.4 Variables that influence treatment outcome

1.5.1.4.1 Integration status.

Three articles following the same group of patients investigated the role of initial integration as a variable that influences the outcome of inpatient treatment (Ellason & Ross, 1996; 1997; 2004). In all three studies, therapists judged patients' integration status according to Kluft's (1984) six criteria for stable integration: patients must demonstrate continuity of present memory, no behavioural signs of separate identities; a lack of different self-states during hypnosis; a unified self-perception; evidence that the patient has incorporated hitherto disconnected attitudes and awareness; and transference phenomena must reflect the unified self.

Integrated patients displayed lower initial symptoms of depression than non-integrated patients in all three studies. In their 1996 study, Ellason and Ross found that integrated patients showed the greatest meaningful change on several scales of MCMI-II: demonstrating categorical change from a clinical problem to the mean score for a clinical population on the Avoidant, Passive-Aggressive, Self-defeating, Borderline, Major Depressive and Dysthymia scales. Integrated patients also showed significantly greater improvements on measures of dissociation and distress (Ross & Ellason, 1997). At two-year follow-up integrated patients continued to demonstrate significantly lower levels of general distress than their non-integrated counterparts (Ellason & Ross, 2004).

1.5.1.4.2 Initial dissociation.

Two inpatient studies examined the impact of initial levels of dissociation upon treatment outcomes in the same sample of patients (Jepsen, Langeland & Heir, 2013; Jepsen, Langeland & Heir, 2014). Jepsen, Langeland and Heir (2013) used the DES-T to investigate the outcomes of those patients who were experiencing pathological levels of dissociation. Pre-admission DES-T membership significantly predicted greater psychiatric and interpersonal symptomatology at discharge. Using a hierarchical regression, a significant interaction was identified between initial dissociation and change in interpersonal functioning before commencing treatment, which predicted greater general psychiatric symptoms and interpersonal problems at both discharge and follow-up.

Treatment outcomes in this sample were also compared according patients' scores on two further measures of dissociation: somatoform and psychoform dissociation (Jepsen, Langeland & Heir, 2014).Somatoform dissociation manifests as disruptions to the integration and perception of physical sensation and function, whereas psychoform dissociation involves disruption of the integration of cognition and affect. Patients were assigned to one of three mutually exclusive groups: a high somatoform and psychoform dissociative group; a high somatoform (low psychoform) dissociative group; and the non-dissociative group (low on both somatoform and psychoform dissociation). Patients who were in the high somatoform and psychoform group reported higher levels of PTSD, general distress and destructive behaviours (self-mutilation, eating problems and suicidality) at admission than the high somatoform dissociation group. At follow-up, they demonstrated significantly fewer reliable improvements on at least one symptom measure at discharge than both the high somatoform dissociative group and non-dissociative group. However, there was no significant difference between the groups in reliable improvement at follow-up and they did not differ in the frequency of reliable deterioration at discharge or follow- up.

Table 2. Inpatient treatment studies.

Reference & quality rating	Study design	Sample characteristics	Intervention characteristics	Outcome measures	Overall findings	Variables that influence treatment outcome	Strengths	Limitations
Choe, & Kluft (1995) IV: - EV: -	Pilot, pre- & post-design	21 female, adult ps with DID (then MPD) Mean age = not reported USA	**Targets**: dissociative pathology **Duration**: at least 4 weeks **Modality**: Individual psychodynamic psychotherapy usually with hypnosis & 12 groups per week	DES within 48h of admission & discharge	At discharge: Improvement on DES total score, Absorption & depersonalisation/ derealisation factors. Worsening on Amnesia factor	n/a	Diagnoses confirmed with DDIS & unanimous consensus of 3 clinicians	? validity of baseline DES scores (different instructions at admission & discharge) Non-random sampling: 21 of 66 consecutive discharges met inclusion criteria
Ross & Haley (2004) IV: + EV: -	Follow-up study	46 psychiatric ps (44 females) 52% DID, 28% DDNOS, 11% Dissociative Amnesia, 7% Depersonalisation Disorder & 2% Dissociative Fugue Mean age = 36.1 years. USA	**Targets**: acute stabilisation **Duration**: Average stay 18.2 days **Modality**: Based on trauma model (Ross, 2000), focus on attachment & trauma. CBT & experiential therapies. 35 hrs/week group & 3hrs/week individual therapy	Admission, discharge & 3-month follow-up: SCL-90-R, BDI, BSSI, BHI, DES	Significant improvement on all measures at discharge. Improvements maintained at 3-month follow-up.	n/a	Diagnoses confirmed DDIS (self-report version)	Attrition: 23% did not complete all outcome measures. Reasons not given. ? validity of self-report DDIS
Ross & Ellason (2001)	Follow-up study	50 Psychiatric ps (48 female), 37 DID, 4 DDNOS, 9	**Targets**: Acute stabilisation	Admission & discharge:	Significant improvements on SCL-90-R, BDI, BSSI & BHI. No sig change in DES scores across treatment.	n/a	Diagnoses confirmed: DDIS (self-report version)	Sampling bias: 50 out of 391 admissions in 22 months.

IV: - EV: -		Major Depressive Disorder with Psychotic Features, Mean age 38.6 years USA	**Duration**: Average stay 19.5 days Modality: Inpatient & partial hospitalisation trauma program	SCL-90-R, BDI, BSSI, BHI, DES	No significant correlations between length of stay & treatment outcomes			? validity of self-report DDIS Limited information regarding treatment modality
Ellason & Ross (1997) IV: + EV: -	Follow-up study	135 DID ps at admission 54 of 135 DID ps completed DDIS at admission & follow up (88.9% female) Mean age: 39.2 years USA	**Target**: Acute stabilisation **Duration**: not reported **Modality**: Inpatient trauma program. 50 (92.6%) consistently had outpatient treatment following discharge (no details given)	During treatment & at 2-year follow-up: SCID-I & II, BDI, HDRS, DES DDIS	12 (22.2%) participants reached integration. At follow-up: All ps showed improvement in symptoms of mood & anxiety disorders, Schneiderian first-rank symptoms, dissociative symptoms, & somatization	At baseline: Integrated ps had lower scores on measures of depression (HDRS & DDIS). At follow- up: Integrated ps significantly more improved on all variables	Diagnoses confirmed: DDIS, clinical diagnosis based on DSM-III-R & proposed DSM-IV criteria & 'behavioural evidence' of DID DDIS at follow-up Combination of therapist and self-report measures	Attrition: 81 (60%) lost to follow- up
Ellason & Ross (1996) IV: - EV: -	Follow-up study	96 DID ps at admission, 35 (31 female) at follow-up, mean age: 39.7 years USA	**Target**: acute stabilisation **Duration**: not reported **Modality**: Inpatient trauma program – no further information	During treatment & at 2-year follow-up: MCMI-II,	8/35 ps (22.9%) achieved integration during 2-year follow-up Improvement on raw scores for: Self-defeating, Borderline, Paranoid, Anxiety, Somatoform, Dysthymia, Alcohol dependence, Drug dependence, across both integrated & non-integrated ps. Clinically meaningful base rate reductions on Self-defeating, Borderline, Avoidant, Passive-aggressive, Anxiety, Dysthymia & Major Depression	Most meaningful changes (reduction from the cut-off for clinical problem [BR of 75] to the mean for clinical ps [BR of 60]) occurred for integrated ps on the Avoidant, Passive-Aggressive, Self-Defeating, Borderline, Major Depression, & Dysthymia scales. Integrated ps scores on the Dependent, Compulsive, Anxiety Disorder & Alcohol Dependence scales, which did not initially exceed the clinical cut-off approached the non-clinical cut-off (30)	No sig differences in baseline characteristics of those ps who participated in the follow-up & those who did not	Attrition: 61 (64%) were lost to follow-up No statistical comparisons between integrated and non-integrated ps
Ellason & Ross (2004) IV: + EV: -	Follow-up study	101 ps with DID & 36 (31 female) at follow-up.	**Target**: acute stabilisation **Duration**: not reported	During treatment	Significant reductions in average GSI scores from baseline to 2-year follow-up	GSI of SCL-90-R was significantly lower for integrated than non-	No sig differences in baseline characteristics of those ps who participated in the	Attrition: Only 62/135 (45.9%) could be located & 36 who had completed

		Mean age: 39.6 years at follow-up USA	**Modality**: Inpatient trauma program – no further information	& 2-year follow-up: SCL-90-R	Significant reductions on all subscales (somatisation; obsessive-compulsive; interpersonal sensitivity; depression; anxiety; hostility; phobic anxiety; paranoid ideation; psychoticism) 9 (25%) ps reached integration (met all 6 of Kluft's (1984) criteria; negative for DID on DDIS; therapist corroboration).	integrated ps at 2-year follow-up) & all subscales were significantly lower	follow-up & those who did not	SCR-90-R agreed to be interviewed Lack of information regarding treatment program No information regarding at what stage of treatment the SCL-90-R was administered
Jepsen, Langeland, Sexton & Heir (2014) IV: + EV: +	Naturalistic follow-up study	56 adults with history of Childhood Sexual Abuse (CSA), 52 female, mean age 39.5 years (range 25-58). 23 (41.1%) CDD subgroup (DID & DDNOS-1), 33 (58.9%) non CDD subgroup. Norway	**Target**: management of trauma-related symptoms **Duration**: 3 months, (Mean time pre-care – admission=11.2months) **Modality**: Specialised inpatient trauma treatment program for adults with CSA & mixed trauma. Individual (1-2 weekly) & group therapy (2x daily): psychodynamic, CBT, supportive interventions. Emphasis on relational work. Did not address severe dissociation involving memory & identity alteration & somatoform dissociation	Pre-care, admission, discharge & 1-year follow-up: IES BDI-II SCL-90-R, GSI IIP-C (Norwegian version) DES-II	Ps with CDD had consistently higher symptom levels than non-CDD ps. Both subgroups showed parallel improvement from admission to follow-up, with CDD ps taking longer to demonstrate improvement. No statistically significant subgroup (CDD or non-CDD) x time interaction effect. Clinical and reliable change: at follow-up CDD and non CDD groups demonstrated equal levels of depression and general psychiatric distress, but fewer CDD ps demonstrated reliable change on stress related, dissociative and interpersonal problems than non-CDD ps.		Diagnosed with DID using SCID-D–R at entry to study Low drop-out rate from pre-care to treatment (n=4; 3%)	8/56 original ps excluded due to missing data Small n in subgroups may have underpowered interaction effects in MANOVA No control group Different sample sizes in CDD & non-CDD subgroups

Jepsen, Langeland & Heir (2013) IV: + EV: +	Naturalistic follow-up study	48 adults with history of Childhood Sexual Abuse (CSA), 45 female, mean age 38.9 years. DID (n=4, 8.3%) & DDNOS-1 (n=18, 37.5%) Norway	**Target**: management of trauma-related symptoms **Duration**: 3 months **Modality**: Specialised inpatient trauma treatment program for adults with CSA & mixed trauma. Individual (1-2 weekly) & group therapy (2x daily): psychodynamic, CBT, supportive interventions. Emphasis on relational work.	Pre-care, admission, discharge & 1-year follow-up: SCL-90-R, GSI IIP-C (Norwegian version) DES-T	Admission-follow-up: sig improvement in general psychiatric symptoms, & interpersonal problems Admission - discharge: sig improvement on SCL-90-R & IIP-C. Discharge - follow-up: Gains maintained, but no further improvement	DES-T membership at pre-admission predicted greater general psychiatric symptoms & interpersonal problems at discharge Interaction between dissociation at discharge & pre-treatment change in interpersonal functioning predicted greater psychiatric problems at follow-up	Pre-admission to admission: no change in SCL-90-R or IIP-C scores Recorded that all ps accessed outpatient therapy pre-admission & post discharge (details unavailable). Low level of attrition.	
Jepsen, Langeland & Heir (2014) IV: + EV: +	Naturalistic follow-up study	55 adults with history of Childhood Sexual Abuse (CSA), 52 female, mean age 39.5 years (range 25-58). 23 (41.1%) CDD (DID & DDNOS-1) Subgroups: Hboth (n=18) HSDQ (n=22) LBoth (n=15) Norway	**Target**: management of trauma-related symptoms **Duration**: 3 months **Modality**: Specialised inpatient trauma treatment program for adults with CSA & mixed trauma. Individual (1-2 weekly) & group therapy (2x daily): psychodynamic, CBT, supportive interventions. Emphasis on relational work	Pre-care, admission, discharge & 1-year follow-up: IES BDI-II SCL-90-R, GSI IIP-C (Norwegian version) DES-II SDQ-20	Ps showing reliable improvement at discharge & follow-up, respectively: IES; 30 (54.5%) & 29 (51.8%) SCL-90-R GSI; 28 (50.9%) & 27 (49.1%) BDI-II; 21 (38.2%) & 23 (41.8%) IIP-C; 16 (29.1%) & 20 (36.4%) SDQ-20; 7 (14.9%) & 12 (21.8%) DES-II; 8 (14.5%) & 14 (25.5%) At baseline, compared to HSDQ ps & LBoth ps, HBoth ps reported higher levels of DD diagnosis	HSDQ ps showed reliable improvement on at least one outcome measure at discharge more often than HBoth ps (effect size, phi = 0.40). No sig difference in rates of reliable deterioration at discharge or at follow-up.	Pre-admission to admission: no change in SCL-90-R & IIP-C scores Recorded that all ps accessed outpatient therapy pre-admission & post-discharge (details unavailable). Low level of attrition.	Small number in subgroups Reliance on self-report

Quality rating used is NHS quantitative studies checklist (NICE, 2012): IV = Internal Validity; EV = External Validity
- = few or no checklist criteria have been fulfilled and conclusions are likely/very likely to alter
+ = some criteria fulfilled, where not fulfilled/described conclusions are unlikely to alter

Table 3. Effect sizes for inpatient studies.

Study	Time-points	SCL-90-R (GSI)	SCL-45	BDI	HDRS	TAS	BSS	BHS	DES	IES	PCL-C	IIP-C
Ross & Haley 2004	Baseline – discharge:	0.79		1.47			0.89	1.16	0.29			
	Baseline – 3 month fu:	0.88		1.50			0.93	1.18	0.34			
Ross & Ellason, 2001	Baseline – discharge:	0.91		1.22			0.60	0.89	0.13			
Ellason & Ross, 1996, 1997, 2004	Baseline-2 year fu:	Total pts= 0.84 Integrated pts= 2.84		0.81	1.22				0.99			
Choe & Kluft 1995	Baseline-discharge								Total: 1.20 Amnesia: -0.82 Absorp: 0.72 Dep: 0.32			
Jepsen et al, 2013, 2014, 2014	Baseline – 1 year fu		0.28	0.19					0.09	0.59		0.16

All effect sizes were calculated using Hedge’s g statistic
0.2 indicates a small effect size, 0.5 a medium effect size and 0.8 a large effect size

1.4.2 Outpatient Studies

Ten articles reported the effectiveness of nonrandomised outpatient treatment for patients with DID. The proportion of participants with diagnoses of DID or DDNOS ranged from 69% – 100% across the ten studies. Only one article reported data from a comparison group and none used a control group. Eight papers reported data from the same international sample of participants, the TOP-DD study (Brand et al., 2009; Brand et al., 2013, Brand & Loewenstein, 2014; Brand & Stadnik, 2013; Cronin, Brand & Mattanah, 2014; Engleberg & Brand, 2012; Myrick et al., 2012; Myrick, Brand & Putnam, 2013). Two papers report data from a further two American samples (Coons & Bowman, 2001; Gantt & Tinnin, 2007). Only one outpatient study outlined the treatment protocol, whereas the remaining nine studies merely reported descriptive data relating to therapist orientation and modalities of treatments received. All ten outpatient studies included a combination of individual psychotherapy and group therapy.

1.4.2.1 Distress (General Distress, Depression, Hopelessness PTSD, suicidal ideation)

Four studies examined the effect of phasic outpatient treatment on symptoms of distress (Brand et al., 2009; Brand et al., 2013; Coons & Bowman, 2001; Gantt & Tinnin, 2007). All four studies reported significant reductions on measures of general distress and PTSD. Two demonstrated significant reductions in depression and one study showed decreases in alexithymia following outpatient treatment for DID.

Coons and Bowman reported systematic data from a case series study of 25 patients consecutively diagnosed with DID. Twelve patients provided outcome data at 10-year follow-up, during which time two participants dropped out of therapy. Patients who continued to engage in therapy reported reduction of depressive symptoms from admission to discharge. The results of this study were descriptive; no statistical analyses were calculated due to the small sample size, thus limiting the conclusions that can be drawn from them.

Symptoms of distress were also shown to decrease following treatment in an intensive outpatient trauma program (Gannt & Tinnin, 2007). Patients with DID, DDNOS and PTSD attended therapy for seven hours per day, five days per week, for either one or two weeks. Therapy consisted of a combination of art therapy, hypnosis and video therapy and the treatment protocol was outlined in detail. Patients with DID and DDNOS improved significantly on self-report measures of depression, general distress and alexithymia, with a third meeting criteria for ‘recovery’ and over half categorised as ‘improved’. Effect sizes were large for measures of general distress and PTSD, and medium for reductions in alexithymia. There was no significant difference in response to treatment between the diagnostic groups. The naturalistic design of this study mean that there was no control group with which to compare treatment results and as such it is not possible to infer causality, however, the comparison of outcomes across different diagnoses suggests that gains across treatment may at least in part be due to the psychotherapy.

Brand and colleagues (2009) used a practice network methodology to recruit a large international sample of patients engaged in phasic outpatient treatment for DID or DDNOS with their therapists. This study was the first in a number of published papers reporting outcome data from the Treatment of Patients with Dissociative Disorders (TOP DD) study. It provided baseline data for a prospective longitudinal study as well as providing cross-sectional between-patient data regarding outcomes at each of the five phases of treatment. Patients had been in therapy with their therapist for an average of five years at entry to the study and had received treatment from therapists with a range of orientations. All patients accessed individual psychotherapy and many had also received adjunctive pharmacological and therapeutic interventions. The study used a combination of patient- and therapist-report measures and found that patients in the later stages of treatment reported lower levels of general distress and PTSD than those in stage one of treatment. The statistically lower levels of distress were supported by a medium effect size for a measure of general distress and a large effect size for a measure of PTSD. Furthermore, therapist participants reported that patients in the later stages of treatment displayed greater overall functioning, as well as increased capacity to manage their mood and impulses than patients in stage one of treatment.

In a later TOP DD study, longitudinal data were reported for the same patients at four time points: at baseline and follow-ups at six months, 18 months and 30 months (Brand et al., 2013). Again, both patient- and therapist- report data was used to study treatment outcomes. Symptoms of general psychiatric distress, depression and PTSD significantly decreased over time in treatment. The reduction in symptoms attenuated over time, suggesting that the greatest reductions in symptoms of distress occur during the early stages of treatment.

The current evidence suggests that phasic outpatient treatment of DID is associated with significant reductions in symptoms of distress, and that these improvements are attenuated by time. However, in order to attribute causality to the treatment itself, further controlled research is required.

1.4.2.2 Dissociative symptomatology

Five treatment studies investigated the effectiveness of phasic outpatient psychotherapy on dissociative symptoms of patients with DID (Brand et al., 2009; Brand et al., 2013; Brand & Loewenstein, 2014; Coons & Bowman, 2001; Gantt & Tinnin, 2007). All five studies reported reductions in overall dissociative symptomatology on the DES over the course of treatment. One study also found a significant decrease specifically in identity alteration over the course of treatment. In contrast however, the one study that reported data regarding dissociative amnesia found that there was no significant decrease over the course of treatment.

Intensive outpatient trauma treatment was associated with significant reductions in dissociative symptoms for both patients with DID and DDNOS and those with a diagnosis of PTSD, with medium effect sizes reported (Gantt and Tinnin, 2007). There was no significant difference between the diagnostic groups, with comparable improvement in dissociation across diagnoses. Cross-sectional data from the TOP-DD study also found a significant association between stage of therapy and dissociative symptomatology (Brand et al., 2009). Patients in the later stages of treatment reported significantly lower levels of dissociation than those in stage one of treatment. Effect sizes for changes in the DES were small when comparing stage one with stages two and three, and medium when comparing stage one with stages four and five. This suggests that there may be a greater effect of treatment in the later stages of phasic treatment. However, it is important to note that the results were from independent samples and so may have been confounded by pre-existing differences in symptomatology.

There was also a significant decrease in the symptoms of dissociation over time in the longitudinal follow-up of TOP DD patients (Brand et al., 2013). This improvement did not attenuate over time, suggesting that patients continued to make significant improvements over six-, 18- and 30- month follow-up. A further analysis of the longitudinal TOP DD data, demonstrated that there was a significant decrease over time in identity alteration as measured by a single item on the DES. However, no such association was present on the amnesia subscale of the DES, on which patients showed no significant improvement or worsening over the course of treatment. The majority of TOP DD therapists reported targeting dissociation in their interventions and the results suggest that treatment which specifically targets the dissociative pathology of DID is associated with improvements on the DES.

Whilst it is not possible to attribute causality to treatment, the evidence suggest that phasic treatment of DID results in significant reductions in dissociative pathology, both at discharge and follow-up. However, treatment does not appear to be associated with changes in dissociative amnesia. Further examination of the amnesia subscale data from DES is required in order to ascertain if this finding is replicable.

1.4.2.3 Variables that may influence treatment outcome

1.4.2.3.1 Age.

Three studies have examined the impact of patients' age on outpatient treatment outcomes (Brand et al., 2009; Coons & Bowman, 2001; Myrick et al., 2013). In a case series study reporting descriptive data, younger patients reached integration more rapidly than older patients, taking on average 1.75 years as compared to 5.4 years for the older patients. Due to the small sample of this study, no further statistical analyses were possible and therefore it is not possible to say whether this is a significant result or not.

In their cross-sectional study Brand and colleagues (2009) reported that when adjusted for age, there was no difference in the number of self-harm attempts reported by patients across the five stages of phasic treatment for DID, suggesting that maturation is associated with decreased self-harm. Myrick and colleagues (2012) also examined age as a variable that may influence treatment outcome, and compared two mutually exclusive groups of patients: young adults, aged 18-30 years; and older adults, aged 31 years and over. Again, they reported descriptive data only due to the small sample size of the young adults and unequal sizes of the two subgroups. They also reported that younger patients demonstrated more rapid improvement than the older patients, but rather on measures of general distress, PTSD and in their adaptive capacities. However, the reverse was true for dissociative symptoms. The younger adults displayed higher levels of dissociation from admission to the study and throughout all time points as compared to the older adult group. So, whilst their dissociative symptoms reduced over time, they remained above the clinical cut-off, whereas the older adult group's symptoms of dissociation had decreased to below the clinical cut- off at 30 month follow-up.

The results suggest that patient age may influence treatment outcomes in DID, however the case for this is currently undermined by the lack of statistical comparison of the two age groups. Further data from a much larger sample is required in order to elucidate the potential effect of age on treatment outcome.

1.4.2.3.2 Integration status.

Only one study investigated the role of integration status as a variable that may influence treatment outcome (Coons & Bowman, 2001). Integrated patients showed greater symptom reductions in dissociation, depression and somatization than unintegrated patients as well as fewer hospitalisations following commencement of treatment. This study included a very small sample, which precluded statistical analysis of data and as such the conclusions that can be drawn from the descriptive results are minimal. Furthermore, the researchers did not report how they assessed integration status, which further limits the interpretation of this results. However, whilst the level of evidence is poor, given that similar findings were reported in inpatient outcome studies, further investigation of the impact of integration in outpatient psychotherapy would help to elucidate the relationship.

1.4.2.3.3 nitial dissociation.

One article reporting data from the TOP-DD study, investigated initial dissociation as a variable that may influence treatment outcomes in DID and DDNOS (Brand & Stadnik, 2013). Initial dissociation as measured by the DES was associated with initial levels of PTSD and general distress, however it did not predict change in either of these outcomes to 30-month follow-up. Nevertheless, initial dissociation did predict change in dissociation from admission to 30-month follow-up when controlling for length of follow-up and therapist experience. Reduction in dissociative symptoms was also positively related to change in the symptoms of general distress and PTSD, suggesting that improvement in dissociative symptomatology may lead to improvements in other areas of DID symptomatology. However, the change in dissociation only explained 18% of the variance in change on dissociation, and as such there are likely a number of other variables which impact on this.

1.4.2.3.4 Initial depression.

One study investigated the impact of initial depression on treatment outcomes following outpatient treatment for DID. Engleberg and Brand (2012) reported self-report data from the TOP-DD study, in which symptom-levels of depression at intake to the study were significantly positively correlated with self-harm and suicide attempts. More severe depression was significantly associated with greater reductions in suicide attempts and increased involvement in social activities, but was also associated with less improvement in impulsive actions. Initial depression severity was not associated with change in symptoms of dissociation, PTSD, or general distress. Initial depression severity, whilst statistically significant, only accounted for 3.9-5.3% or total variance in treatment outcome. Interpretation of the results of this study are also limited by the naturalistic, uncontrolled design. The lack of further research into the relationship between initial depression severity and subsequent treatment outcomes requires further research before its effect on treatment outcome can be substantiated.

1.4.2.3.5 Therapeutic alliance.

Only one study investigated the effect of the therapeutic alliance upon symptom outcomes following outpatient treatment for DID in the TOP-DD study. Cronin, Brand and Mattanah (2014) used both a patient-reported measure of therapeutic alliance and therapist-rated measure and found that the two were moderately inter-correlated, suggesting that there was some agreement between therapists and patients, but that there is also some discrepancy between their ratings. Both measures of alliance were significantly associated with fewer symptoms of dissociation, PTSD and general distress and higher therapist-rated adaptive functioning. After controlling for patients adaptive capabilities, higher patient-reported alliance predicted better outcomes on all three symptom measures over time. However, as with all TOP-DD studies it is not possible to imply causality in this model: it may be that reduction in symptomatology may have in fact raised patients' perceptions of the therapeutic alliance. The alliance outcome measures were not included in the TOP-DD study from intake; it is therefore possible that other factors confounded alliance ratings. Further studies investigating the impact of the alliance on treatment outcomes should use the measures from intake to the study in order to investigate if there is an association with attrition. Patient-rate therapeutic alliance only explained 7-11% of the variance in change on symptom measures, and as such it is likely that a number of other factors are also involved.

1.4.2.3.6 Revictimisation.

One study investigated the effect of revictimisation upon symptom outcomes following outpatient treatment. Myrick, Brand and Putnam (2013) recorded incidences of current revictimisation in a subset of 49 patient-therapist pairs enrolled in the TOP-DD study. Thirty-four patients demonstrated significant symptom reductions on measures of dissociation, PTSD and general distress and were assigned to the 'improving' group and 25 patients who demonstrated significant increases in symptoms were assigned to the 'worsening' group. There were significantly higher levels of revictimisation in the worsening group than in the improving group, suggesting that there is an association between current revictimisation and treatment outcome. However, the small overall sample and use of sub-groups, precluded statistical analyses. Results were descriptive and as such it is not possible to draw firm conclusions from them, however, they do suggest that there is a need for further research to explore the influence of this variable upon treatment outcomes.

Table 4. Outpatient treatment studies.

Reference & quality rating	Study design	Sample characteristics	Intervention characteristics	Outcome measures	Overall findings	variables that influence treatment outcome	Strengths	Limitations
Brand, Classen, Lanins, Loewenstein, McNary, Pain & Putnam (2009). IV: + EV: +	Naturalistic cross-sectional study using practice network methodology. TOP-DD Study	280 adult ps with DID or DDNOS (264 female, mean age 43.7years) & 292 therapists Average 6.8 years since diagnosis International	**Target**: 94% therapists reported specifically targeting dissociation, including work with self-states **Duration**: (Mean): Stage 1:2.8yrs Stage2:4.1yrs Stage3:4.1yrs Stage4:7.4yrs Stage5:8.4yrs Average 5 years with their current therapist **Modality**: Phasic. Therapist orientation CBT (17%), Psychodynamic (49%), Family systems (3%), Humanistic/experiential (8%), Other (22%) Individual therapy (100%), Psychiatric meds (80%) Group therapy (19%) 12 step groups (13%) Family therapy (5%) Couples therapy (13%) Art therapy (22%)	Baseline: **Patient measures**: Behavioural checklist DES PCL-C **Clinician measures**: PITQ Clinical Data Form GAF	**Patient-report**: lower levels of distress, dissociation, PTSD, hospitalisations and self-harm and higher levels of school/volunteer job attendance in ps in later stages of treatment as compared to stage 1 **Clinician-report**: higher overall functioning, better social/work functioning, greater capacity to manage mood, impulses, self-states, and fewer incidences of self-harm, suicide attempts and hospitalisations for ps in later stages compared to stage 1	Increasing age is association with decreasing self-harm.	Large, international sample Use of both self-report and clinician report outcome measures Few exclusion criteria	Unknown response rate Self-selected clinicians (chose to respond) may have introduced bias Clinician-selected patient participants may have introduced bias No information regarding specific treatment No pre-treatment or follow-up data Between subjects design limits conclusions regarding stage of treatment Observational design – no causality Patient-report behavioural checklist is not validated Therapist measures: PITQ is not validated & GAF is a non-standardised scale & has been criticised as subjective

			Other expressive therapy (41%)					
Brand, McNary, Myrick, Classen, Lanius, Loewenstein, ... & Putnam (2013) IV: + EV: +	Naturalistic, prospective longitudinal study using practice network methodology. TOP-DD study	Baseline: 226 ps with DID or DDNOS & 295 therapists 6 month: 171 ps & 189 therapists 18 month: 131 ps & 174 therapists 30 month: 111 ps & 135 therapists At intake average 6.8 years since diagnosis International	**Target**: 94% therapists reported specifically targeting dissociation, including work with self-states **Duration**: At intake average 5 years with their current therapist **Modality**: Phasic Therapist orientation CBT (17%), Psychodynamic (49%), Family systems (3%), Humanistic/experiential (8%), Other (22%) Individual therapy (100%), Psychiatric meds (80%) Group therapy (19%) 12 step groups (13%) Family therapy (5%) Couples therapy (13%) Art therapy (22%) Other expressive therapy (41%)	Baseline,6 month, 18 month & 30 month: **Patient measures**: Behavioural checklist DES PCL-C **Clinician measures**: PITQ Clinical Data Form GAF	**Patient-report**: Significant decrease over time in symptoms of general psychiatric distress &, depression and PTSD, which attenuated with time. Significant decrease in dissociation over time (which was not attenuated over time). Sig decreases reported in 30-day rates of self-harm, doing something impulsive & doing something dangerous Increases in odds of going to school/volunteering, feeling good feelings and participating in social activities increased each month **Clinician-report**: GAF showed significant linear increases over time, PITQ significantly increased over time and attenuated with time. Clinicians reported that patient self-harm decreased over time. Unlike patient reports, clinicians reported that suicide attempts decreased over time	n/a	Large, international sample Prospective, longitudinal design Use of both self-report and clinician report outcome measures Few exclusion criteria Calculated full information maximum likelihood (FIML) supplanted with auxiliary variables (Collins, Schafer & Ham, 2001; Enders, 2005) to accommodate missing data and to reduce bias	Attrition-rate of 54% of therapist and 51% ps by time 4 (30 months). Selection bias (clinical and patient, as above) No information regarding specific treatment Observational design – no causality Patient-report behavioural checklist is not validated Therapist measures: PITQ is not validated & GAF is a non-standardised scale & has been criticised as subjective

Brand, & Loewenstein, (2014) Low	Naturalistic longitudinal study using practice network methodology. TOP-DD study	Baseline: 237 ps with DID or DDNOS & 298 therapists 6 month: 171 ps & 189 therapists 18 month: 131 ps & 174 therapists 30 month: 111 ps & 135 therapists International	**Target**: 94% therapists reported specifically targeting dissociation, including work with self-states **Duration**: At intake average 5 years with their current therapist **Modality**: Phasic. Therapist orientation at intake CBT (17%), Psychodynamic (49%), Family systems (3%), Humanistic/experiential (8%), Other (22%)	Baseline,6 month, 18 month & 30 month: **Patient measures**: SCL-90_R (hearing voices item) DES (Amnesia scale & item 22: identity alteration) **Clinician measures**: GAF	**Patient-report:** Significant decrease over time in identity alteration Significant decrease over time in frequency of hearing the voices of self-states No significant change in dissociative amnesia over time **Clinician-report:** Ps became significantly more functional over time.	n/a	Large, international sample Use of both self-report & clinician-report measures Few exclusion criteria	Observational design – no causality Use of single items to measure constructs (i.e. identity alteration and hearing voices)
Coons & Bowman (2001) IV: + EV: +	Case series	25 ps consecutively diagnosed with DID, 12 ps provided follow up data Mean age at follow-up: 39.6 years USA	**Target**: not reported **Duration**: 10/12 were still in outpatient therapy **Modality**: Psychotherapy (100%), Journal writing (100% Hypnosis (83%) Hospitalisation (79%) Art therapy (67%), Psychoeducation (83%) Group therapy (50%) Marital therapy (33%) Family therapy (17%) Dance therapy (8%)	Baseline & 10-year follow-up**:** **Patient measures**: DES Civilian Version of Mississippi PTSD Ham-D LES **Clinician measures**: MMPI-I SCID-D	4 reached and maintained integration, 8 remained unintegrated Mean number of years to integration: 5.4, 2 teenage ps reached integration in 1.5 & 2 years Ps who continued in treatment experienced improvements in dissociative and non-dissociative symptoms	Integrated ps showed had lower initial symptomatology and showed greater improvements compared to unintegrated Successful integration was associated with: 1. Younger age 2. Fewer self-states 3. Less initial general psychopathology 4. Fewer therapists after diagnosis 5. Fewer hospitalisations after beginning treatment	Length of follow-up Ps provided feedback on the utility of treatment methods	Attrition:52% did not complete follow-up measures, 4% committed suicide No statistical comparisons due to the small sample size No controls No information on how judged if integrated

Gantt & Tinnin (2007) IV: + EV: +	Naturalistic follow-up study	First 72 ps to complete treatment program 13 DID, 37 DDNOS, 22 PTSD 77% female Mean age: 38 years USA	**Target**: trauma **Duration**: 1 or 2 weeks, 7 hour days, 5 days per week **Modality**: intensive trauma therapy using art therapy, hypnosis & video therapy. 4 stages: 1. Baseline testing & psychoeducation; 2. narrative trauma processing; 3. reversal of dissociation using video dialogue procedure; & 4. modification of victim mythology using video dialogue	Baseline, 1 week, 3 month follow-up, 6 month follow-up: **Patient measures**: SCL-45 DES IES TAS	32% of DID/DDNOS participants met criteria for recovery: 54% were improved, 12% were unchanged & 4% worsened following treatment ANOVA showed no significant difference in treatment response between the diagnostic groups DID/DDNOS ps showed Significant improvement on all symptom measures from pre- to post- treatment	n/a	Compared completers and non-completers baseline measures and found no difference between them	Non-random sample Attrition (4 ps did not complete follow up measures) Reliance on self-report measures
Engelberg, & Brand. (2012) IV: + EV: +	Naturalistic longitudinal study using practice network methodology. TOP-DD study	280 ps at intake & 131 ps at 30-month follow-up (TOP-DD data) International	**Target**: 94% therapists reported specifically targeting dissociation, including work with self-states Duration: At intake average 5 years with their current therapist **Modality**: Phasic. Therapist orientation at intake CBT (17%), Psychodynamic (49%), Family systems (3%),	Admission & 30 month follow-up: **Patient measures:** SCL-90-R (Depression subscale) Behavioural checklist DES-II PCL-C		Depression severity correlated positively with self-harm & suicide attempts Over 30 months more severe depression was associated with greater reduction in suicide attempts & greater engagement in social activities but less improvement of impulsive actions. Depression severity was not significantly associated with any change in dissociative experiences, PTSD, general distress or self-harm	Large international sample Few exclusion criteria	Self-selected clinicians (chose to respond) may have introduced bias Clinician-selected patient participants may have introduced bias No information regarding specific treatment Observational design – no causality Patient-report behavioural checklist is not validated No control group

			Humanistic/experiential (8%), Other (22%)					
Cronin, Brand & Mattanah (2014) IV: + EV: +	Naturalistic longitudinal study using practice network methodology. TOP-DD study	131 ps & therapists (final 2 phases of TOP-DD data) Average age = 45.7 years International	**Target**: 94% therapists reported specifically targeting dissociation, including work with self-states **Duration**: At intake average 5 years with their current therapist **Modality**: Phasic. Therapist orientation at intake CBT (17%), Psychodynamic (49%), Family systems (3%), Humanistic/experiential (8%), Other (22%)	18-month follow-up & 30-month follow-up: **Patient measures:** CASF-P DES PCL-C SCL-90-R Therapist measures: PITQ WAI-T		Patient & therapist rated alliance moderately inter-correlated Significant association of alliance (patient & therapist-rated) with fewer symptoms & better overall functioning After controlling for patient adaptive capacities, self-rated alliance scores predicted better outcomes over time. Patient–rated alliance was a better predictor of outcomes than therapist-rated alliance.	Large international sample Few exclusion criteria	Self-selected clinicians (chose to respond) may have introduced bias Clinician-selected patient participants may have introduced bias No information regarding specific treatment Observational design – no causality PITQ – not validated No control group
Myrick., Brand, McNary, Classen, Lanius, Loewenstein, ... & Putnam (2012) IV: + EV: +	Naturalistic longitudinal study using practice network methodology. TOP-DD study	29 young adult ps (YA:18-30 years) & 43 therapists 187 older adult ps (OA:31+) & 233 therapists International	**Target**: 94% therapists reported specifically targeting dissociation, including work with self-states **Duration**: At intake average 5 years with their current therapist **Modality**: Phasic Therapist orientation at intake CBT (17%), Psychodynamic (49%), Family systems (3%),	Baseline,6 month, 18 month & 30 month: **Patient measures**: DES PCL-C SCL-90-R **Clinician measures:** Clinical data form PITQ		YA's had higher dissociation scores than the OA group at both intake and follow-up. OA's had higher adaptive capacities than YA at intake. Both groups showed improvement over time. YAs showed more rapid improvement than OAs & at 30-month follow-up showed higher adaptive capacities than OAs. Both groups had similar levels of PTSD & general distress at	international sample Few exclusion criteria Use of patient & therapist-report methods	Self-selected clinicians (chose to respond) may have introduced bias Clinician-selected patient participants may have introduced bias No information regarding specific treatment Observational design – no causality PITQ – not validated No control group Descriptive statistics only

			Humanistic/experiential (8%), Other (22%)			baseline, YA scores decreased more rapidly than OAs YAs demonstrated higher levels of destructive behaviours & more hospitalisations than OAs at baseline. Over 30 months, the YA group showed greater improvement than OAs		Attrition: 74.5% YAs & 22% OAs did not complete all measures
Brand & Stadnik (2013) IV: + EV: +	Naturalistic longitudinal study using practice network methodology. TOP-DD study	110 ps with DID/DDNOS (97.3% female) & 111 therapists at intake 109 ps & 111 therapists at 30-month follow-up Mean age=45.15 International	**Target**: 94% therapists reported specifically targeting dissociation, including work with self-states **Duration:** At intake average 5 years with their current therapist **Modality**: Phasic. Therapist orientation at intake CBT (17%), Psychodynamic (49%), Family systems (3%), Humanistic/experiential (8%), Other (22%)	Intake & 30-month follow-up: DES-II PCL-C SCL-90-R		Initial dissociative symptoms (inc. amnesia, depersonalisation/derealisation & absorption) were related to initial levels of PTSD & general distress Initial dissociation significantly predicted change in dissociation at 30 months after controlling for length follow-up, and therapist experience (length of time as a therapist & treating DID)	international sample Few exclusion criteria	Self-selected clinicians (chose to respond) may have introduced bias Clinician-selected patient participants may have introduced bias No information regarding specific treatment Observational design – no causality Reliance on self-report No control group
Myrick, Brand & Putnam (2013) IV: + EV: +	Naturalistic longitudinal study using practice Network methodology.	49 therapist-patient (DID/DDNOS) pairs **Worsening ps**: (n=25) 20% increase in symptoms (20-point increase	**Target**: 94% therapists reported specifically targeting dissociation, including work with self-states **Duration:** At intake average 5 years with their current therapist	Baseline,6 month, 18 month & 30 month: **Patient measures**: DES PCL-C SCL-90-R	Revictimisation decreased over 30 months.	Ps who improved had significantly fewer overall stressors & revictimisations than ps who worsened Across types of abuse the worsening subgroup had significantly higher	international sample Few exclusion criteria	Self-selected clinicians (chose to respond) may have introduced bias Clinician-selected patient participants may have introduced bias

TOP-DD study	On DES, 20-point increase on PCL-C, 0.7-point increase on SCL-90-R) **Improving ps:** (n=34) 20% decrease in symptoms (20-point decrease on DES, 20-point decrease on PCL-C, 0.7-point decrease on SCL-90-R)	**Modality**: Phasic. Therapist orientation at intake CBT (17%), Psychodynamic (49%), Family systems (3%), Humanistic/experiential (8%), Other (22%)	Baseline,6 month, 18 month & 30 month: **Patient measures**: DES PCL-C SCL-90-R	Revictimisation decreased over 30 months.	Ps who improved had significantly fewer overall stressors & revictimisations than ps who worsened Across types of abuse the worsening subgroup had significantly higher	international sample Few exclusion criteria	Self-selected clinicians (chose to respond) may have introduced bias Clinician-selected patient participants may have introduced bias

Quality rating used is NHS quantitative studies checklist (NICE, 2012)
IV = Internal Validity
EV = External Validity
- = few or no checklist criteria have been fulfilled and conclusions are likely/very likely to alter
+ = some criteria fulfilled, where not fulfilled/described conclusions are unlikely to alter

Table 5. Effect sizes for outpatient studies.

Study		SCL-90-R (GSI)	SCL-45	BDI	HDRS	TAS	BSS	BHS	DES	IES	PCL-C	IIP-C
Gantt & Tinnin 2007	Baseline-post treatment		0.90			0.78			0.66	1.34		
Brand et al, 2009	Between-ps											
	Stage 2 vs stage 1	-0.16							-0.33		-0.40	
	Stage 3 vs stage 1	-0.31							-0.45		-0.52	
	Stage 4 vs stage 1	-0.46							-0.62		-0.66	
	Stage 5 vs stage 1	-0.71							-0.64		-1.00	

All effect sizes were calculated using Hedge's g statistic: 0.2 indicates a small effect size, 0.5 a medium effect size and 0.8 a large effect size

1.5 Discussion

There is a somewhat sparse body of empirical evidence reporting psychotherapy outcome data for DID. The current review identified 19 studies, which investigated treatment outcomes and variables that may influence outcomes. The aim of was to critically evaluate the empirical findings and consider the clinical implications of these findings, allowing some tentative conclusions to be drawn.

1.5.1 Interpretation of Findings

The current review divided outcome studies into those providing inpatient and those providing outpatient treatment for adults with DID. It is important to note that several studies included herein report data from the same cohort of participants, and as such the results should be interpreted with caution. The literature suggests that both inpatient and outpatient treatment of DID is associated with reductions in psychiatric distress across measures of general distress, PTSD, depression, hopelessness and alexithymia. Longitudinal outpatient studies have reported that these results are attenuated by time, with the greatest improvements demonstrated early after treatment and stabilising across time (e.g. Brand et al., 2013). There is also evidence that patients with DID follow a similar treatment trajectory to patients without severe dissociative pathology, albeit it at a significantly slower rate (Jepsen et al., 2013).

The results of this review suggest that both inpatient and outpatient treatment of DID is associated with reductions in dissociative symptoms, although the evidence in not unanimous. The literature suggests that treatments which specifically target the dissociative pathology of DID may be associated with reductions in dissociative experiences, both at discharge and follow-up. The association between treatment and levels of dissociation is less clear for treatment programs which do not specifically target dissociation; the majority reported decreases in dissociative symptomatology but one inpatient study found no such association. The two studies that used comparison groups reported conflicting results regarding symptomatology of dissociation. Jepsen and colleagues (2014) reported scarcely any reliable change in dissociation for highly dissociative DID patients versus PTSD patients with lower levels of initial dissociation; whereas Gantt and Tinnin (2007) found that both PTSD and DID patients showed comparable reductions in dissociative symptoms. Whilst it is not possible to attribute causality to the treatment delivered, it is of interest that the two studies differed in the treatment programs offered, with the former offering inpatient treatment which did not focus on severe dissociation whereas the latter offered intensive outpatient treatment which did specifically target severe dissociative pathology.

Longitudinal outpatient studies found that reductions in dissociative symptomatology were not attenuated by time; suggesting that patients continued to make improvements over the course of follow-up data collection (Brand et al., 2013). Clearly more research is needed using comparison groups in order to reveal how the treatment trajectories of patients with DID compare to those without a complex dissociative disorder.

The evidence for the impact of psychotherapy on interpersonal problems is less robust.

Only three articles from one study investigated this outcome measure (e.g. Jepsen et al., 2013), all of which were based on an inpatient treatment program that specifically targeted relational aspects of DID. Whilst the treatment was significantly associated with reductions in interpersonal problems, the effect size was negligible for patients with a diagnosis of DID or DDNOS, suggesting that they showed less improvement that patients without a dissociative disorder. Including a measure of interpersonal problems in future research may help to clarify this relationship.

A number of variables have been identified from the literature, which potentially influence treatment outcomes. These included integration status, initial levels of dissociation, and age of participants at baseline. Few studies report statistical analyses for these variables, and those that do suggest that the amount of variance attributed to them is typically around or below 10%, suggesting that other latent factors may also affect symptom measures. A number of studies report that improvement occurs more rapidly in younger adults than in older adults, however this finding is based upon descriptive comparison of groups and further research is needed to investigate if this is supported by statistical analyses.

There is some evidence that integration status was associated with treatment outcomes. Integrated patients demonstrated lower symptom levels across all time-points in a number of studies within both inpatient and outpatient treatment programs. Integrated patients also consistently showed greater improvement on measures of distress and dissociation than non- integrated patients. However, integration was not measured using a standardised instrument and this subjectivity may have introduced researcher bias.

The results of the review suggest that the link between initial levels of dissociation and later treatment outcomes is not clear. Studies consistently demonstrate an association between initial dissociation and initial symptoms of distress. However, research has also reported inconsistent findings regarding initial dissociation and later symptomatology and as such no clear conclusions can be drawn. More research is required to further understanding of this variable upon treatment outcomes.

Only one study investigated the effect of the therapeutic alliance upon symptom outcomes with higher patient-reported alliance predicting better outcomes on measures of general distress interpersonal problems and dissociation. However, the evidence is not sufficient to suggest a reliable effect and further research is needed to see if the result is stable across different samples and different treatment modalities.

The ISSTD guidelines propose that DID should be treated with phasic psychotherapy which targets dissociative symptomatology and aims to integrate different self-states. The results of this review are commensurate with the guidelines, suggesting that symptomatic improvements are associated with phasic treatment and that reductions in dissociative symptoms are associated with treatments that specifically target the dissociative pathology.

1.5.2 Methodological Limitations and Further Research

In order to assess the effectiveness of psychotherapy in naturalistic studies, studies should employ prospective, longitudinal designs; with large unbiased samples; provide information pertaining to treatment modality; and duration of treatment; and use a range of standardised measures (Seligman, 1995). No one study included in the current review fulfils all five of Seligman’s criteria. A particular difficulty of this type of naturalistic treatment for such a complex presentation is that the treatment regime is necessarily multifaceted and non-standardised. The results of this review have highlighted a range of methodological weaknesses, upon which future research should aim to improve.

1.5.2.1 Observational designs.

Observational studies do not allow the attribution of causality and as such in order to study treatment effectiveness it is important to limit all possible confounds. There is a chance that the symptom improvements reported were not related to treatment, but rather to the passage of time and regression to the mean. Whilst there are issues regarding causality, naturalistic studies are ecologically valid; providing a more accurate reflection of community treatment than experimental research. Studies with rigorous controls can result in unrepresentative samples and produce results that are less useful to clinicians working with clinical populations with high comorbidities.

The observational designs employed by all of the studies in this review, limit the conclusions that can be drawn regarding the relative merits of different treatment programs. However, the results do provide compelling evidence that many patients who are engaged in treatment demonstrate improvements on a range of symptom measures. Further controlled studies are required to examine this association in more detail and to ascertain if improvements are directly related to treatment or whether they represent regression to the mean.

1.5.2.2 Sampling and attrition

The review has identified multiple sources of sampling bias in DID treatment outcome studies. For example, several early studies recruited small samples of non-consecutive admissions, which may not be representative of all patients within treatment programs. The recent TOPDD study (Brand et al., 2009) recruited using a practice network methodology, which generated a large international sample of patients and therapists and reduced potential bias inherent in studies of patients all treated by the same clinician. However, this sampling method also introduced sampling biases via the self-selection of therapists and therapist-selection of one patient for inclusion. It may be that therapists chose a client who was engaging particularly well in treatment and as such the sample may not be representative of the DID population. Sampling difficulties are likely exacerbated by the relative rarity of the presentation.

Future research should employ a prospective design, with a non-biased sample of patients with DID. Whilst the selection of random samples may not be feasible, future studies should recruit consecutive admissions to treatment programs in order to reduce sampling bias. Ideally studies should follow patients from the point of diagnosis in order to best monitor symptoms and progress. In lieu of this type of design, studies should endeavour to gather information pertaining to date of diagnosis and previous treatment undertaken prior to enrolment in research.
Furthermore, reporting on the type and duration on psychotherapy would also allow for a clearer understanding of the outcomes recorded.

The review also highlighted high rates of attrition, particularly for those studies providing longitudinal data, which may have introduced bias into the studies. It is possible that patients who dropped-out may have experienced less improvement or even worsening of symptoms compared to those who remained in treatment. Whilst some studies reported few differences in baseline demographics and symptomatology between completers and non-completers, it is not clear if progress in treatment impacted upon attrition rates.

1.5.2.3 Measures

This review has highlighted that the current treatment outcome literature is particularly reliant on self-report measures. The majority of measures used are well-validated, although some studies also use unvalidated measures to collect categorical data (e.g. PITQ). The TOP DD study triangulated both patient-rated and therapist-rated measures, a method that should be utilised in future studies in order to reduce response bias.

A number of studies in this review measured integration according to Kluft’s

(1984) six criteria, however, this non-standardised approach is subjective and may have introduced bias. There is a need for a standardised measure of integration to be included in future research in order to better understand the impact of integration on treatment outcomes. In a recently published paper, Barlow and Chu (2014) have reported data using the Integration Measure (IM), a new measure of integration, which may be appropriate for use in future outcome studies.

1.5.2.4 Diagnosis and pre-care assessment

A strength of the majority of papers reviewed was the corroboration of the diagnosis of DID with the use of either a validated diagnostic instrument (Ross & Ellason, 2001) or with a combination of a diagnostic tool and clinical judgement (e.g. Choe & Kluft, 1995; Ellason & Ross, 1997). Given the recent changes to the diagnostic criteria for DID, it is likely that there will be an increase in the number of patients receiving this diagnosis (and conversely a decrease in the proportion of new DDNOS cases). Future research may therefore be better placed to recruit participants with DID and to further the research in this important area.

Critics of the DID diagnosis suggest that treatment of DID artificially raises symptomatology.By comparing pre-care and admission symptom measures it is possible to ascertain if symptoms are raised following treatment. Three articles reporting data from one study reported patient data from the point of initial diagnosis (Jepsen et al, 2013). This was a particular strength of the design as it was therefore possible to track symptoms from diagnosis to treatment and beyond. This controlled for any increases in symptomatology as a result of iatrogenesis. Future prospective, longitudinal studies should aim to recruit in the same way.

1.5.2.5 Interventions

The review revealed a range of inpatient and outpatient interventions. Inpatient treatment programs often described a combination of individual and group psychotherapy as well as adjunctive treatments such as psychopharmacology. Whilst outpatient studies reported predominantly individual psychotherapy, patients frequently reported accessing adjunctive treatment including psychopharmacology, 12-step groups and expressive therapies (e.g. Brand et al., 2009). The impact of the heterogeneity of interventions is compounded by the lack of sufficient information regarding treatment, particularly in studies of outpatient psychotherapy.

This likely reflects the lack of standardised treatment protocols for DID due to its polysymptomatic nature and the multiplicity of the presentation. In order to improve upon the current evidence base, further research should therefore endeavour to provide a clear outline of the nature and duration of treatment.

1.5.2.6 Follow-up

The duration of follow-up varied across the 19 articles. A number of studies provided no follow-up data, reporting only data from discharge; whereas others reported follow-up data ranging from three months to 10 years. Coons and Bowman (2001) have suggested that ideally longitudinal studies should span 15-20 years to reflect the time taken to achieve integration. However, the results of long-term follow up are necessarily confounded by intercurrent treatment. For example, long-term outcomes of inpatient DID treatment are confounded by engagement in subsequent outpatient treatment.

1.5.2.7 Comparison groups

Few studies reported the use of comparison groups. Whilst it is not ethical to withhold treatment for DID patients in order to have a control group, there is a clear need for future studies to include comparison groups to enable firm conclusions to be drawn regarding the impact of treatment upon symptomatology. The two studies that did report comparisons examined the treatment outcomes of patients with and without DID undergoing the same treatment regime (Jepsen et al, 2014; Gannt & Tinnin, 2007). Another proposal is that patients with DID could be assigned to one of two treatment groups; for example trauma treatment (treatment as usual) versus DID specific treatment.

1.5.3 Clinical Implications

The evidence reviewed herein suggests that patients with DID or DDNOS can respond favourably to a range of treatment programs including acute inpatient, non-emergency inpatient, intensive outpatient and outpatient psychotherapy. These patients tend to be more symptomatic at baseline than patients without a diagnosis of DID or DDNOS, and may take longer to respond to treatment than their non-dissociative disordered counterparts. Aspects of general trauma programs are effective and inpatient trauma programs have been associated with significant improvements in a wide range of psychiatric symptoms (depression, PTSD, etc.), however, they do not reliably show reductions in overall dissociation. Treatment which specifically targets dissociation and personality self-states is associated with improvements in dissociative symptomatology. This suggests that there is a need to develop DID specific treatment, in order to best address the specific symptoms encountered by this patient group.

Evidence suggests that when patients with DID are in crisis they may benefit from inpatient stabilisation treatment in order to reduce levels of distress and suicidality. For non-emergency treatment however, patients with DID appear to benefit from treatment which targets both the trauma and the severe dissociative pathology that underpins the condition. The results suggest that complex dissociative disorders may require treatment that differs from that of conventional PTSD and trauma treatment in that it needs to specifically target the fragmentation and dissociative processes present in DID.

There is some evidence that patients who reach integration demonstrate greater symptom reductions than those who do not. This supports the ISSTD guidelines (2011), which suggest that integration is the overall aim of treatment in DID. It should be noted that the evidence suggests that those patients who do not reach integration also tend to make gains in treatment, although to a lesser extent.

The review also identified the tentative finding that patients with DID may exhibit different treatment responses depending on their age. Younger patients may exhibit greater and faster gains than older patients, which emphasises the need for quick and accurate diagnosis and treatment in order to maximise treatment gains. Further research is needed to investigate the influence of this variable upon outcome, as there is currently only weak evidence supporting it.

1.5.4 Limitations of the review

This review focused only on treatment studies reporting systematic outcome data for DID and highlighted that a number of studies did not provide detailed information regarding the modality and duration of treatment. It may be that the inclusion of case studies would have added to the evidence for specific treatment modalities, however they were beyond the scope of this particular review. Given the tentative finding that younger adults may follow a different treatment trajectory it would be interesting to consider these findings alongside studies using an adolescent population and therefore the inclusion of only adult populations may have limited the review.

The review included only English language articles and hence may have excluded valid treatment studies from non-western cultures. It is also noteworthy that that different countries have differing thresholds for inpatient admissions and therefore as the inpatient studies included samples from across the USA as well as Norway, the articles herein may not represent a homogenous group of patients. Likewise, naturalistic studies reporting outcomes of outpatient psychotherapy may also be affected by cultural factors, for example dominant therapy approaches may vary across countries and as such this treatment group may limit the homogeneity of this group.

The results of the review were considered in narrative form. No meta-analysis was conducted and therefore it is not possible to statistically examine the outcome data to reveal trends and areas of disagreement. Brand and colleagues (2009) conducted a meta-analysis of eight treatment studies however, and found that the effect sizes for dissociative disorder treatment studies were comparable to those of PTSD patients. However, the results were not specific to DID and DDNOS as they included other dissociative disorder diagnoses in the analysis. The current review includes eleven additional papers and is specific to DID samples, as such a new meta-analysis would provide a useful addition to the literature.

The review included patients with diagnoses of both DID and DDNOS due to the substantial overlap in symptomatology and reports that DID is often misdiagnosed as DDNOS. However, the DDNOS patients may represent 'partial' DID symptomatology as such could confound the results due to their lower symptom levels. It is also possible that DDNOS patients demonstrate different treatment response than the highly symptomatic DID patients, which again may confound the results. It is hoped that the changes to the diagnostic criteria for DID (DSM-5) will reduce the overlap between DID and DDNOS and will lead to improved validity of diagnoses, thus enabling future studies to focus specifically on the outcomes of DID patients and perhaps even to make comparisons between DID and DDNOS patients.

The current review reported only continuous outcome variables measured by standardised instruments. As such, conclusions cannot be drawn regarding outcomes such as frequency of hospitalisations, episodes of self-harm or suicide, or changes in comorbidity. Finally, the conclusions drawn from this review are limited due to the low quality of the evidence base to date.

1.5.5 Conclusions

The aim of the review was to review articles reporting psychotherapy outcome data for DID and the variables that may influence treatment outcome, as well as to critically evaluate the empirical findings and consider the clinical implications of these findings. The results suggested that both inpatient and outpatient treatment is associated with symptom reductions on several measures of psychiatric distress. There is some evidence that treatment that specifically targets dissociative pathology is associated with reductions in dissociative symptoms, although further research is needed to explore this association. Overall it appears that highly dissociative patients may benefit from phasic psychotherapeutic interventions, although they may take a long time to demonstrate significant improvements in dissociation. Whilst it is not possible to infer causality in any of the treatment studies, the evidence for the association between treatment and symptom reduction in DID is a promising one and warrants further attention. The quality of treatment outcome studies in DID is low, however the methodologies employed are becoming increasingly rigorous, with the inclusion of an increasingly well-validated range of standardised measures, large sample sizes and prospective longitudinal designs. This review highlights the need for a more meticulous approach to documenting the specific interventions in order to further explicate the effectiveness of such treatment programs.

Chapter 2: Empirical Paper

Formulating Dissociative Identity Disorder in Clinical Practice: A Q-study

2.1 Introduction

2.1.1 DID diagnosis

Dissociative Identity Disorder (DID) is a complex and often poorly understood psychiatric presentation. Despite the inclusion of DID in diagnostic criteria for the past 34 years, the validity of this diagnosis remains the topic of debate. Sceptics have suggested that DID is not a valid psychiatric disorder, but a socially-constructed, and even an iatrogenic, condition (e.g. Lilienfeld et al., 1999). Proponents of DID argue that the validity of DID is comparable to that of other psychiatric diagnoses (Gleaves, May & Cardena, 2001), and it is in fact "disturbingly under-studied by all professionals and [is] both undiagnosed and misdiagnosed" (Sinason, 2002, p.9).

More recently, emerging research has begun to provide evidence for the validity of the diagnosis. Brain imaging studies have highlighted smaller hippocampal and amygdalar volumes in DID patients than in healthy controls (Vermetten et al., 2006) alongside similar areas of cortical activation in DID and PTSD (e.g. Chalavi, et al., 2015a). The medical, diagnostic model has been criticised for its reductionist approach (e.g. Boyle, 2007). Diagnoses are atheoretical and as such do not provide the clinician with clear information pertaining to aetiology, prognosis or treatment (Johnstone & Dallos, 2006). Diagnostic criteria imply that there are discrete boundaries separating disorders. However, reaching a diagnosis based on taxonomic criteria can result in patients with only partially overlapping or even entirely different clusters of symptoms receiving the same diagnosis (Tarrier & Calam, 2002; Kendell & Jablensky, 2003). In their position statement, the British Psychological Society (BPS) argued that diagnosis may marginalise clients' experiences and opinions and may lead to their disempowerment. They suggest that a new paradigm is needed that is "multi-factorial, contextualises distress and behaviour, and acknowledges the complexity of the interactions involved in all human experience." (Division of Clinical Psychology; DCP, 2013, p. 4).

2.1.2 Impact of controversy on the client

The controversy surrounding the diagnosis of DID can produce what Sinason calls a 'curious secondary splitting' of teams of professionals (2002, p. 12), systemically echoing the fragmentation of the individual. Floris and McPherson (2015) interviewed seven newly-diagnosed adults with DID about their experiences of receiving the diagnosis and found that disagreement between professionals, and continued questioning of clients' past and current experiences may damage their "already fractured sense of self" (p. 492). The authors concluded that the proposed paradigm shift from sole reliance on diagnosis to increased emphasis on formulation (DCP, 2013) may therefore be beneficial. This highlights the need for a more holistic approach when conceptualising DID in order to validate and contextualise clients' experiences.

2.1.3 Case formulation

Case formulation provides an alternative conceptual framework for understanding a client's difficulties (Johnstone & Dallos, 2006). It "is the summation and integration of the knowledge that is acquired by the assessment process" (BPS, 2011, p. ii). Formulation synthesises clinical research and theory along with the experience of the client (Kuyken, Padesky & Dudley, 2009), serving as a working hypothesis regarding the aetiology, symptomatology, and maintaining factors underpinning an individual's difficulties (Johnston & Dallos, 2006). Standardised, problem-specific formulations provide a point from which to then develop person-specific and individualised formulations (BPS, 2011). A key strength of this process is that it offers a bridge to treatment (Restifo, 2010, p. 210), informing therapists' understanding of their clients' difficulties and ultimately allowing them to develop tailored and effective interventions (Summers, 2006).

The key features of formulation remain constant across all therapeutic traditions: summarising the clients' main difficulties; identifying how problems relate to one another; drawing upon psychological models to explain the aetiology of the client's presenting problems; and generating an intervention plan (Johnstone & Dallos, 2006). In contrast to deficit-focused diagnostic criteria, formulation also highlights the individual's strengths in surviving difficult circumstances.

Despite published guidelines from the BPS (2011), there remain questions regarding the validity of case formulation (Mumma, 2011). Bieling and Kuyken (2003) report that there is no clear consensus as to what should be included in a good formulation and research has demonstrated low inter-rater reliability between therapists when formulating the same client (Kuyken, Fothergill, Musa and Chadwick, 2005). Whilst formulation often involves the integration of a number of theoretical models, there is currently a lack of appropriate frameworks with which to achieve this (BPS, 2011).

There is a clear rationale for the use of formulation, nevertheless there remains a lack of consensus pertaining to the most important aspects to include. Thus there is a need for further research regarding which aspects to prioritise and how best to integrate theoretical models (BPS, 2011; Flitcroft, James, Freeston, & Wood-Mitchell, 2007).

2.1.4 Formulating DID

The task of formulating DID is complicated by the lack of national clinical guidelines (e.g. NICE), despite the publication of international treatment guidelines (ISSTD, 2011). Furthermore, presentations of DID, with obvious symptomatology are uncommon and occur in only 6% of this client group (Kluft as cited in ISSTD, 2011). As a result DID can remain unseen by both the client and the therapist, resulting in clients presenting co-morbid symptoms (e.g. depression, substance abuse) being labelled as the primary diagnosis (ISSTD, 2011). Formulation is particularly useful when conceptualising complex cases, especially when working with clients who present with co-morbid diagnoses (Tompkins, 1999). In order to include explanatory information with which to contextualise clients' difficulties it is necessary that therapists draw upon appropriate theories and models of DID when constructing their formulations.

2.1.5 Models of DID

Several models of DID have been proposed, which therapists can draw on when conceptualising this presentation (e.g. Putnam, 1997; Kennedy et al., 2004). However there is currently a paucity of literature supporting these and no widely accepted central model. Whilst describing all available models of DID in detail is beyond the scope of the current paper[2], there follows an outline of the two main categories: trauma models and sociocognitive models.

2.1.5.1 Trauma Models

Trauma models (TMs; e.g. Ross, 1997) posit that DID develops during infancy or childhood as a response to severe, intolerable trauma from which the child cannot physically escape. Dissociation enables the child's mental escape; however, repeated reliance on this mechanism results in disruption to personality integration. Trauma models can be further subdivided into attachment models and structural models (see Stokoe, 2014).

Attachment models (e.g. Barach, 1991; Liotti, 2004) postulate that in the context of disorganised attachment relationships, information pertaining to an abusive or negligent caregiver is not mentally or behaviourally integrated. This leads to the development of a number of attachment models, which allow the individual to maintain attachments with inconsistent caregivers. These unintegrated attachment models account for the resulting dissociated self-states in adulthood.

The structural model (Nijenhuis, van der Hart & Steele, 2010) suggests that humans have evolved to protect themselves from traumatic material by structurally splitting the personality; separating emotional systems from those involved in daily functioning. For example, compartmentalising traumatic material in order to allow the individual to function without awareness of it in everyday life.

2.1.5.2 Sociocognitive model

The sociocognitive model of DID (SCM; Spanos, 1994) proposes that patients unconsciously 'enact' different self-states due to differing social and cultural roles, which in turn are shaped and differentially reinforced by legitimisation of symptoms by therapists and the media. The sociocognitive and trauma models differ greatly in their understanding of the aetiology of DID. Unlike trauma models, the sociocognitive model does not support the role of trauma in the development of DID, instead suggesting that clients are more prone to fantasy and suggestion (Piper & Merskey, 2004).

2.1.5.3 Validity of competing models

There is continued debate regarding the relative importance and validity of these competing models, particularly regarding the role of trauma in the development of DID. A recent review of the literature found significant evidence for the trauma model and failed to confirm the sociocognitive model (Brand et al., 2014). Comparisons of diagnosed and enacted DID suggest that actors are unable to replicate the psychophysiological and neural reactions of DID patients (Boysen & Van Bergen, 2013; Reinders, Willemsen, Vos, den Boer, & Nijenhuis, 2012). It is possible that social reinforcement contributes to the maintenance of self-states, however there remains a dearth of empirical support for this claim.

Both clinical studies and imaging research have demonstrated a strong association between trauma and DID (e.g. Coons, 1994; Chalavi et al., 2015b). In light of the empirical evidence supporting the trauma model, it has been suggested that ignoring the post- traumatic symptomatology of DID could be harmful to clients (Gleaves, 1996; Gleaves, May & Cardena, 2001). Measurable differences in brain activation and psychobiological responses have been demonstrated between the emotional and functional systems proposed by the structural model (Reinders et al., 2003, 2006). Longitudinal data suggests that both trauma (age of onset, chronicity and severity) and attachment patterns (avoidant and disorganized) are strong predictors of dissociation (Ogawa, Sroufe Weinfield, Carlson, & Egeland, 1997). However, as the study used a non-clinical sample, there is a need to extend this research to examine the efficacy of this model with DID. The empirical support for both attachment and structural models suggests that they are non- conflicting. However, the manner in which clinicians integrate these differing models in clinical practice is an area that requires further research.

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[2] For a comprehensive review of the literature, see Stokoe, 2014.

2.2 Rationale

Despite the ongoing debate regarding the models of DID, there is a lack of research investigating formulation within the DID population. Good formulation informs intervention by clarifying hypotheses and prioritising problems (Butler, 1998) and can prove to be a powerful intervention in its own right (BPS, 2011). Understanding how clinicians formulate DID may extend our knowledge of this complex presentation and therefore warrants further attention.

The research protocol was adapted from a paper by Flitcroft and colleagues (Flitcroft, James, Freeston, & Wood-Mitchell, 2007), who used Q-methodology to investigate what therapist participants felt were the most important features of a Cognitive Behavioural Therapy (CBT) case formulation of depression. This study examined what therapists felt were the most essential items to include in their conceptualisation and formulation of DID.

2.3 Q-methodology: a method for studying subjective viewpoints

Q-sort methodology (Stephenson, 1935) is used to systematically and quantitatively study subjectivity (participants' points of view regarding a particular topic), allowing statistical analysis of *gestalt,* inter-rater comparisons (Brown, 1996). Essentially, participants are asked to rank-order (Q-sort) a set of statements (the Q-set) pertaining to the topic in question. Participants are purposively selected in order to obtain a sample that is hypothetically relevant to the research subject under consideration (Brown, 1980). In doing so, the researcher aims to include participants who are expected to have a distinct or strongly held perspective regarding the research question, and therefore may define a particular viewpoint or 'factor' (Brown, 1980).

Q-studies consist of a series of phases. Initially, sample statements are collected by the researcher to develop a Q-set, which is drawn from and representative of the concourse (the total sum of statements about the topic; Brown, 1993). These statements can be selected using a number of different approaches including interrogation of the literature on a chosen topic or analysis of interview data. Following this, the Q-set is administered to a group of participants (the P-set), who Q-sort the value of each statement (i.e. rank) according to their own beliefs and understanding of the topic (Flitcroft et al., 2007). Participants then elaborate on why they chose the statements they placed under the poles of the distribution (representing their strongest [dis]agreement with items).

The analysis of Q data utilises a form of factor analysis, whereby 'n' Q-sorts are ranked by 'm' participants (Stephenson, 1936). The meaning and significance of the analysed configurations "must then be attributed *a posteriori* through interpretation rather than through *a priori* postulation" (Brown, 1980, p. 54). Q-methodology does not produce generalizable outcomes; however, it is a useful exploratory technique, which is data- rather than theory-driven. A particular strength of this approach is in its theory-generating potential (Stenner, Dancey & Watts, 2000) as a precursor to hypothetico-deductive testing. Given the lack of consensus regarding the theoretical models of DID, a Q-methodology study of how therapists make sense of this presentation in clinical practice will help clarify their subjective viewpoints and to extend the literature.

2.4 Research Questions

The aim of the current study is to examine a range of subjective viewpoints communicated by therapist participants. There are therefore three main research questions:

1. What key factors (themes) capture therapists' understanding, description and formulation of DID in real-world clinical practice?
2. What variation exists within this?
3. How do any factors that are identified relate to models of DID?

2.5 Method

2.5.1 Ethical considerations

The study received full ethics approval from the University of Southampton's Ethics Committee (appendix B). Research governance approval was obtained from each participating NHS trust site and approval was granted by the European Society for Trauma and Dissociation (ESTD) Research Committee (appendix C).

2.5.2 Participants

2.5.2.1 Sample Size

Q-methodology does not demand a large number of participants (Watts & Stenner, 2005, 2012). The diversity and breadth of the sample, or P-set, is more important than the quantity (Brown, 1996). "Q-methodology aims to reveal (and to explicate) some of the main viewpoints that are favoured by a particular group of participants" (Watts & Stenner, 2005, p. 79) and as such, the P-set need only contain enough participants to establish the existence of a factor in order to compare one factor with another (Brown, 1980).

In Q-methodology, in order to retrieve factors there should be at least twice as many items in the Q-set as there are participants in the P-set (e.g. Webler, Danielson, & Tuler, 2009). In the current study, the number of items in the Q-set was 54 (see section 2.5.3.3 below for information regarding the development of the Q-set) and therefore the P-set for the current research should not exceed 27 participants.

2.5.2.1 Sampling Strategy

Data was collected in two phases. In the initial phase, participants were recruited via an online screening survey, using an opportunistic sampling method. Participants for the second phase were purposively sampled from those who had completed the screening survey. Given that the effectiveness of case formulation is affected by the competence and experience of practitioners (Eells, Lombart, Kendjelic, Turner, & Lucas, 2005) therapists who had worked with a client with DID for at least 3 months were recruited for the Q-sort task. The participants were drawn from a range of professions and theoretical orientations, with the aim of maximizing the diversity of the P-set, whilst upholding a minimum level of expertise.

2.5.2.2 Inclusion and Exclusion Criteria

The inclusion and exclusion criteria for this study are outlined in Table 2, below.

Table 2. Participant Inclusion and Exclusion Criteria.

Survey Phase	
Inclusion Criteria	*Exclusion Criteria*
Participants were included if they were qualified therapists.	Therapists were not included if they had not yet completed a formal qualification (E.g. Assistant or Trainee Clinical Psychologists).
Q-sort Phase	
Inclusion Criteria	*Exclusion Criteria*
Participants were qualified therapists who had completed the online survey and had opted in to the Q-sort phase of the study. All selected participants indicated that they had worked therapeutically, for at least three months, with a patient who met the diagnostic criteria for DID.	Therapists who had not worked therapeutically with a patient who met the diagnostic criteria for DID for at least three months were not included in the study. Therapists who could not read English were excluded from the study.

2.5.2.3 Demographics

In total, 81 therapists completed the screening questionnaire, 64 of whom volunteered to participate in the Q-sort phase of the study. Of these, 56 met the inclusion criteria and were invited by email to complete the Q-sort. A total of 18 participants completed the Q-sort, giving a recruitment rate of 32%. Of those who did not complete the Q-sort, two were unable to participate due to lack of time and three encountered significant technical difficulties and could not complete the sort. A further 30 participants did not respond to the request to participate and as such it is not possible to comment on the reasons for their attrition. Finally, one participant completed the Q-sort, but subsequently contacted the researcher to explain that on reflection they did not feel that their sort accurately reflected their opinion on the research question. As such this participant’s data was excluded from the analysis.

For the Q-sort, ages of participants ranged from 26-60 years. They ranged in experience as therapists from four years to over 10 years, and from three to six-months experience of working with a client with DID to over 10 years. Participants practiced a range of professions: Clinical Psychologists (7, 38.89%), Psychotherapists (6, 33.33%), Counsellors (3, 16.67%), Counselling Psychologist (1, 5.56%) and CBT Therapist (1, 5.56%).

2.5.3 Measures / Apparatus

2.5.3.1 Screening questionnaire

An online screening survey was developed to gather demographic information, to ascertain therapists’ experience of DID and to introduce and recruit participants for the Q-sort (see appendix D).

2.5.3.2 Video vignette

Typically Q-studies use a written clinical vignette as a springboard for the sorting process (e.g. Flitcroft et al., 2007). The current study, however, used a video vignette which portrayed a montage of therapy with a client with DID across several sessions. It featured an actress who played a client with DID and a therapist colleague who portrayed the therapist. The original footage was developed and filmed as part of a previous study, but was not used in the final project (Stokoe, 2014). The researcher, in consultation with the supervisory team[3] edited the video from 82 minutes, down to 34 minutes. The video was piloted with a sample of Trainee Clinical Psychologists (N= 7) in order to assess length and pacing of the clip. The pilot sample were recruited using opportunistic sampling. The video was then further edited in line with the feedback received before it was embedded in the online software.

2.5.3.3 Q-set generation

In the Q-methodology vernacular, the sum of possible discourses around a particular topic is referred to as the concourse. A Q-set (or Q-sample) is sampled from, and aims to be broadly representative of, the concourse. It comprises a variety of statements, each of which communicates a point of view in relation to the issue under consideration. Typically, a Q-set contains 40 to 50 statements (van Exel & de Graaf, 2005); however, it is possible to conduct a Q-study with more or fewer items than this (e.g. Van Eeten, 1998, as cited in van Exel & de Graaf, 2005). A sample of the concourse is selected based on a structure, which may be *imposed* on the concourse *a priori* based on theory or *emerge* from further examination of the statements in the concourse. Varied statements are selected in order to ensure the Q-set is comprehensive, balanced and broadly representative (Brown, 1980).

First, to survey the `conceptualisations of DID' concourse, *quasi-naturalistic statements*[4] were adapted directly from interview data from eight expert therapists (Stokoe, 2014). Statement selection was structured around the 3 major categories comprising the "Phenomena" in Stokoe's (2014) constructivist grounded theory analysis

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[3] Dr Lusia Stopa (University of Southampton), Dr Tess Maguire (Southern Health NHS Foundation Trust) and Dr Nicole Stokoe (Solent NHS Trust)

[4] Quasi-naturalistic statements refer to items taken from participants who are external to the current study

of interviews with ‘expert therapists’, namely: ‘‘The Rationale’; ‘The Client’s Internal World’ and ‘The Appearance of the Internal World to the Outside World’ (see Table 7 for a description of each category and Appendix E for a diagram of Stokoe’s 2014 staged therapeutic model of DID). *Ready-made* statements were also developed, based on the DID literature pertaining to the sociocognitive model of DID in order to produce a hybrid sample (McKeown & Thomas, 2012). The resultant list of statements targeted the features, or concepts, which inform the conceptualisation or ‘formulation’ of DID. Editing of items by the researcher was kept to a minimum and the natural phrasing of items was retained wherever possible (McKeown & Thomas, 2013). Consultation took place with three experienced therapists, in order to remove repetitious or ambiguous items.

A structured sampling technique was employed to select a subset of statements for the Q-set (McKeown & Thomas, 2013). Eighteen items were selected per major category, with the aim of providing a broadly representative sample of the variety of statements in the concourse (see Table 7 for example statements for each of the major categories). Thus a final hybrid Q-set was constructed, comprising of 3 x 18 = 54 statements in total (see Table 9 for the final list of statements).

Table 7. Description and example statements for major categories.

Category	Description	Example statements
Rationale	Why DID develops	“Humans have an innate internal mechanism that enables dissociation”
Client’s Internal World	Self-states and the dynamics between them	“Switching can be triggered by both internal and external stimuli which are perceived as threatening”
Appearance of the Internal World to the Outside World	Presenting problems and helpful aspects of DID	“Individuals with DID experience a sense of confusion and disorientation”

2.5.3.4 Online Q-sort development

Traditionally, Q-sorts are completed in paper form and are administered by the researcher (e.g. Stephenson, 1953). Increasingly, researchers are making use of the internet to conduct Q-methodological studies, with several purpose-made programmes existing to fulfil such a brief. In their validation study, Reber, Kaufman, and Cropp (2000) found no apparent difference in the reliability or validity of computer-based and face-to-face Q-sorts. The current study used FlashQ (Hackert & Braehler, 2007), which was selected based on its ease of use and apparent ecological validity: using a physical "drag and drop" sorting method designed to be analogous to the offline traditional sorting method.

Clear instructions are crucial when developing a Q-methodological study, and are of particular importance when participants are invited to complete the sort remotely (Watts & Stenner, 2012). As such, the instructions included in the FlashQ software were adapted by the researcher to provide a clear and comprehensive step-by-step guide on how to complete the sort (see appendix F for the full instructions). The instructions, along with the overall FlashQ programme were piloted with individuals who had never before completed a Q-sort and were subsequently updated in line with the feedback received.

The present study employed an inverted quasi-normal 'forced' distribution; whereby a specific number of statements were prescribed for each rank. The 11-point rating scale ranged from -5 to +5 (see Figure 2, below) in keeping with Brown's (1980) recommendation for Q-sets containing 40-60 items. Unlike Likert-style scales, the distribution grid in a Q-sort ensures that each item is sorted *in relation* to each other item. As such, each Q-sort represents a 'gestalt' model of the sorter's subjective engagement with the research question.

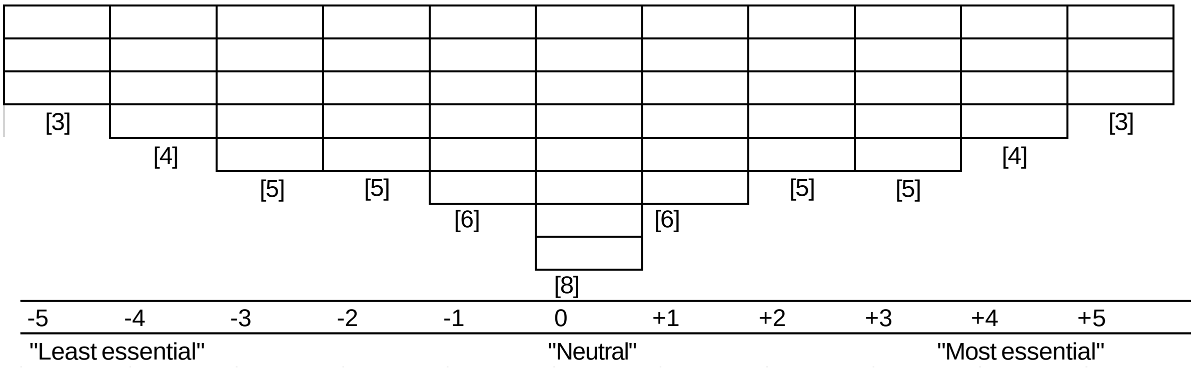

Figure 2. The quasi-normal forced Q-distribution grid: Ranking values ranged from -5 to +5. Numbers in [brackets] indicate the number of items that can be assigned to each particular rank.

Both the video vignette and the FlashQ software were embedded within an online survey form and were hosted on the University of Southampton’s secure server.

2.6 Procedure

2.6.1 Recruitment procedure

All mental health NHS Trusts in England were approached to participate in the research (56 Trusts in total) and of these, 12 agreed to participate (see appendix G). In addition, the study was approved by the research committee of the European Society for Trauma and Dissociation.

A recruitment email, containing a link to the online screening survey and an information sheet, was circulated by each organisation involved to enable therapists to participate voluntarily (appendices H & I). An email was also circulated by the researcher to private UK therapists with an interest in dissociative disorders, who advertised their practices online and to UK members of the ISSTD as advertised on their website.

2.6.2 Screening questionnaire

Upon completion of the online survey participants were provided with information about the next phase of the research (appendix J). They were then given the opportunity to *opt in* to participate in the Q-sort by checking a box and entering an email address by which they could be contacted.

2.6.3 Administration of the Q-sort

Participants accessed the Q-sort via an online web link emailed from the researcher (appendix K). They were first asked to watch the embedded clinical vignette video clip and then to begin the Q-sort task. The Q-set was presented to each participant in a randomised sequence and they were asked to sort all 54 items according to the following instructions:

> You have met with the patient shown in the film over several assessment sessions with the aim of delivering a therapeutic intervention. When developing your conceptualisation / formulation for her, which features would you consider most essential to include, and which would you consider least essential?

Participants were instructed to complete two sorts of the Q-set. The initial 'rough' sort involved organising the statements into three piles ("Least essential", "Neutral" and "Most essential"), determined by the extent to which they valued the statements in relation to the research question. Following the initial sort, participants were then asked to further sort the statements on a Q-distribution grid, based on an extended scale, from - 5 to +5 (with -5 representing the "least essential" items and +5 representing the "most essential" items). The kurtosis of the distribution grid was determined by the nature of the topic: a flatter distribution was deemed appropriate in order to allow strong (dis)agreement with statements as participants were expected to have well-articulated opinions on the subject (van Exel & de Graaf, 2005).

Participants were asked to review their sort to ensure that they were satisfied that the configuration best represented their current views before being asked to give a written explanation for their choice of statements placed at the poles of the distribution (-5 and +5). Finally participants were given the opportunity to suggest any items that they felt were missing from the Q-set and were invited to leave any further comments regarding either their work with clients with DID or regarding the study in general. The mean time taken to complete the Q-sort was 56 minutes and 54 seconds.

2.6.4 Analysis strategy

In Q-methodology, the overall *configuration*s created by the participants are examined *by-person*, and as such overall Q-sorts are inter-correlated and factor-analysed (Watts & Stenner, 2012). A number of dedicated online software packages exist to appropriately analyse the results of Q-studies. The current study used PQMethod, a freely available and widely used programme, which was downloaded from the internet (Schmolck, 2002).

There are two contending statistical methods used for Q-factor extraction; namely Centroid Factor Analysis (CFA) and Principal Components Analysis (PCA). A number of studies suggest that there is little difference in the solutions generated by each method (see Costello & Osborne, 2005, for a review of this topic). Although PCA is more widely used outside of the Q community, traditionally the method of choice for Q-methodological studies is CFA. Indeed, it is argued that only factor analysis can truly estimate underlying constructs or factors in Q-studies (Schmolck, 2002).

A ‘best-estimate’ factor array was produced to characterise each factor from an amalgamation of all of the participants who load significantly onto that factor. Factor interpretation is based upon the interrogation of the configuration of these ‘best-estimate’ factor arrays in conjunction with the qualitative feedback for each of the items ranked at the poles. The factors were interpreted together with open-ended comments written by participants about their individual sort, in order to highlight the commonalities and divergences in participants’ responses.

2.7 Results

2.7.1 Statistical Overview

The completed Q-sorts were entered individually into the dedicated computer package PQMethod (Schmolck & Atkinson, 2012) and inter-correlated, producing an 18 x 18 correlation matrix. Factor analysis of these sorts resulted in the identification of four factors with eigenvalues above 1.00 (Brown, 1980). However, none of the 18 Q-sorts loaded significantly onto the fourth factor (no factor loadings exceeded ±0.35) and as such, it was excluded from the final solution (Brown, 1980).

Three factors were therefore extracted using CFA and were rotated using a varimax criterion in order to maximise the difference between factors. This solution accounted for 50% of the total study variance (Factor A 19%, Factor B 19% and Factor C 12%). Factor loadings of ±0.35 or above were significant at the p < 0.01 level. All 18 Q-sorts loaded significantly onto at least one of the three factors.

Identification of defining sorts, which load significantly onto one factor only, known as 'factor exemplars' provided a focused perspective of each particular factor (Brown, 2000). In order to better distinguish between factors and to minimise confounded sorts, only loadings in excess of ±.45 were flagged as 'factor exemplars' (Watts & Stenner, 2012). Fifteen out of 18 Q-sorts were flagged as factor exemplars. Table 8 below presents the factor loadings of the 18 Q-sorts for the three factors and includes the total variance for each factor.

Table 8. Factor Matrix with an X Indicating a Defining Sort.

	Loadings					
Q-sort	1		2		3	
1	0.1231		0.1515		0.6746	X
2	0.6056	X	0.2567		0.4242	
3	0.5885	X	0.0350		0.2130	
4	-0.1211		0.8276	X	0.3012	
5	0.0740		0.3724		0.4894	X
6	0.3765		0.5566	X	-0.0055	
7	0.5194	X	0.4018		0.3570	
8	0.5495		0.5151		0.1978	
9	0.3586		0.4094		0.3930	
10	0.5261	X	0.3148		0.1770	
11	0.2843		0.6599	X	0.0530	
12	0.2528		0.6416	X	0.1392	
13	0.3242		0.5142	X	0.3067	
14	0.6473	X	0.1386		0.2447	
15	0.4006		0.1866		0.5493	X
16	0.6705	X	0.1435		-0.0572	
17	0.5357		0.0817		0.5397	
18	0.0601		0.6246X	X	0.3246	
% expl.Var.	19		19		12	

Note: "X" indicates defining factor loadings flagged for computing factor score.

Statements are sorted into a similar configuration across factor exemplars, which suggests that they represent similar viewpoints regarding the issue in question. For example, the six sorts that load significantly onto Factor A share a particular pattern of sorting and hence a shared perspective regarding the conceptualisation of DID.

In order to interpret each factor holistically, factor exemplars were amalgamated using weighted averages to produce a 'factor array' for each factor; a single exemplary Q-sort that best represents the configuration of each of the three factors. Table 9 below outlines the factor arrays for each of the three study factors. To aid the interpretation of each factor, distinguishing statements that statistically differentiate between the three factors were considered alongside consensus statements, which identify areas of similarity between factors. Items rated at the extremes of the sorting scale were also considered alongside the qualitative feedback given for them.

Even with the emergence of three discrete factors, 11 items were determined to be 'consensus statements' due to the lack of a statistically significant difference between their sorting positions across the three factors. These consensus statements represent areas of agreement across *all* therapists regarding their relative importance when formulating with this client group. Three consensus statements were clustered at the "least essential" end of the sorting distribution (-5), and included items pertaining to the 'creation' of DID either by the therapist-client dyad (49) or by popular culture (54), as well as an item stating that DID is a culturally specific disorder (51). The remaining eight consensus statements were clustered around the "neutral" centre of the distribution.

One item focused on the development of DID in order to ensure the individual's physical survival (13). Five items focused on switching between self-states: as automatic coping mechanisms (25); which results in individuals presenting differently in different situations (9, 21, 33); and experiencing feelings of helplessness (29). The final two consensus items focused on their current experience of past trauma: amnesia (12) and a sense of shame (41).

Table 9, Abbreviated Q-set with factor arrays: Consensus and distinguishing items indicated.

↕= distinguishing statement, with significance at p<.01

→ =consensus statement, with non-significance at p>.05

			Factor Arrays		
	Q set statement		A	B	C
1	Humans have an innate internal mechanism that enables dissociation		-1	0	-3
2	DID is a result of severe & enduring trauma during critical periods of infant brain dev…		2	0	-3
3	The development of DID occurs in the context of extreme vulnerability, powerless…		4	↕0	4
4	DID arises when a trauma is too overwhelming for a child to process in an integrative way		5	5	↕1
5	Individuals with DID are not necessarily victims of abuse		-3	-4	-4
6	Individuals with DID experience attachment figures as powerful, controlling, punitive…		1	-1	-1
7	Individuals develop DID to preserve an attachment with an abusive... care-giver		↕5	↕-4	↕1
8	Individuals with DID develop several attachment models which results in several self…		0	-2	↕5
9	Individuals present very differently in different situations…	→	-2	0	0
10	Different memories are held within different self-states		1	3	3
11	Individuals with DID lack an integrated sense of self		0	-1	-2
12	Individuals with DID experience either partial or total amnesia regarding their traumatic past		1	1	2
13	DID develops in order to ensure an individual's physical survival		0	-1	0
14	DID develops as an automatic survival response		↕-1	↕4	↕-4
15	DID provides a sense of safety to ensure an individual's mental survival		4	2	↕-1
16	Individuals with DID, amnesia acts as an unconscious defence against their traumatic past		0	4	2
17	Different self-states can enable the person to function… and fulfil a variety of roles		↕0	↕2	↕5
18	DID can protect the individual from experiencing traumatic events		0	-2	-4

Table 10 cont, Abbreviated Q-set with factor arrays: Consensus and distinguishing items indicated.

↕= distinguishing statement, with significance at p<.01

→ =consensus statement, with non-significance at p>.05

			Factor Arrays		
	Q set statement		A	B	C
17	Different self-states can enable the person to function… and fulfil a variety of roles		↕0	↕2	↕5
18	DID can protect the individual from experiencing traumatic events		0	-2	-4
19	Self-states can vary in: age, beliefs, attitudes, values, behaviours, preferences and agendas		1	3	1
20	In DID there is a separation of emotional self-states from self-states that enable functioning		↕3	↕0	↕5
21	The self-states that enable day-to-day functioning often display reduced emotional reactiv…	→	-2	-3	-1
22	Individuals are often afraid of upsetting or angering a punitive abusive self-state		↕4	-2	0
23	There is usually a functioning 'front' self-state		0	1	3
24	There is a hierarchy of power and influence within the internal system		-1	-3	↕3
25	Switching between self-states becomes an automatic coping strategy for individuals with…	→	2	1	1
26	Individuals with DID are often unaware of the switching between self-states that occurs		↕-3	2	3
27	Different self-states are all parts of one fragmented personality		-1	2	2
28	Switching between self-states is obvious to the onlooker		↕-4	-1	-2
29	Individuals with DID often experience feelings of helplessness and lack of control	→	-1	0	1
30	Switching can be triggered by internal & external stimuli which are perceived as threat…		3	3	4
31	There is a tension between self-states that want to know the truth & those that don't		↕3	-3	-3
32	Different self-states may hold different information, some more distressing than others		1	2	4
33	Some self-states may be more willing than others to engage with the therapist	→	2	1	1
34	Therapy can be sabotaged by aspects of internal system if it challenges their internal…		5	↕-2	3
35	Individuals with DID are often phobic of uncovering the truth about past trauma		3	↕-3	2
36	Individuals with DID are often secretive as they have learnt to keep quiet to keep safe		-2	0	2

Table 11 cont, Abbreviated Q-set with factor arrays: Consensus and distinguishing items indicated.

↕= distinguishing statement, with significance at p<.01

→ =consensus statement, with non-significance at p>.05

			Factor Arrays		
	Q set statement		A	B	C
37	Individuals with dissociative identity disorder often experience many symptoms of PTSD		1	-1	-1
38	Individuals often initially access therapy for problems such as anxiety...rather than DID per se		3	3	↕-1
39	Individuals with DID experience a cycle of acute mental health crisis		-3	-2	0
40	Individuals with DID may be at ongoing risk of harm from self or others		↕4	↕1	↕-2
41	Individuals with DID experience a sense of shame regarding their traumatic past	→	0	0	0
42	Individuals with DID often experience interpersonal problems		-3	↕3	-2
43	Individuals with DID often experience periods of time that they are unable to account…		2	5	4
44	Individuals lack a coherent autobiographical timeline into which experiences are…		2	1	↕-2
45	Definably different self-states can be signified by observable differences		-2	↕4	0
46	It is possible for more than one self-state to be present at a time		-1	-1	-3
47	Individuals with DID are often surprised by the feedback that they receive from others		↕-3	↕4	↕0
48	Individuals with DID experience a sense of confusion and disorientation		-2	↕5	-1
49	DID is co-created by the therapist and the client	→	-4	-5	-5
50	Individuals with DID are more prone to cognitive distortions		-4	-3	-4
51	DID is a culture-specific disorder	→	-5	-5	-5
52	Individuals with DID are more prone to fantasy		-5	-4	↕-3
53	Individuals with DID are highly suggestible		-4	-4	↕-1
54	DID is constructed by popular culture	→	-5	-5	-5

2.7.2 Factor Interpretation

The aim of factor interpretation is to reveal the shared perspectives represented by each factor. It is a hermeneutic process, involving the careful consideration of the entire configuration of each factor array in order to understand the viewpoint in its entirety. Figure 3 provides an illustration of the factor array for Factor A presented as a gestalt to aid interpretation.

Least Essential — Neutral — Most Essential

-5	-4	-3	-2	-1	0	1	2	3	4	5
54	53	47	48	46	41	37	44	38	40	34
52	50	42	45	29	23	32	43	35	22	7
51	49	39	36	27	18	19	33	31	15	4
	28	26	21	24	17	12	25	30	3	
		5	9	14	16	10	2	20		
				1	13	6				
					11					
					8					

Figure 3. Factor array for Factor A.

Each factor is described below in narrative form, accompanied by the rankings of specific items. Demographic details are also summarised for those participants whose Q-sorts loaded significantly onto the factor in question. Participants were invited to provide a written explanation of their choices at the extreme ends of the distribution and these comments are used to assist the process of interpretation where they clarify the viewpoint. Throughout the factor interpretations, the relevant item number and its rank in the factor array are included in parenthesis; for example, (4: +5) indicates that item 4 is ranked at +5 (most essential) position relative to other items in the Factor A array.

2.7.2.1 Factor A: “Trauma, attachment and the internal system”

This factor accounted for nearly a fifth of the total study variance (19%) and was defined by six sorts which loaded onto it significantly and uniquely. The participants who completed defining Q-sorts occupied a range of professions: Psychotherapists (4), Clinical Psychologist (1) and

Counselling Psychologist (1). Five participants were female and one was male, with ages ranging from 31-35 to 56-60 years.

The exemplars in this factor emphasised the importance of the inclusion of childhood trauma in their conceptualisations. DID develops in the context of extreme fear and vulnerability (3: +4), when a trauma is too overwhelming for a child to integratively process (4: +5), DID "serves a function, to protect the young child from unbearable fear and vulnerability" (Participant 7). One participant explained:

> I see this as a form of coping. If a child is unable to articulate or process a trauma in an integrative way, or s/he soon learns unhelpful beliefs such as "it is bad to be silly," "it is bad to feel sad," then the child may switch to alternative states to help him/her cope with the trauma. This may be similar to fragments of one's personality e.g. 'my strong side,' angry self, 'part of me that can't say no' etc. (Participant 16).

Exemplars in this factor also highlighted the importance of including information pertaining to the individual's attachments in their formulations. Individuals with DID often experience attachment figures as powerful and dangerous (6: +1). DID develops in order to protect the individual's mental well-being (15: +4) and to preserve the attachment with an abusive or negligent care-giver (7: +5) "to ensure survival of self or others by developing self-states that either satisfy the needs of an abuser or where the person perceives that seeking help will not provide help" (Participant 2). One defining participant explained that:

> Repeated abuse often occurs at the hands of care givers, hence the need to 'seal off' awareness of the abuse in order to preserve the attachment. This leads to the conflictaround knowing about the trauma, manifested in different parts having different attitudes to the therapy. (Participant 7).

The importance of the dynamics and tensions present in the internal system of self- states when formulating with clients with DID was prioritised. The factor exemplars highlighted the separation of emotional self-states from the states that enable functioning (20: +3). The need to acknowledge that there may be tension between different self-states due to differing attitudes to uncovering the truth (31: +3) was also prioritised. The impact of this internal system upon the individual with DID was stressed as the individual may be afraid of angering punitive self-states (22: +4) and may be at ongoing risk of harm from self or others (40: +4). The importance of the impact of the internal system on the therapeutic process was also highlighted, as aspects of the internal system may sabotage therapy (34: +5). “This may lead to therapy interfering behaviours and so needs to be prioritised in formulation and therapy” (Participant 10) and “reminds us that as the therapy is aimed at reducing the effectiveness of the psychological structure of DID, this is likely to be very threatening and so resisted” (Participant 14).

Factor A exemplars did not prioritise items pertaining to the visibility of DID to the clients themselves (47: -3; 26: -3) or to onlookers (28: -4). They also placed less emphasis on the functional benefit of DID than other factors (17: 0). Clients’ proneness to fantasy was ranked as least essential by this factor (52: -5) with participants stating that they disagreed with the statement: “I don't think that capacity for fantasy is enhanced by DID structure, though fantasy may be more concretely engaged with by the client, leading to the misreading of situations through transference projections being more powerfully felt.” (Participant 14).

The consensus item pertaining to DID as a disorder which is constructed by popular culture (54: -5) was also ranked not only as least essential but was described as unhelpful: “This suggests that DID it is not real, something that is hard to accept when you have witnessed someone with DID and the fear, confusion and distress they experience.” (Participant 7). The difference between the disorder being created by popular culture and being misrepresented by it was also highlighted:

> DID is sensationalised by popular culture, much like most psychological difficulties like bipolar disorder, depression, OCD, schizophrenia etc. Although media, popular culture etc. increase awareness, presentations

> are often exaggerated and this construction is often untrue and stigmatising to people diagnosed with DID. (Participant 16)

Finally, the concept of DID as a culturally specific disorder was also ranked as least essential (51: -5) and feedback noted participants' rejection of this idea: "This implies that it is created by conscious choice ...who would choose this way of being?" (Participant 3). However, the idea that the internal system may be influenced by culture was acknowledged:

> It seems probable that the different parts or states of DID are influenced by people's cultures, however, I believe that DID itself is most likely to develop in the context of overwhelming trauma that cannot be processed at the time and developmental stage that it is experienced. (Participant 10).

Interestingly, whilst therapists ranked this item as least essential in their formulations due to their belief that DID develops naturally, one participant also highlighted the link between culture and specific types of abuse, stating that they "would put in essential if the statement means mind control induced or satanic ritual abuse in which case I would call that culture specific. I see as development from naturally occurring mechanism." (Participant 2).

2.7.2.2 Factor B: "The conscious experience of DID"

This factor accounted for nearly a fifth of the total variance (19%) and was defined by six Q-sorts. This factor was defined by the Q-sorts of four Clinical Psychologists and two Counsellors. Four were female and two were male, and they ranged in age from 26- 30 to 66+ years.

The exemplars in this factor also highlighted development of DID when a trauma is too overwhelming to be processed in an integrative way (4: +5): “trauma is a significant cause of DID. I believe there is significant hope and benefit in working with trauma” (Participant 6). Emphasis is also placed on the automatic nature of this as a survival response (14: +4).

The main area of focus of their formulations was on the individuals’ conscious experience of DID. They emphasised that whilst self-states are often observable to others (45: +4), the individuals themselves are often unaware of their switching (26: +2), and experience periods of time for which they cannot account (43: +5) as such “loss of time is a strong indication of dissociative experiences” (Participant 11). Subsequently, individuals with DID often experience feelings of confusion (48: +5), the inclusion of which is essential in the formulation to “help validate their experiences” (Participant 4). This amnesia was highlighted as a defence (16: +4) albeit unconscious, which can enable people to function in their lives (17: +2). Individuals with DID often experience interpersonal problems (42: +3) and are frequently surprised at the feedback that they receive from others (47: +4). As such, this patient group often initially access therapy for reasons other than DID per se (38: +3).

The development of DID as a mechanism to preserve an attachment was ranked as less essential by factor B exemplars (7: -4; 8: -2). Items considering the power and influence of the internal system were not prioritized (24: -3; 22: -2; 31: -3; 20: 0), nor was the reluctance of some self-states to reveal the truth about past trauma (35: -3) or the influence of this tension upon the individual’s engagement with therapy (34: -2).

Factor B exemplars rated the three consensus items as “least essential” in their formulations. The idea that DID is co-created between the therapist and client was strongly rejected (49: -5) with DID stated to be “is a genuine survival response, as explained in the 'most essential' section.” (Participant 13) and “whilst the influence of the therapist must always be considered, I think that it would be incorrect to state that DID is a construction of therapy.” (Participant 12). The disagreement with this statement was also validated in relation to the research around trauma: “This is not a statement that is correct based on the current evidence of our understanding of how individuals deal with trauma.” (Participant 11).

Factor B exemplars also categorically disagreed with the concept that DID is a culture-specific disorder (51: -5):“trauma and extreme trauma is not culture specific" (Participant 11). They also rejected the idea that DID is constructed by popular culture (54:-5), highlighting this as an invalidating and unhelpful way of conceptualising DID, which "would be dismissive of the client's lived experience" (Participant 4).

2.7.2.3 Factor C: "Helpful aspects of DID: Compartmentalising emotions to enable functioning"

This factor accounted for 12% of the total study variance and was defined by 3 Q- sorts. Two participants loading significantly onto this factor were Clinical Psychologists and one was a Psychotherapist. Two were female and one was male, and their ages ranged from 36-40 to 56-60 years.

Factor C exemplars emphasised the importance of the role of DID in enabling the individual to function and to fulfil a range of roles (17: +5) "It enables the ANP (apparently normal person) and therefore the system to function with the least disruption or publicising of the adaptive system, in order to maintain an apparent 'okay' way of being" (Participant 1). An essential consideration was the emergence of several different attachment models in the development of DID (8: +5) "because dissociative disorders are so much a matter of disorganized attachment" (Participant 15).

The resulting self-states are viewed as part of one fragmented personality (27: +2), with some self-states holding distressing information (32: +4). Switching between different self-states can be triggered by threatening internal or external stimuli (30: +4). There is a hierarchy of power and influence within the internal system (24: +3), which comprises of a functioning 'front' state (23: +3), which is separated from emotional self- states (20: +5) because:

> …in order to function the intense emotions are suppressed and may be allocated to, or held by alters which have limited external interactions with the 'outside world'. This is to support the functioning of the body or Apparent Normal Personality[4] (Participant 1).

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[4] Apparent Normal Personality refers to dissociated part of the personality that allows the individual to function in day-to-day life in the structural model of dissociation

Individuals with DID may also have learnt to keep quiet to stay safe (36: +2).

Relative to factors A and B, factor C exemplars also prioritized items suggesting that individuals with DID are highly suggestible (53: -1) and prone to fantasy (52: -3) although these were ranked as neutral and less essential items in their formulations. They did not prioritise items relating to the development of DID as an automatic survival response (14: -4) when trauma is too overwhelming to be processed (4: 1) in order to preserve the individual's mental wellbeing (15: -1). Neither did they prioritise the concept that DID results from severe and enduring trauma during critical periods of infant brain development (2:-3). Furthermore, the exemplars ranked the ongoing risk of harm to the client with DID as less essential in their conceptualisations of DID (40: -2).

As with the previous two factors, they rejected the ideas that DID is co-constructed in therapy (49: -5), or that it is culture specific (51: -5). These participants strongly rejected the idea that DID is constructed by popular culture (54: -5) with one stating that "Popular culture most often portrays DID in a distorted way that doesn't really fit the clinical picture of these patients" (Participant 15).

2.8 Discussion

2.8.1 Summary of study

The present study aimed to examine the range of subjective viewpoints (factors) communicated by therapists when deciding what the most important aspects of a formulation were in their clinical practice with clients with DID. Further aims were to explore the variation that existed within these factors and to investigate how they logically related to one another and to the models of DID.

2.8.2 Summary of findings

Using Q-methodology, three distinct factors were revealed, which elucidate therapists' differing perspectives regarding their formulation of DID. The presence of a limited number of statistically significant factors illustrates the overall lack of unanimity regarding what the most important aspects of their formulations are. Areas of consensus were however highlighted across all therapist participants. One significant area of agreement concerned the minimisation of items pertaining to the sociocognitive model; which suggest that DID is iatrogenically induced, specific to certain cultures and is created by popular culture.

2.8.3 How factors logically relate to one another and to models of DID

Each of the three factors revealed differing approaches to formulating with DID. Notably, factors A and C focused on the aetiology of DID and how presenting difficulties arise from this, whereas factor B placed less emphasis on the development of DID, instead emphasising the here-and-now aspects of the formulation. There is therefore need for further discussion in order to examine how the viewpoints identified logically relate to each other and to theories and models of DID. As such, they will be considered under two broad titles: the 'explanatory' and 'descriptive' aspects of the formulations.

2.8.3.1 Explanatory aspects of the formulation

Explanatory aspects of the formulation include items pertaining to the aetiology of DID and the models upon which therapists draw when conceptualising the development of this presentation. Whilst there was consensus regarding the least essential items, there remained subtle differences between those items that were privileged in each of the factors.

2.8.3.1.1 Attachment and trauma models of DID.

There was a degree of consensus across therapist participants from a range of professions and therapeutic approaches, in that they favoured the trauma model when conceptualising DID. This is commensurate with Brand and colleagues review of the empirical literature (2014), which found significant evidence for the trauma model.

Indeed there is a strong association between trauma (particularly childhood abuse) and the diagnosis of DID (e.g. Coons, 1994) which is corroborated in the neuroimaging literature; severity of childhood trauma and dissociative symptoms negatively correlate with hippocampal volumes (Chalavi et al., 2015b).

There was, however, subtle disagreement between the factors in relation to which aspects of the trauma model to prioritise when formulating. Both factor A and factor B prioritised the child’s inability to process overwhelming trauma in an integrative way, whilst factor C ranked this in the neutral section of the distribution. Factor A also prioritised the occurrence of severe and enduring trauma during a critical period of infant brain development, whereas factor C exemplars ranked this as less essential in their formulations.

Therapist participants across all three factors were in agreement that individuals with DID experience caregivers as powerful, controlling, punitive or negligent. However, there were subtle differences between the factors in relation to role of attachment in the development of DID and how this relates to the experience of trauma. Factor A prioritised the development of DID as a way to preserve an attachment with an abusive or negligent caregiver. The exemplars in this factor drew from structural and attachment models of dissociation: emphasising a separation of emotion and functioning, which compartmentalises trauma memories in order to maintain the attachment bond. As the child or infant is dependent on their caregiver, this was understood as a mechanism with which to ensure the individual’s mental and physical survival. Participants’ accounts contributing to this factor proposed a link between trauma and attachment with caregivers often perpetrating abuse.

Factor C also integrated structural and attachment models. Exemplars prioritised the development of a number of attachment models and resultant self-states. Again, this was linked to the separation of emotional self-states and those that enable the individual to function in daily life. However, in contrast to factor A, factor C exemplars did not prioritise the development of DID in preserving an attachment relationship and they placed less emphasis on its role in mentally surviving traumatic events. This factor therefore suggested that disorganised attachment is key in understanding DID as opposed to trauma relating to attachment relationships.

Unlike factors A and C, factor B exemplars did not privilege any of the items relating to attachments with caregivers. In fact, the exemplars of this factor viewed the protection of attachment relationships as less essential; suggesting that this was not a focus of their formulation.

2.8.3.1.2 Sociocognitive model of DID.

There was consensus across all three factors in their rejection of the sociocognitive model. It is important to note that when utilising Q-methodology, the "least essential" items do not necessarily equate to 'non-essential items' due to the relative nature of the sorting process. However, the qualitative feedback from participants consistently suggested that they did not find these items useful in their formulations. Participants viewed the suggestion that DID is constructed by popular culture as both incorrect and invalidating to the client. Participants referred to the media's portrayal of DID as sensationalising and inaccurate. The notions that DID is culturally specific and is constructed through the therapeutic process were also refuted, with feedback suggesting that these ideas minimise the importance of trauma in the development of DID. Again, these findings corroborate the findings of Brand and colleagues (2014), who identified a dearth of empirical support for the sociocognitive model.

Interestingly, whilst aspects of the sociocognitive model which invalidated the clients' experiences were consistently refuted, therapist participants were not entirely opposed to acknowledging the role of culture, suggestibility and fantasy-proneness in the presentation of DID. An exemplar in factor A identified that it is plausible that developed self-states are influenced by culture but rejected the idea that their development is a result of cultural influences. Although factor A exemplars disputed the idea that DID enhances capacity for fantasy, they acknowledged that clients with DID may engage more concretely with fantasy. Items relating to fantasy-proneness and the suggestibility of clients with DID were ranked significantly higher by factor C than factors A and B (although still in the less essential and neutral range respectively), which suggests that perhaps these are also viewed as more adaptive functions of DID as opposed to 'risk factors' for the development of DID. These interpretations suggest that whilst culture, suggestibility and fantasy-proneness are not seen as important considerations regarding the aetiology of DID, they may influence the individual’s particular presentation.

2.8.3.2 Descriptive aspects of the formulation

Descriptive aspects of formulations include items concerning the presentation and symptomatology of DID. Both factors A and B prioritised the difficulties experienced by people with DID above that of factor C, which highlighted the ways in which DID helps the individual to function.

2.8.3.2.1 Presenting problems.

Factor A focused on problems and tensions within the internal system of self-states.

Exemplars emphasised the internal tensions regarding uncovering memories of past trauma and highlighted the resultant risk of harm to the individual from self or others and potential therapy-interfering behaviours elicited by certain self-states. Factor B however, focused on the individuals’ conscious experience of DID, emphasising the clients' lack of awareness of their switching between self-states. As such, exemplars highlighted the amnesia, confusion and interpersonal problems encountered by clients as a result of this unseen switching. Factor B exemplars also stressed that most clients with DID do not access therapy for their DID per se, but rather for co-morbid difficulties such as anxiety.

2.8.3.2.2 Helpful aspects of the presentation.

Factor C however did not focus on difficulties, but rather on the helpful or adaptive aspects of DID. Exemplars in this factor emphasised the development of different attachment models in order to preserve relationships and the role of compartmentalisation in protecting the individual from traumatic and distressing memories. They highlighted the ability of the individual to fulfil a number of different roles in their lives, due to the separation of emotional and functional self-states.

2.8.4 Clinical Implications

There was a lack of consensus across therapist participants regarding the most essential aspects of the formulation. The International Society for the Study of Trauma and Dissociation (ISSTD, 2011) strongly recommend that clinicians working with clients with DID have training in the diagnosis and treatment of DID. The current findings would also suggest that therapist training should focus on the formulation of DID, in order to bridge the gap between diagnosis and treatment and to inform treatment plans. Training is associated with improved quality of CBT and psychodynamic formulations (Eells et al., 2011; Kendjelic & Eells, 2007). Therefore, understanding how experienced clinicians conceptualise and formulate this disorder in their clinical practice may be helpful in informing the education of inexperienced therapists.

All three factors prioritised the role of trauma in the aetiology of DID, drawing upon both attachment and structural dissociation models. Subtle differences reflected differing views regarding the relationship between attachment and trauma in the development of DID. These results suggest that neither model provides a comprehensive and widely accepted solution to the conceptualisation of DID. It is therefore suggested that therapists' training considers a range of trauma and attachment-based models in order to inform their idiosyncratic formulations.

The lack of consensus pertaining to descriptive aspects of the formulation is a significant finding, given that formulation informs intervention by prioritising problems (Butler, 1998). Whilst each of the three factors prioritise different aspects of the presentation (i.e. the internal system, the problems experienced and the helpful aspects of DID), all three factors relate logically to the first stage of the guidelines for phasic treatment of DID (ISSTD, 2011); namely establishing safety, stabilization and symptom reduction.

The emphasis placed on the internal system by factor A exemplars is commensurate with Brand and colleagues' (2014) finding that treatment that does not engage with self- states to repair identity fragmentation is associated with poor outcomes. Moreover, the ISSTD guidelines (2011) recommend "working with alternate identities" (p. 197) by identifying the system of interacting or conflicting self-states and encouraging the client to take responsibility for the behaviour of each of these in the first stage of phasic treatment.

The emphasis on conscious, presenting problems within factor B also fits with the ISSTD guidelines, which place importance on the management of symptoms during phase one of treatment. Factor B exemplars also highlighted that patients with DID may seek treatment for co-morbid diagnoses rather than the DID per se, which reflects the widely reported finding that individuals with DID often meet criteria for a range of co-morbid axis I and II disorders (Rodewald et al., 2011).

The focus on the protective function of DID in factor C highlights the need for clinicians to be aware of the role fulfilled by DID. Reliance on pathological dissociation implies a lack of alternative skills to keep the individual safe and enable functioning in their everyday lives. Formulations which prioritise these aspects of clients' presentations would likely suggest interventions to build alternative ways of tolerating distress and regulating emotions, before trying to reduce the 'maladaptive' switching of self-states.

Skills training such as that used in dialectical behaviour therapy (DBT; Linehan, 1993) for example, may increase adaptive coping skills with this population. Again, this is in keeping with the ISSTD guidelines (2011) for phasic treatment of DID, which suggest that the first stage of treatment should focus on safety and should include building of skills.

Formulation is associated with therapists' improved understanding of and ability to validate clients' experiences and has a positive impact on the therapeutic relationship (Morberg Pain, Chadwick, & Abba, 2008). The use of formulation to validate the client's experiences was highlighted by therapists' rejection of items which they perceived to be stigmatising and invalidating for the individual. Case formulation places emphasis on 'usefulness' rather than 'truth' (DCP, 2013) and these findings suggest that those items perceived as undermining the individuals' experience were therefore less useful to the client and thus least essential in the formulation. This is consistent with treatment guidelines (ISSTD, 2011), which prioritise the building of a safe therapeutic relationship in the first phase of treatment.

2.8.5 Limitations

There are a number of limitations in the current study. Firstly, whilst attempts were made to ensure that the Q-set was representative of the concourse, it is possible that the researchers' own biases may have influenced the final selection. There is a distinct lack of objective guidance on this process and selection of items for the Q-set has been described as "more an art than a science" (Brown, 1980, p. 186). In order to mitigate the risk of bias, the researcher employed the help of three experienced clinicians when constructing the Q-set. McKeown and Thomas (2013) suggest that attempting to assess if items are selected correctly is not appropriate as the sample is a "means to an end" (p.

25) and meaning is attributed through the process of sorting (Brown, 1993). Research suggests that Q-sets using different items often converge on the same results (Thomas & Baas, 1992). Participants were given the opportunity to identify further items that they felt should have been included in the Q-set. Eleven participants provided additional items relating to: risk to self and others; differing presentations of self-states; inconsistency of goals in therapy; fugue states; decoupling of physiological experiences from the body; and the overlap in symptomatology with psychosis (see appendix L for a full list). The video vignette may have biased a particular interpretation of the essential aspects of a formulation. However, feedback suggested that the majority of participants viewed it as valid representation of DID (see appendix M).

As participants were self-selected by their responding to a recruitment email, there is a possibility of selection bias. Therapists holding specific viewpoints may have been more motivated to participate. Those participants who chose not to participate may have held different views to those who did. However, issues of generalisability are somewhat irrelevant in Q-studies as the aim of this method is to reveal specific viewpoints (Watts & Stenner, 2012). No attempt is made by the current study to exhaust all possible accounts or to make claims about the ontological status of DID. As such all conclusions drawn are limited to those who participated in the Q-sort.

The FlashQ program was utilised as it allowed the researcher to access participants covering a large geographical area and its 'drag and drop' method interface provided an analogous method of sorting to paper-based Q-sorts. However, the use of this online sort was not without drawbacks. Three participants contacted the researcher to explain that they had encountered significant technical difficulties (e.g. unable to access the webpage on their computer) and were unable to complete the Q-sort task.

FlashQ does not allow participants to save their progress and as such participants were required to set aside at least an hour to complete the task. Whilst participants were made aware of this before commencing the Q-sort, it is likely that this contributed to the high attrition rate (68%).

The aim of factor interpretation in Q-methodology is to reconstruct the subjective opinions underpinning the sorting process (Stenner, Dancey & Watts, 2000). It is important to acknowledge the potential risk of interpretation bias due to the subjective nature of factor interpretation, which is reliant on the researcher's analytical skills (Cross, 2005). This was the researcher's first Q-study and as such they lacked experience in the interpretation of the identified factors. It is common practice in Q-studies to validate the interpretation of factors by conducting follow-up interviews with participants. Due to time constraints this was not possible in the current study and thus factor interpretation was not validated in this way.

2.8.6 Areas for future research

The factors identified in this study have highlighted the differing perspectives regarding the relative importance of attachment and trauma in the development and presentation of DID. Further research is needed to better understand this multifaceted presentation and to develop models which accurately capture clinicians' conceptualisations of DID.

The present study could be extended by utilising the same method with newly qualified therapists, or those who have never worked with a client with a diagnosis of DID. This would allow for comparison of the key features emerging in their formulations and would highlight areas of need for the training of therapists working with DID.

The same Q-set could also be used with patients who have been given a diagnosis of DID. This would allow for comparison between clinicians' and clients' perspectives regarding the formulation of DID and would highlight the aspects that clients feel are most essential to being understood by their therapists.

2.9 Conclusions

The present study identified three statistically significant factors, which illustrated an overall lack of unanimity regarding the most important aspects of therapists' formulations. All three factors prioritised items relating to the role of trauma in the development of DID, suggesting that trauma models are widely utilised as a framework within which to understand this presentation in clinical practice. However, there was disagreement regarding the specific models underpinning therapists' formulations, with differing accounts of the interplay between attachment and trauma in the development of DID.

Research suggests that there is often discord regarding theoretical aspects and increased agreement regarding descriptive aspects of formulation (Kuyken, Fothergill, Musa and Chadwick, 2005). The current findings however, appear to somewhat contradict this finding, with a degree of unanimity in therapists' acceptance of trauma models and the greatest discord concerning which descriptive aspects to privilege. This likely reflects the complexity of the presentation, the wide range of severe and chronic symptoms experienced and the number of co-morbidities present in this population (Foote, Smolin, Neft, & Lipschitz, 2008; Rodewald, Wilhelm-Gossling, Emrich, Reddemann, & Gast, 2011). Whilst there is a lack of consensus regarding which aspects of the formulation to prioritise, each factor logically relates to an aspect of the first stage of phasic treatment for DID (ISSTD, 2011).

This study does not claim to have identified all possible accounts of DID. The accounts highlighted herein reflect those specific to the therapists who participated in this research. It is possible that, were the study re-run with a different sample of participants, different perspectives might be revealed. However, despite the lack of generalisability of these findings, they do provide an insight into some of the different ways in which therapists conceptualise this complex presentation.

Appendices

Appendix A Diagnostic Criteria

DSM-IV-TR (APA, 2000)	DSM-5 (APA, 2013)	ICD-1 (WHO, 1991)
A. Two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self)	A.Two or more distinct identities or personality states are present, each with its own relatively enduring pattern of perceiving, relating to and thinking about the environment and self. Personality states may be seen as an "experience of possession." These states "involve(s) marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual."	A. The existence of two or more distinct personalities within the individual, only one being evident at a time.
B. At least two of these identities or personality states recurrently take control of the persons behaviour	A. Amnesia must occur, defined as gaps in the recall of everyday events, important personal information and/or traumatic events.	B. Each personality has its own memories, preferences and behaviour patterns, and at some time (and recurrently) takes full control of the individual's behaviour.
B. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness	C. The person must be distressed by the disorder or have trouble Functioning in one or more major life areas because of the disorder.	C. Inability to recall important personal information, too extensive to be explained by ordinary forgetfulness.
C. The disturbance is not due to the direct physiological effects of a substance or a general medical condition	D.The symptoms are not due to the direct physiological effects of a substance (such as blackouts or chaotic behavior during alcohol intoxication) or a general medical condition (such as complex partial seizures).	D. Not due to organic mental disorders (e.g. in epileptic disorders) or psychoactive substance-related disorders (e.g. intoxication or withdrawal).
	D. The disturbance is not part of normal cultural or religious practices.	

Appendix B Southampton University Ethics Approval

Email from Southampton Ethics and Research Governance (ERGO) confirming ethics approval:

From: ERGO [mailto:ergo@soton.ac.uk]

Sent: 22 January 2015 17:54

To: Davis L.L. <lld1g12@soton.ac.uk>

Subject: Your Ethics Amendment (Ethics ID:13594) has been reviewed and approved

Submission Number 13594:
This email is to confirm that the amendment request to your ethics form (How Do Therapists Conceptualise Dissociative Identity Disorder: DID formulation in clinical practice. (Amendment 6) has been approved by the Ethics Committee.

You can begin your research unless you are still awaiting specific Health and Safety approval (e.g. for a Genetic or Biological Materials Risk Assessment)

Comments
1.Please ensure that you have specific permission form the R and D sections to circulate relevant staff using mailing lists - and that you are not breaching any Data Protection regulations.

Click here to view your submission

ERGO : Ethics and Research Governance Online
http://www.ergo.soton.ac.uk

DO NOT REPLY TO THIS EMAIL

Appendix C ESTD ethics approval

Email approval from Andrew Moskowitz – lead for research in the European Society for Trauma and Dissociation: UK Branch

From: Andrew Moskowitz [mailto:andrew@psy.au.dk]

Sent: 26 February 2015 08:46

To: Davis L.L. <lld1g12@soton.ac.uk>

Subject: RE: Research - online study investigating therapists' formulation of Dissociative Identity Disorder

Hi Laura,

It's all set. I'll ask tomorrow for your email to be sent to all ESTD members. Good luck with your project!

Best
wishes,
Andrew

From: Davis L.L.

Sent: 23-02-2015 18:43

To: Andrew Moskowitz

Subject: RE: Research - online study investigating therapists' formulation of Dissociative Identity Disorder

Dear Andrew,

I have updated the information sheet in line with your colleagues comments. The link for the video has since been changed, apologies for missing this. The link is: https://www.youtube.com/embed/pHf62s3j_PE (this is embedded within the survey).

In terms of the link to the survey, I have a draft email (pasted below), which contains the link and my intention was to ask for the email and information sheet to be circulated to your members.

Please do let me know if you need any further information.

With best wishes,

Laura Davis

Trainee Clinical Psychologist

University of Southampton

Researchers at the University of Southampton invite you to take part in a survey about therapists' experience of working with people with Dissociative Identity Disorder (DID).

All levels of experience and all therapy orientations are welcome. The aim of the survey is to capture a range of therapist's experiences and to gain a greater understanding about this complex difficulty. It is hoped that the findings will contribute to the evidence base in order to support therapists in their therapeutic practice with people with DID.

The survey will take between 5 - 10 minutes to complete, with a mixture of multiple choice and free text answers.

Please use this link to take part: https://www.isurvey.soton.ac.uk/14077

If you would like further information about this survey please contact Laura Davis, Trainee Clinical Psychologist: lld1g12@soton.ac.uk

From: Andrew Moskowitz [mailto:andrew@psy.au.dk]
Sent: 23 February 2015 09:57
To: Davis L.L.
Subject: VS: Research - online study investigating therapists' formulation of Dissociative Identity Disorder

Hi Laura,

My colleague has looked at your protocol, and has a few comments. Could you read and respond please?

Best

wishes,

Andrew

………..

Hi Andrew,

This looks like a very interesting project. I think on the participant information sheet DID should be fully written with the acronym then given, when it is first used (as potentially some people may read this who haven't seen DID, even though they won't go further and participate in the the study). I couldn't see anything on this sheet that gave access to the survey site or told the potential participant what to do next if they want to continue (it said what they would do, but not how to continue). Do the researchers see this as a problems? Finally, I clicked on the youtube sites, but they were 'empty', so in case the researchers believe they are active, they should check this.

Good luck to them.

…….

Appendix D Online screening questionnaire

Questions for iSurvey screening questionnaire. Version 1. January 2015

Question 1.1
Please indicate your gender
Male/Female/Would prefer not to
state **Question 1.2**
Please indicate your age
<20
21-25
26-30
31-35
36-40
41-45
46-50
51-55
56-60
61-65
66+

Question 1.3
What is your profession?

Question 1.4
Has the majority of your career been
working in: NHS
Private
practice
Both
Other (please state)

Question 1.5
How many years' experience do you have working as a therapist? (To the nearest year since starting a training qualification or having your own caseload)

Question 1.6
How much experience have you had of working with clients with Dissociative Identity Disorder?
None
Less than 3
months 3-
6 months
6 months
– a year 1
year
2 years
3 years
4 years
5 years
6 years
7 years
8 years
9 years
10 or more years

(Quick logic: if answer is not ‘none’) **Question 1.6a**
Which therapeutic approach(es) do you use in your work with clients with DID? (Please check all that apply)

Art Therapy
Cognitive Analytic Therapy
Cognitive Behavioural
Therapy Counselling
Dialectical Behavioural
Therapy Narrative
Therapy Psychodynamic
Psychotherapy Other
(Please state)

Question 1.7

Did you receive teaching about Dissociative Identity Disorder as a part of your therapist training?

(Quick logic – if 'yes') **Question 1.7a**

Approximately how many hours?

Question 1.7b What did this teaching cover?

Question 1.8

Have you attended training on Dissociative Identity Disorder since qualifying?

Y
e
s
N
o
Not sure

(Quick logic – if 'yes') **Question 1.8a**

Approximately how many hours?

Question 1.8b

What did the training cover?

Question 1.9

Have you received specialist supervision for your work with clients with Dissociative Identity Disorder?

Y
e
s
N
o
Not sure

(Quick logic – if 'yes') **Question 1.9a**

Was the specialist supervision further to your usual supervision? Yes
No
Not sure

Question 1.9b

Approximately how often do you receive specialist supervision?

Wee
kly
Fort
nigh
tly
Mo
nthl
y
Every few

months Yearly
Ad hoc

Question 1.10

Any further comments

Question 1.11

I am looking to recruit participants for the second phase of this study. This involves watching a 30 minute clinical vignette video and then ranking a series of statements in order of importance based on your clinical experience of working with clients with DID. This will contribute to our knowledge and understanding of DID and it is hoped that the outcomes of this study will support therapists in their work with people with DID.

If you would like to be considered as a participant for the next phase of the study please enter your email address in the box below. I will contact participants by email, so please ensure that it is an account that you check regularly. Your email address will only be seen by myself (Laura Davis, Trainee Clinical Psychologist) and will only be used to contact you with regard to your participation in this study.

Thank you!

Yes I would like to be contacted for the next stage of the study

Appendix E Stokoe (2014) Therapeutic Model of DID

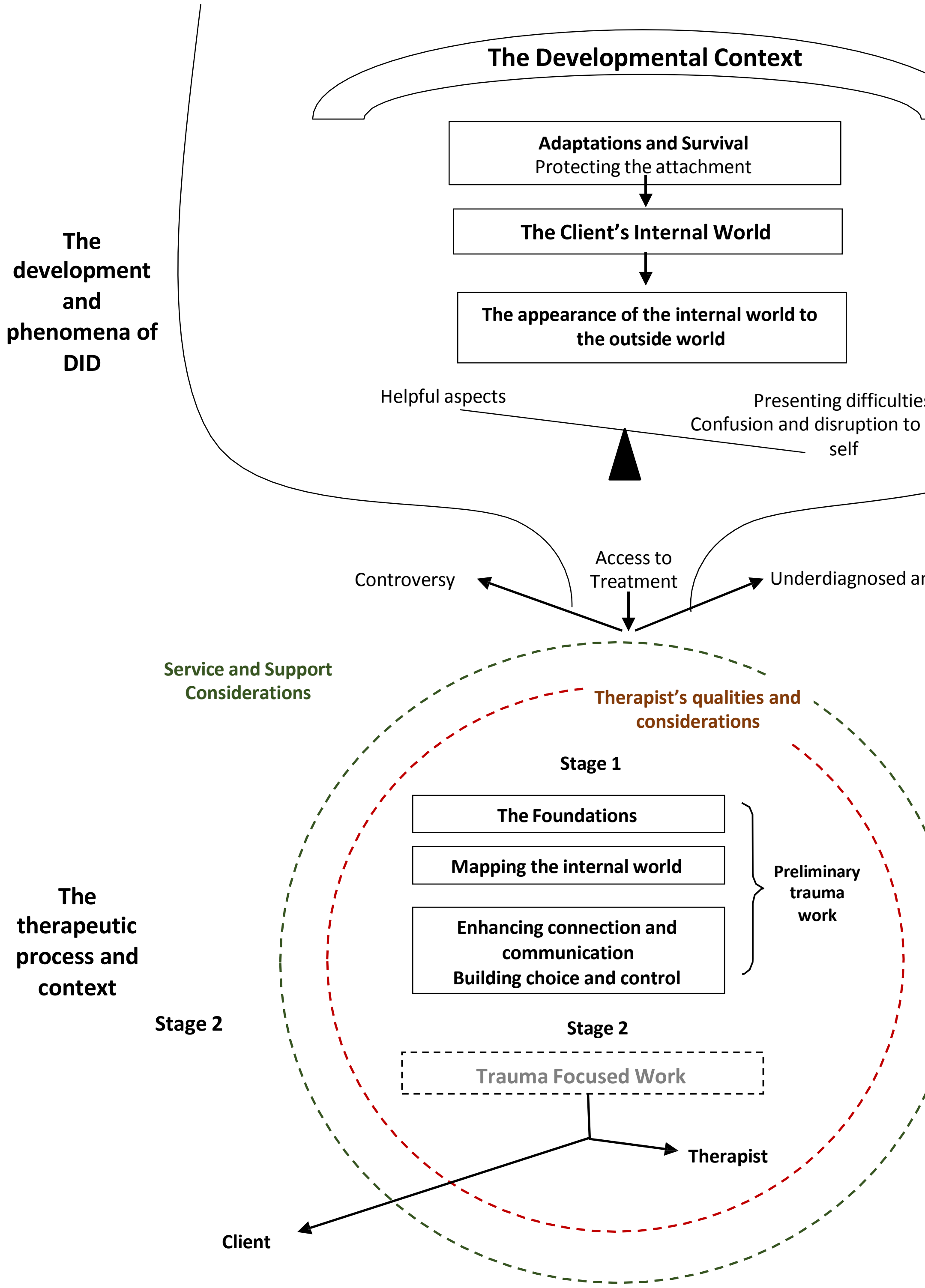

Figure 9: Staged Therapeutic Model of DID
(reproduced with permission from the author)

Appendix F Written instructions for Q-sort task

Step 1 of 5:

Please read the following items carefully and split them up into three piles based on the research question: **Which items are the most important to inform your conceptualisation / formulation of individuals with DID?**

- a pile for items that you feel are least essential

- a pile for items that you feel are most essential

- and a neutral pile for those items about which you feel indifferent, unsure or ambivalent

You can either drag the cards into one of the three piles or press 1, 2, 3 on your keyboard. There are no limits to how many items you can place in each pile. Please note that this initial sort is provisional and changes can be made in the next stage.

Step 2 of 5:

Take the cards from the "MOST ESSENTIAL" pile and read them again. You can scroll through the statements by using the scroll bar. Next, select the three statements you feel are the most important to inform your conceptualisation / formulation and place them on right side of the score sheet below the "+5”.

Now read the cards in the "LEAST ESSENTIAL" pile again. Just like before, select the three statements you feel are the least important in your conceptualisation / formulation of DID and place them on the left side of the score sheet below the "-5”.

Next, select the statements you feel are the second most important and place them under "+4" / "-4". Follow this procedure for all cards in the "MOST ESSENTIAL" and "LEAST ESSENTIAL" pile.
Then, read the "NEUTRAL" cards again and arrange them in the remaining open boxes of the score sheet.

Gradually fill the piles for -3 / +3, -2 / +2, -1 / +1 and 0.

Note: You will be able to review this initial sort of the statements in the next step.

Step 3 of 5:

Now you have placed all cards on the score sheet. Please check over your distribution once more to ensure you are happy with the sort. You can move the cards around if you want to.

Please hover your mouse over each statement in order to read it fully.

Cards can be placed on the white areas of the screen to allow you to reposition statements on the grid.

Step 4 of 5:

Please explain why you feel that the following statements, which you have placed below "+5" or "- 5" are most or least essential in your conceptualisation / formulation of DID.

Step 5 of 5:

Finally, please answer the questions on the screen.

Appendix G List of approved NHS Trusts

The following trusts granted permission to recruit participants from their sites:

2gether NHS Foundation Trust (Gloucestershire)

Cheshire and Wirral Partnership NHS Foundation Trust (CWP)

Cornwall Partnership NHS Foundation Trust

Cumbria Partnership NHS Foundation Trust

Greater Manchester West Mental Health NHS Foundation

Trust Hertfordshire Partnership University FT

Isle of Wight NHS Trust Kent and Medway NHS and Social Care Partnership Trust

Lincolnshire Partnership Foundation

North Essex Partnership University NHS Foundation

Trust Solent NHS Trust South Essex Partnership

Trust

South Essex Partnership University NHS Foundation

Trust Southern Health NHS Foundation Trust

Appendix H Recruitment email: Phase one

Emails sent out by NHS trusts and ESTD UK group to employees/members:

Researchers at the University of Southampton invite you to take part in a survey about therapists' experience of working with people with Dissociative Identity Disorder (DID).

All levels of experience and all therapy orientations are welcome. The aim of the survey is to capture a range of therapist's experiences and to gain a greater understanding about this complex difficulty. It is hoped that the findings will contribute to the evidence base in order to support therapists in their therapeutic practice with people with DID.

The survey will take between 5 - 10 minutes to complete, with a mixture of multiple choice and free text answers.

Please use this link to take part: https://www.isurvey.soton.ac.uk/14077

If you would like further information about this survey please contact Laura Davis, Trainee Clinical Psychologist: lld1g12@soton.ac.uk

Appendix I Information sheet 1: Questionnaire

UNIVERSITY OF Southampton
School of Psychology

Participant Information Sheet
Date: January 2015: Version 2

Title: 'How Do Therapists Conceptualise Dissociative Identity Disorder: DID formulation in clinical practice'
Researcher: Laura Davis Ethics number: 13594

Before you decide whether you would like to participate in this survey, please take some time to read the following information.. If you consent to participating in this study please select the option below and press the link to continue.

What is the research about?
We are interested to find out how therapists conceptualise and formulate the presentation of DID. We hope to understand the essential features of this presentation. This will enhance our current understanding and knowledge of DID and ultimately could support other therapists in their practice by sharing the outcomes.

This brief screening questionnaire will help the researcher to identify potential participants for the next stage of the study. You will be given the option to volunteer to participate in the second phase at the end of this questionnaire. The second phase involves ranking a series of statements in order of importance based on your clinical experience of working with clients with DID.

Who can participate?
Any qualified therapist who has worked therapeutically with an adult with DID can take part. This includes CBT Nurses, Clinical Psychologists, Psychotherapists and other qualified Therapists. Unfortunately, Trainee Clinical Psychologists and Assistant Psychologists cannot participate in this study.

Do I have to take part?
No! Not at all. It is completely up to you whether or not you would like to take part.

What will happen to me if I take part?
You will complete an online survey which will take approximately 5-10 minutes. At the end of the survey, you will be asked to leave contact details if you consent to being contacted for the second phase of the study. If you are chosen to participate in the second phase, the researcher will contact you by email.

Are there any benefits in my taking part?
You will be contributing to the development and improvement of our understanding of the presentation of DID. It is hoped that this research will

provide a springboard from which

other research can be launched so that this presentation can be better understood and effective treatment approaches identified. Ultimately, it is hoped that the outcomes of this study will support therapists in their work with people with DID.

Are there any risks involved?
There are no known risks to participating in this study.

Will my participation be confidential?
Storage of data will comply with the Data protection act and NHS policy. The information you provide will be made anonymous. The only person who will have a record of who has taken part will be the researcher (Laura L Davis). The only time that anonymity will be broken is if there is a disclosure that suggests there is a serious risk of harm to yourself or to others.

What happens if I change my mind?
You have the right to withdraw at any time during the survey, simply click the cancel button in the top right of the screen. If following completion of the survey, you change your mind and decide that you no longer wish for your data to be included in the study, please contact the researcher using the contact details at the bottom of this form to withdraw your consent.

Where can I get more information?
If you would like any further information or have any concerns regarding this study, please contact:

Academic supervisor: Dr Lusia Stopa, University of Southampton: l.stopa@soton.ac.uk

Clinical Supervisor: Dr Tess Maguire, Clinical Psychologist:
Tess.Maguire@southernhealth.nhs.uk

Or you can contact the researcher directly lld1g12@soton.ac.uk

If you have questions about your rights as a participant in this research, you may contact the Chair of the Ethics Committee, Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: +44 (0)23 8059 4663, email slb1n10@soton.ac.uk.

Thank you for taking the time to read this information.

Appendix J Information Sheet 2: Q-sort

UNIVERSITY OF
Southampton
School of Psychology

Participant Information Sheet
Date: January 2015: Version 2

Title: 'How Do Therapists Conceptualise Dissociative Identity Disorder: DID formulation in clinical practice' - Qsort
Researcher: Laura Davis Ethics number: 13594

Before you decide whether you would like to participate in this survey, please take some time to read the following information. If you consent to participating in this study please select the option below and press the link to continue.

What is the research about?
We are interested to find out how therapists conceptualise and formulate the presentation of DID. We hope to understand the essential features of this presentation. This will enhance our current understanding and knowledge of DID and ultimately could support other therapists in their practice by sharing the outcomes.

Why have I been asked to participate?
You have been invited to participate in phase 2 of the study, because you completed the online screening questionnaire (www.isurvey.soton.ac.uk/14077) and indicated that you would be interested in participating in the Qsort.

Do I have to take part?
No! Not at all. It is completely up to you whether or not you would like to take part.

What will happen to me if I take part?
You will be asked to watch a video clinical vignette. You will then complete an online Qsort. This invloves ranking a series of statements in order of importance based on your clinical experience of working with clients with DID.

Are there any benefits in my taking part?
You will be contributing to the development and improvement of our understanding of the presentation of DID. It is hoped that this research will provide a springboard from which other research can be launched so that this presentation can be better understood and effective treatment approaches identified. Ultimately, it is hoped that the outcomes of this study will support therapists in their work with people with DID.

Are there any risks involved?
There are no known risks to participating in this study.

Will my participation be confidential?
Storage of data will comply with the Data protection act and NHS policy. The information you provide will be made anonymous. The only person who will have a record of who has taken part will be the researcher (Laura L Davis). The only time that anonymity will be broken is if there is a disclosure that suggests there is a serious risk of harm to yourself or to others.

What happens if I change my mind?
You have the right to withdraw at any time during the survey, simply click the cancel button in the top right of the screen. If following completion of the survey, you change your mind and decide that you no longer wish for your data to be included in the study, please contact the researcher using the contact details at the bottom of this form to withdraw your consent.

Where can I get more information?
If you would like any further information or have any concerns regarding this study, please contact:
Academic supervisor: Dr Lusia Stopa, University of Southampton: l.stopa@soton.ac.uk Clinical Supervisor: Dr Tess Maguire, Clinical Psychologist on Tess.Maguire@southernhealth.nhs.uk
Or you can contact the researcher directly lld1g12@soton.ac.uk

If you have questions about your rights as a participant in this research, you may contact the Chair of the Ethics Committee, Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: +44 (0)23 8059 4663, email slb1n10@soton.ac.uk.

Thank you for taking the time to read this information.

Appendix K Recruitment email: Phase two

Email sent to individuals who had completed the screening questionnaire and opted in to participating in the Q-sort by giving their contact details.

Dear colleague,

Thank you for your participation in the survey examining your experience of working with Dissociative Identity Disorder and for consenting to be contacted to complete the Qsort task.

To participate in the Qsort, please click on the link below:

https://www.isurvey.soton.ac.uk/14062

After you have completed the Qsort you will be asked to enter your 'Participant ID': Please enter the number 'XX' to allow me to link your survey results with your Qsort.

If you would like to view the instructions at any point when completing the Qsort, please click on the yellow question mark in the bottom right-hand corner of the screen. I have also attached a word document outlining the instructions in case these may be of use to you.

If you have any questions, please do not hesitate to contact me. Thank you again for your participation thus far, I really appreciate your giving up your time and expertise.

With best wishes,

Laura Davis

Trainee Clinical

Psychologist University

Appendix L Q-sort Feedback: Extra items for Q-set

Participants were invited to suggest any further items they felt should have been included in the Q-sort. The following are direct quotes from their forms:

“The management of risk (especially risk to others, in the case of the client in the video). Risk may sometimes be under- or over-reported in DID. People who are more prone to taking risky behaviour (e.g. people with borderline personality presentations) may be dismissed as typical of their presentations.
Alternatively, these individuals may be discriminated and judged as irresponsible or unfit, which can also adversely affect the therapeutic relationship. Managing risk, particularly daily and recurrent risk, can be draining on the service/clinician’s resources and it would have been interesting to provide information on how essential this may be to the formulation.”

“Perhaps something on self-harm/other coping mechanisms”

“More about Fugue states , I know it was memtioned "finding onself in the kitchen" time loss..hypervigalence and internal voices.”

“Difficulties with having consistent goals in therapy due to conflcits between different self states\rCertain professionals can be dismissive towards the concept”

“Im my experience tehre can be confusion between psychosis and DID when there individuals are co- conscious with altered states that can lead to misdiagnosis or diferent treatment modailities.”

“I am very interested in how dissociation fits with the experience of the body- specifically how physiological experiences can be decoupled from awareness and the experience of intrusive physiological experiences and body memories with dissociative patients. \rI would also be interested in a question about modality in working with such populations.”

“Each part/state may need to be allowed space to express feelings (and perhaps share their memories) in their own specific way.\rEach part/state needs genuine acceptance and empathy from the therapist.\rEach part may have their own internal landscape (which may be experienced as good or bad).\rParts/states may or may not have an awareness of each other.\rPeople with DID can experience internal conflict and 'clamour'/noise when several parts are trying to talk at once.\rWorking towards improving internal communication and co-operation ('team work' among the parts) can be helpful.”

“The levels of fear and confusion usually present for DID patients and the sense that they are "crazy" “

“Perhaps something more concentrated on the 5 core symptoms & how they are differentiated from other disorders e.g. schizophrenia & Dissociative disorders are commonly confused especially when clients acknowledge hearing voices.”

“That the clarity of distinctions between different parts/self-states may be very variable from one person to the next, so that the individual concerned may have very variable awareness of them, or of how many there are. In my (limited) experience the definition between parts/self-states is not at all clearly presented, and may take a long time to become apparent”

”Therapist need more specialised supervision when working with DID clients. \rTherapy with DID survivors is long term work. \r\rI am not able to recall but did you specify 'different gender' - when talking about different ages, preverences etc for self-states ?”

Appendix M General Feedback

Any further comments about your experience of working with clients with DID?

“I have worked with complex trauma, dissociation and DID for 30+ years.....a combination of talk therapy and experential therapy and alternative approaches (EMDR, EFT, etc.), seems to yield the best results for me....”

“I believe that one of the big things I learnt through experience is, that in the beginning I was so foccused on the self-states of DID that I did not fully see the importance of the attachment work that needs to happen with DID survivors. \rThe other thing I want to mention again is the importance of good and specialised supervsion for therapists. Support with possible secondary traumatisation.”

“that the way in which I have learnt to work with the different patients with this presentation is very different for each one, save that I have tried to adapt and adjust the way in which I relate to them dependent upon how they are. With the people I have worked with it appears to me that there is a sense that different parts haven't come together, rather than different parts have split off.”

“I have worked with several people with DID, and they each presented very differently, and had different levels of awareness and acceptance of the condition.\rI find the work challenging and stretching but also very interesting and rewarding!”

“My 'on the job' learning about DID has come from some relevant texts and general clinical experience. I would love some formal training from someone with greater knowledge, skills and expertise than myself! If you know of anyone- please ask them to come to XXX!”

“Safety and normalisation of client experience seems key to progress. Feedback from clients suggests that this makes all the difference from early stages, especially when they are generally able to identify very closely with the various attributes of the condition. Once clients accept and understand the condition they can make so much difference in pursuit of a much more positive existence” “its never clear cut! Highlighy confusing for the therapist and teams are often unaware of it as a differential/ or dont believe in it which can be hard to work with”

“ I think the need for a trauma focussed therapy is so important for these clients, particularly methods that reduce the fear felt in the body, such as EMDR and Energy Therapy (such as EFT), as often there is absolute terror experienced in the body at a young age, and it is this is being defended against - a fear of physical and mental annihilation. The body goes into the 'Fight/Flight/Freeze ' response - and DID is the extreme form of 'Freeze' response in that the experience is frozen and held by part of the mind , separate from the whole. This cannot be put into words and talk based therapy cannot always deal with this. I have found these body based therapies very helpful for processing the traumas that the DID 'parts' present in the session.

“patience, compassion and holding the hope.\ralso if there is ritual abuse memories there may be contat with the abusing group”

Any other comments?

“ I am grateful to the people who do this research and other research into DID, as this helps it to be more known and for DID to become more of an accepted diagnosis which can not be treated with medication, but can be successfully treated with long term theraeutic work.”

“This study appears to work from the perspective that DID causes fragmentation of a personality by parts of that personality as it were splitting off. My experience of working in this field is that it can be, especially when the trauma has begun early in a person's life, more as if different more or less embryonic parts/self-states haven't been enabled to develop and coallesce with each other in the coming together/forming of a coherent self. that parts will often appear to remain at the level of psychological development and age at which they became isolated, or as it were frozen as they were.”

“I thought that your video case vignette was absolutely super. The actor playing the patient was excellent and her performance gave me chills. This really reminded me of some of the most rollercoaster cases in my experience of working with people who dissociate!”

": I am delighted that research is being undertaken. My experience as a psychotherapist is that through lack of understanding, it is much maligned, misunderstood and avoided in terms of intervention with the greatest cost of all being to clients who having endured such extreme experiences in childhood and should have to continue to struggle. They deserve so much more, do not require high levels of medication that will do nothing for this condition and I believe can do much to support others through education, sharing and understanding their experience."

"I think this is a useful study, because not many therapists work with this presentation and we need more information and knowledge about it."

"Glad you are doing it....."

"Reasearch on this matter is very imprtant."

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