Volume 2

Frontiers in the Psychotherapy of Trauma & Dissociation

*The Official Clinical Journal of
the International Society for the
Study of Trauma and Dissociation*

**Treatment Outcomes Across
Ten Months of Combined
Inpatient and Outpatient
Treatment In a Traumatized and
Dissociative Patient Group**

*Colin A. Ross, M.D., Caitlin Goode,
M.S., and Elizabeth Schroeder, B.A.*

International Society for the
Study of Trauma and Dissociation

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The Official Clinical Journal of the ISSTD

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Frontiers in the Psychotherapy of Trauma & Dissociation is published by the International Society for the Study of Trauma and Dissociation, Inc., 8400 Westpark Drive, 2nd Floor, McLean, Virginia, 22102, USA.

Annual Subscription, Volume 2, 2018

Online subscription is part of the membership dues of the International Society for the Study of Trauma and Dissociation. Visit <http://www.isst-d.org/default.asp?contentID=44>.

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ARTICLE

Treatment Outcomes Across Ten Months of Combined Inpatient and Outpatient Treatment In a Traumatized and Dissociative Patient Group

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Thirty-seven inpatients in a hospital-based Trauma Program completed a set of measures at admission and at 6 and 10-months follow-up. On the Dissociative Disorders Interview Schedule, the average number of secondary features of dissociative identity disorder at baseline was 3.6 (SD = 4.2), and the average score on the Dissociative Experiences Scale (DES) was 37.8 (SD = 21.9). At 10 months follow-up, average scores on the DES had declined significantly from 37.8 to 31.1; average scores on the Beck Depression Inventory-II had declined from 36.9 to 24.3; and average scores on the Somatoform Dissociation Questionnaire had declined from 41.5 to 32.5. Treatment outcomes for complex dissociative disorders are supported by replicated prospective studies and are evidence based at Level II according to the criteria of the United States Preventive Services Task Force.

KEYWORDS *dissociative disorders; treatment outcome; dissociation; depression*

The first systematic treatment outcome studies for multiple personality disorder (MPD) were conducted by Coons (1986) and Kluft (1984; 1985), who reported on series of cases treated to stable integration. These studies by Coons and Kluft were preceded by case reports, including the

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two landmark cases of Chris Costner Sizemore (Sizemore & Pittillo, 1977; Thigpen & Cleckley, 1957) and Shirley Mason (Schreiber, 1973), both of whom were treated to long-term stable integration. Since then, prospective treatment outcome studies for complex dissociative disorders including dissociative identity disorder (DID) have been conducted by two groups, one headed by Brand (Brand & Loewenstein, 2014; Brand & Stadnik, 2013; Brand, Classen, Lanius, Loewenstein, McNary, Pain, & Putnam, 2009; Brand, McNary, Myrick, Loewenstein, Classen, Lanius, Pain, & Putnam, 2013; Cronin, Brand, & Mattanah, 2014; Engelberg & Brand, 2012; Myrick, Brand, McNary, Classen, Lanius, Loewenstein, Putnam, 2012; Myrick, Brand, & Putnam, 2013; Myrick, Chasson, Lanius, Leventhal, & Brand, 2014; Webermann, Brand, & Chasson, *in press*) and the other by Ross (Ellason & Ross, 1997; Ellason, Ross, & Fuchs, 1996; Ross, 2005; Ross & Burns, 2007; Ross & Ellason, 2001, 2005; Ross & Haley, 2004).

The existing treatment outcome literature spans four decades and consists of replicated, prospective studies using valid measures; large and small case series based on retrospective chart reviews; and single-case reports. The treatment of complex dissociative disorders, therefore, is evidence based and meets criteria for Level II evidence as defined by the United States Preventive Services Task Force (2002). The literature, nevertheless, lacks Level I evidence, which consists of randomized, prospective controlled trials with replications and meta-analyses.

We sought to add to this literature by following a sample of inpatients in a hospital Trauma Program specializing in chronic, complex dissociative disorders for ten months post-discharge, having assessed the patients with a number of different measures upon admission. The patients continued to receive outpatient treatment from their referring therapists post-discharge, and none were readmitted to the hospital during the study period. Although the treatment practices of the referring therapists were not monitored, we assume that they were consistent with the principles of Trauma Model Therapy (Ross & Halpern, 2009) and with the DID Treatment Guidelines of the International Society for the Study of Trauma and Dissociation (2011).

The inpatient portion of the treatment was based on Trauma Model Therapy, (Ross & Halpern, 2009) and included 32 hours a week of group therapy and three hours a week of individual therapy. The therapy groups included: cognitive therapy; process group; discharge planning; several different experiential groups; and a trauma education group. The purpose of the experiential groups was to activate conflicted feelings in order for the patients to practice affect management skills in a structured setting and to desensitize them to their feelings, which they tended to avoid. These feel-

ings included fear, anger, and sadness, with specific groups designed to address each one of these.

The individual therapy focused on the core elements of Trauma Model Therapy including conflicted, ambivalent attachment to perpetrators and self-blame and self-punishment. Almost all patients were acutely suicidal at admission: the primary goal of treatment was to reduce the suicidal ideation to a level that warranted a return to a less restrictive level of care, namely outpatient treatment. The rationale and details of the treatment model are described in Ross and Halpern (2009).

We hypothesized that scores on the three outcome measures, the Dissociative Experiences Scale (DES), the Beck Depression Inventory-II (BDI) and the Somatoform Dissociation Questionnaire (SDQ), would all decline significantly from admission to 10-month follow-up.

METHOD

Participants

Participants were 37 consecutively admitted inpatients in a hospital Trauma Program who agreed to participate. No patients who agreed to participate were excluded. Demographic data were available on 20 participants; the rest of the demographic data was missing due to raw data being misplaced: 17 were women; 10 were single, 5 were married, and 5 were separated or divorced; and the average age was 45.4 years ($SD=9.5$). All participants provided written informed consent. The study was approved by the Medical Staff Committee of the hospital, which acts as the Internal Review Board. Following discharge from the Trauma Program, the participants received individual therapy from their referring outpatient therapists. None were readmitted to the Trauma Program during the follow-up period. Patients are admitted to the Trauma Program because they meet inpatient acuity criteria, usually acute suicidal ideation, and because they report a history of trauma during their admission interviews; this trauma may not necessarily be captured by the research measure used to inquire about childhood physical and sexual abuse, the Dissociative Disorders Interview Schedule (DDIS) (Ross, 1997; Ross & Halpern, 2009). In the Trauma Program, clinical diagnoses are made by the attending psychiatrist based on DSM-5 criteria as ascertained during a clinical interview, and trauma histories are clarified during the initial psychosocial evaluation and during ongoing individual psychotherapy. Any decisions about which clinical diagnoses are considered to be primary and which are secondary comorbidities are based on clinical judgment. We did not conduct a medical record review to gather any of this information.

Measures

Participants completed the DDIS on admission. The DDIS is a structured interview that makes DSM-IV diagnoses of somatization disorder, major depressive episodes, and the five dissociative disorders. It also inquires about substance abuse, Schneiderian first-rank symptoms, ESP/paranormal experiences, and childhood physical and sexual abuse. The DDIS (Ross, 1997; Ross & Halpern, 2009) has been used in a series of studies in North America (Ross & Browning, 2016; Ross, Duffy, & Ellason, 2002; Ross, Ferrell, & Schroeder, 2014). Scores on the DDIS differentiate DID from other diagnostic categories (Ross & Ellason, 2005). The agreement rates between the DDIS, the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D), and a clinical interview for presence or absence of DID or dissociative disorder not otherwise specified (DDNOS) versus no dissociative disorder are good to excellent (Cohen's kappas, 0.68-0.74) (Ross, Duffy, & Ellason, 2002).

At admission and at 6- and 10-month follow-ups, participants completed the Dissociative Experiences Scale (DES), the Somatoform Dissociation Questionnaire (SDQ) and the Beck Depression Inventory-II (BDI). The DES (Bernstein & Putnam, 1986; Waller & Ross, 1997) is a widely used 28-item self-report measure with good reliability that yields an overall score ranging from zero to 100. Taxometric analysis of eight items from the DES, called the DES-T, yields a decision as to whether an individual is or is not in the dissociative taxon, that is, whether they report pathological dissociation as opposed to normative dissociative experiences.

The BDI (Beck, Steer, & Brown, 1996) is a widely used 21-item self-report measure of depression with good reliability and validity. A score of 20 on the BDI is commonly used as a cutoff for a diagnosis of a major depressive episode. The SDQ is a 20-item self-report measure of somatoform dissociation that correlates strongly with the DES. It too has good reliability and concurrent validity (Nijenhuis, 2010). Individuals with DID have average SDQ scores in the fifties, whereas those with DDNOS have average scores in the forties (Nijenhuis, 2010).

Data Analysis

Scores for each measure at admission and 10-months follow-up were compared to each other using paired dependent *t* tests. Effect sizes (Cohen, 1977) for changes in the DES, BDI and SDQ from admission to 10-months follow-up were calculated, as were reliability change indices (Jacobsen & Truax, 1991; Wilson, Becker, & Tinker, 1997). Additionally, the baseline DES, BDI, and SDQ scores were entered into a Pearson correlation matrix. Significance was set at $p < .05$. For the reliability change index, a significant result was considered to be a score above 1.96, as recommended by Wilson, Becker and Tinker (1997). For the effect sizes, an effect of 0.20–0.50 was considered to be small, of 0.50–0.80 to be medium and greater than 0.80 to be large (Cohen, 1977).

RESULTS

On the DDIS, 10 participants met criteria for dissociative identity disorder (DID) and 7 for dissociative disorder not otherwise specified. The average number of secondary features of DID on the DDIS was 3.6 (SD = 4.2). The average score on the DES was 37.8 (SD = 21.9) and 6 participants were in the dissociative taxon.

Two participants met criteria for somatization disorder, and 17 for major depressive disorder. Five participants reported prior substance abuse. The average number of symptoms on the DDIS symptom clusters was: somatic symptoms, 4.1 (SD = 5.9); Schneiderian symptoms, 2.2 (SD = 3.1); borderline criteria, 2.5 (SD = 2.8); and ESP/paranormal experiences, 1.4 (SD = 2.1). Eleven participants reported childhood sexual abuse and nine reported physical abuse on the DDIS. The DDIS does not inquire about verbal abuse or physical or emotional neglect, nor does it inquire about adult trauma such as domestic violence, accidents, or assaults.

Results for the self-report measures are presented in Table 1. The effect sizes for changes from admission to 10-months follow-up were: DES, 0.42; BDI, 0.99; and SDQ, 0.62. The reliability change indices for changes from admission to 10-months follow-up were: DES, 0.700; BDI, 1.333; and SDQ, 1.136.

TABLE 1 Scores on Self-Report Measures at Admission, 6- and 10-Months Follow-Up.

Measure	Admission	6 Months	10 Months	<i>t</i>	<i>p</i>
DES	37.8 (23.1)	33.3 (21.8)	31.1 (22.8)	2.286	.03
SDQ	41.5 (15.5)	31.6 (9.6)	32.5 (11.9)	4.272	.0001
BDI	36.9 (12.3)	30.0 (14.1)	24.3 (14.4)	3.691	.001

Notes. DES = Dissociative Experiences Scale; SDQ = Somatoform Dissociation Questionnaire; BDI = Beck Depression Inventory-II; *t* tests are for admission versus 10-months follow-up

Scores for each individual participant on the DES at the three time points are shown in Table 2, the BDI scores are shown in Table 3, and the SDQ scores are shown in Table 4. The correlations between the three measures at baseline were: DES-BDI, $r = .259$, $p = .127$; DES-SDQ, $r = .366$, $p = .03$; and SDQ-BDI, $r = .223$, $p = .191$.

DISCUSSION

Consistent with previous studies in populations with similar DES and DDIS profiles, overall scores on the DES, SDQ, and BDI declined from admission to 10-months follow-up. At ten months, scores on all three measures were still well above the normal range, suggesting that considerable symptom

TABLE 2 Dissociative Experiences Scale (DES) Scores on Individual Participants at Admission, and 6- and 10-Months Follow-Up

Patient	Admission	6 Months	10 Months
1	56.4	20.0	13.9
2	36.1	38.9	50.4
3	42.1	—	30.4
4	83.6	62.1	45.7
5	35.3	—	27.1
6	20.0	16.3	15.7
7	93.9	88.2	87.5
8	43.2	30.4	29.6
9	45.7	65.0	—
10	37.5	38.6	16.1
11	35.4	33.9	22.5
12	36.4	47.1	51.4
13	69.3	13.6	10.0
14	29.6	17.1	10.0
15	13.2	41.8	68.2
16	1.4	0.4	0.0
17	34.3	7.1	3.2
18	37.5	57.1	33.6
19	54.6	20.4	18.2
20	21.10	12.14	2.50
21	39.2	30.4	—
22	46.4	30.0	46.8
23	76.8	66.7	52.1
24	44.3	—	—
25	11.4	—	—
26	56.8	56.4	54.3
27	12.9	5.4	6.1
28	42.1	49.3	51.4
29	27.5	37.5	42.9
30	18.9	9.7	—
31	12.1	—	—
32	3.2	4.6	1.8
33	64.3	—	—
34	6.1	46.1	39.6
35	55.0	42.5	58.6
36	82.5	38.3	41.1
37	45.0	6.4	1.1

reduction work remained to be done, however there had been progress in this regard. The results of the effect size and dependent *t* test analyses confirmed our hypothesis that there would be significant score reductions from admission to 10-months follow-up. Although the reliability change indices for the three measures did not meet the threshold for reliable change set by Wilson, Becker, & Tinker (1997), scores on all three measures at admission

TABLE 3 Beck Depression Inventory (BDI-II) Scores of Participants at Admission, and 6- and 10-Month Follow-Up.

Patient	Admission	6 Months	10 Months
1	25	39	18
2	17	25	27
3	41	—	10
4	47	41	8
5	50	—	34
6	26	49	51
7	50	40	35
8	6	12	3
9	48	—	—
10	22	32	27
11	29	38	37
12	28	30	41
13	26	3	3
14	30	24	23
15	53	31	32
16	44	4	10
17	33	43	32
18	48	43	16
19	38	16	20
20	18	26	7
21	36	51	—
22	47	34	49
23	49	43	26
24	56	—	—
25	35	—	—
26	27	22	25
27	23	12	10
28	45	35	32
29	45	45	28
30	45	28	—
31	25	—	—
32	39	12	14
33	52	—	—
34	—	45	53
35	46	36	24
36	49	39	33
37	31	3	0

and 10-months follow-up differed significantly on paired dependent *t* tests, and the effect sizes were small for the DES, large for the BDI, and medium for the SDQ. There were statistically significant improvements according to two widely used measures, however, the reliability of the score changes is questionable according to the reliability change index analyses. These three analyses pertain to the average change scores for the group as a whole; we

TABLE 4 Somatoform Dissociation Questionnaire (SDQ) Scores of Participants at Admission, and 6- and 10-Month Follow-Up.

Patient	Admission	6 Months	10 Months
1	38	26	20
2	21	25	31
3	59	—	45
4	47	24	22
5	33	—	31
6	22	20	21
7	49	34	48
8	39	34	31
9	38	—	—
10	36	31	30
11	45	36	27
12	21	27	22
13	40	20	20
14	49	27	30
15	51	48	64
16	20	20	20
17	41	28	26
18	42	44	42
19	54	38	38
20	72	35	30
21	44	34	—
22	46	31	44
23	63	45	39
24	29	—	—
25	37	—	—
26	51	51	47
27	24	23	21
28	34	27	25
29	35	29	36
30	32	20	—
31	36	—	—
32	39	23	21
33	100	—	—
34	32	46	44
35	55	51	57
36	31	30	24
37	30	22	20

think it most instructive, however, to examine the scores of the individual participants, rather than overall averages, as we discuss below.

Recovery includes other elements not measured by the DES, SDQ, and BDI, such as occupational and social function, reduction in health care utilization, improved quality of relationships, and improved life satisfaction, but nevertheless it is hard to imagine how significant recovery could occur

with no change on these measures. Therefore, we regard the improvement in these scores as a treatment outcome measure. The results demonstrate that, overall, patients admitted to the Trauma Program experience sustained improvement in dissociation and depression from admission up till 10 months post-discharge. In previous studies of similar samples (Ellason & Ross, 1997; Ellason, Ross, & Fuchs, 1996; Ross, 2005; Ross & Burns, 2007; Ross & Ellason, 2001; 2005; Ross & Haley, 2004), there was no reduction in DES scores from admission to discharge; therefore, we assume that most, if not all, of the reduction in DES scores in this study occurred during the post-discharge outpatient therapy.

The observed reduction in scores on the DES, BDI, and SDQ could have occurred for a variety of reasons. These could include: 1) a true reduction in symptoms as part of an overall recovery process; 2) symptom reduction due to denial, avoidance of affect, a flight into health or a similar mechanism; 3) a regression to the mean, that is, a reduction in scores due to whatever crisis caused the admission resolving spontaneously; 4) the influence of any of numerous life factors outside therapy; 5) effects of any post-discharge medication changes; 6) resolution of any concurrent medical problems; or 7) any number of unrecognized variables. Our methodology does not allow us to reach any conclusions about the causes of the observed symptom reductions, but these should be taken into account in future research if possible. They could also be taken into consideration in clinical work.

Symptom reductions such as those observed in the current study do not represent full recovery because they are still well above the normal range. In the study by Ellason and Ross (1997), 12 participants with multiple personality disorder reached integration during the two years of follow-up post-discharge. Integration was confirmed by both the participant and the outpatient therapist based on six criteria developed by Kluft (1984). These criteria are: 1) three stable months of continuity of contemporary memory; 2) absence of behaviorally evident separate identities; 3) a self-perception of internal unity; 4) absence of alter personalities on hypnotic re-exploration; 5) transference phenomena consistent with unity of the parts; and 6) clinical evidence that the patient has incorporated separated attitudes and awarenesses into one unified whole. The twelve integrated participants had an average DES score of 50.5 (SD = 12.2) on admission and 15.4 (10.2) at two-year follow-up. Their average BDI scores were 27.9 (SD = 12.2) on admission and 9.7 (SD = 4.8) at two-year follow-up. These score reductions were accompanied by similar marked improvement on a variety of additional measures including the DDIS. Pronounced score reductions on a wide range of measures provide stronger evidence of meaningful clinical recovery. However, for the results of future research to be conclusive, additional measures of life satisfaction, occupational and social function, and health-care utilization should be employed.

Given the small sample size and the absence of more comprehensive baseline and follow-up evaluations in the current study, which preclude more definitive conclusions about treatment outcomes, we thought it would be instructive to look at the DES, BDI, and SDQ scores of the individual participants at the three time points as shown in Tables 2, 3, and 4. Clearly, not all participants follow the same trajectory. Kluft (1994) described different treatment trajectories of dissociative individuals, all with diagnoses of multiple personality disorder, but there have been no data published on these trajectories since then. Our sample is not directly comparable to Kluft's, because only 10 patients had DID, but nevertheless the sample endorsed high levels of dissociative symptoms. Looking at the DES, some participants (numbers 1, 13, 17, 19, 37) show a dramatic and sustained reduction in dissociation scores, which is the best outcome. Others show a sustained reduction in scores that is less dramatic (numbers 4, 6, 8, 14, 20, 23, 27, 36). Other participants, however, do not show any meaningful reduction in scores and have a basically flat trajectory (numbers 7, 26, 28, 29, 35), or a small amount of improvement or deterioration. A few participants experience a sustained increase in scores (numbers 2, 12, 15, 34) and others have variable patterns. If a response rate is defined as a 50% or greater reduction in DES scores at 10 months, then $10/37 = 27\%$ were responders (numbers 1, 10, 13, 14, 17, 19, 20, 27, 36, 37). If participants who did not complete the DES at 10 months are excluded, then $10/30 = 33\%$ were responders (the same is true for the BDI).

On the BDI, a similar set of variable patterns was observed. Using a criterion of a 50% reduction in BDI score as the definition of a responder, then $10/37 = 27\%$ were responders (numbers 3, 4, 8, 13, 16, 18, 20, 27, 32, 37). Four participants were responders on both the BDI and the DES (numbers 13, 20, 27, 37). Only three individuals reported substantially worse BDI scores at 10 months (numbers 2, 6, 12). On the SDQ, the variation in trajectories was smaller at 10 months, as reflected in the smaller standard deviations than those for the DES and BDI. Only one participant's SDQ score dropped by greater than 50% (number 20).

The correlations between the measures at baseline were insignificant, except for the DES-SDQ correlation, which was $r = .366$ ($p = .03$). From this we concluded that depression and dissociation are largely independent of each other and cannot be accounted for by each other. This is not surprising to us, because depression and dissociation are different constructs, and are quite different clinically. Although somatoform and psychoform dissociation are more closely related to each other than either is to depression, the need for different measures arises from the fact that they are not the same thing; thus, the relatively modest correlation between the two at baseline confirms that neither can be fully accounted for by the other, and both need to be measured in research using different measures. Similarly, in clinical work, we think, therapists should be aware of, monitor, and discuss

the symptoms captured by both measures. This is true whether or not the measures themselves are used in clinical practice.

Participant number 7's scores are of interest because her DES scores were 93.9-88.2-87.5. Scores this high are strongly suggestive of factitious overendorsement of symptoms. This participant's BDI scores were also very high (50-40-35), but did decline over time. We do not have any clinical information that might shed light on this participant, but it is not surprising that the DES scores did not decline if there was a strong factitious element. Understanding the variable individual patterns would likewise require clinical information about the post-discharge period that we do not have. Clearly, however, although there is overall improvement, there is great variability in individual trajectories. Understanding the clinical reasons for the variability in trajectories would be useful for treatment planning.

The varying treatment trajectories that we observed in our sample are consistent with those described by Kluft (1984). Kluft followed 41 patients with multiple personality disorder and observed a heterogeneous array of treatment trajectories similar to those reported earlier by Coons (1986). In our sample, four patients (numbers 1, 13, 17, 19, 37) clearly correspond to Kluft's high trajectory while five (numbers 7, 26, 28, 29, 35) clearly correspond to Kluft's low trajectory. Thirty-four years later, it is still true that these subgroups need to be better characterized in terms of both treatment needs and prognoses.

Our study has a number of limitations. The sample was relatively small and it was obtained from a single treatment facility; because of this small sample size it is not possible to generalize the findings to other populations. Due to a filing error, demographic information was missing on 17 patients. The follow-up was for only 10 months, and no information was gathered about the frequency or type of post-discharge outpatient therapy. The results cannot be generalized to all individuals with complex dissociative disorders, or with high scores on the DES (three participants scored on the normal range on the DES at all three time points; numbers 16, 27, 32). Nevertheless, the treatment outcome literature for complex dissociative disorders including DID now spans four decades and includes replicated prospective studies with widely used, valid measures. Based on this literature, the treatment of complex dissociative disorders can be described as evidence based at Level II of the criteria set by the United States Preventive Services Task Force (2002). Although only 17 patients met criteria for a dissociative disorder on the DDIS, their average DES score of 38.7 on admission indicates that they were a highly dissociative group.

FUNDING

The study was supported by a grant from the Jude Jordan Foundation.

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