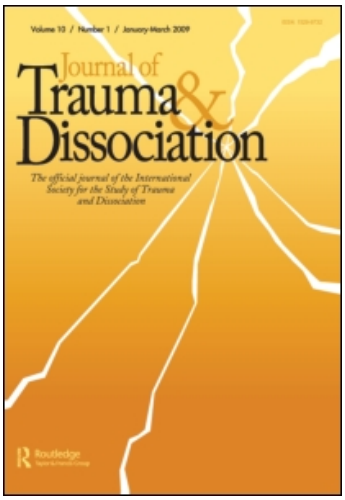

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Guidelines for Treating Dissociative Identity Disorder in Adults, Third Revision: Summary Version

International Society for the Study of Trauma and Dissociation

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Guidelines for Treating Dissociative Identity Disorder in Adults, Third Revision: Summary Version

INTERNATIONAL SOCIETY FOR THE STUDY
OF TRAUMA AND DISSOCIATION

INTRODUCTION

The *Guidelines for Treating Dissociative Identity Disorder in Adults* presents key findings and generally accepted principles that reflect current scientific knowledge and clinical experience specific to the diagnosis and treatment of dissociative identity disorder (DID) and similar forms of dissociative disorder not otherwise specified (DDNOS). This summary version is intended as a useful synopsis for clinicians; further elaboration of all sections and additional sections, along with academic discussion and references, can be found in the full *Guidelines*. It should be understood that information in the *Guidelines* supplements, but does not replace, generally accepted principles of psychotherapy and psychopharmacology. Treatment for DID should adhere to the basic principles of psychotherapy and psychiatric medical management, and therapists should use specialized techniques only as needed to address specific dissociative symptomatology.

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EPIDEMIOLOGY, CLINICAL DIAGNOSIS, AND DIAGNOSTIC PROCEDURES

Diagnostic Criteria for DID

The *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev. [*DSM–IV–TR*]; American Psychiatric Association, 2000) lists the following diagnostic criteria for DID (300.14; p. 529):

A. The presence of 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).
B. At least two of these identities or personality states recurrently take control of the person's behavior.
C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
D. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

The DID patient is a single person who experiences himself or herself as having separate alternate identities that have relative psychological autonomy from one another. At various times, these subjective identities may take executive control of the person's body and behavior and/or influence his or her experience and behavior from "within." Taken together, all of the alternate identities make up the identity or personality of the human being with DID. Although patients and clinicians use many terms to denote the DID patient's subjective sense of self-states or identities, the *Guidelines* have adopted the term *alternate identity* for consistency with the terminology used in the *DSM–IV*.

Dissociation: Terminology and Definitions

Dissociation can be described as the failure to integrate information and self-attributions that should ordinarily be integrated and as alterations of consciousness characterized by a sense of detachment from the self and/or the environment. Contemporary descriptions of dissociation focus on the *DSM–IV*'s central concept of disruption:

> The essential manifestation of pathological dissociation is a partial or complete disruption of the normal integration of a person's psychological functioning. . . . Specifically, dissociation can unexpectedly disrupt,

> alter, or intrude upon a person's consciousness and experience of body, world, self, mind, agency, intentionality, thinking, believing, knowing, recognizing, remembering, feeling, wanting, speaking, acting, seeing, hearing, smelling, tasting, touching, and so on. . . . [T]hese disruptions . . . are typically experienced by the person as startling, autonomous intrusions into his or her usual ways of responding or functioning. The most common dissociative intrusions include hearing voices, depersonalization, derealization, "made" thoughts, "made" urges, "made" desires, "made" emotions, and "made" actions. (Dell & O'Neil, 2009, p. xxi)

Theories of the Development of DID

DID is generally viewed as a developmental psychopathology in which alternate identities result from the inability of many traumatized children to develop a unified sense of self that is maintained across various behavioral states. Severe and prolonged traumatic experiences can lead to the development of discrete, personified behavioral states (i.e., rudimentary alternate identities) in the child, which has the effect of encapsulating intolerable traumatic memories, affects, sensations, beliefs, or behaviors and mitigating their effects on the child's overall development. Secondary structuring of these discrete behavioral states occurs over time through a variety of developmental and symbolic mechanisms, resulting in the characteristics of the specific alternate identities. The identities may develop in number, complexity, and sense of separateness as the child proceeds through latency, adolescence, and adulthood. DID develops during the course of childhood and rarely, if ever, derives from adult-onset trauma (unless it is superimposed on preexisting childhood trauma and preexisting latent or dormant fragmentation). The circumstances leading to the development of DID often occur in the context of relational or attachment disruption that may precede and set the stage for abuse and the development of dissociative coping.

The theory of "structural dissociation of the personality," another etiological model, is based on the ideas of Janet and attempts to create a unified theory of dissociation that includes DID. This theory suggests that dissociation results from a basic failure to integrate systems of ideas and functions of the personality. Following exposure to potentially traumatizing events, the personality as a whole system can become divided into an "apparently normal part of the personality" dedicated to daily functioning and an "emotional part of the personality" dedicated to defense. Defense in this context is related to psychobiological functions of survival in response to life threat, such as fight/flight, not to the psychodynamic notion of defense. It is hypothesized that chronic traumatization and/or neglect can lead to secondary structural dissociation and the emergence of additional emotional parts of the personality.

Developmental models of DID posit that the disorder does not arise from a previously mature, unified mind or core personality that becomes shattered or fractured. Rather, DID results from a failure of normal developmental integration, which is caused by overwhelming experiences and disturbed caregiver–child interactions (including neglect and the failure to respond) during critical early developmental periods. This, in turn, leads some traumatized children to develop relatively discrete, personified behavioral states or subsystems of their core personality.

Diagnostic Interviewing

A careful clinical interview and thoughtful differential diagnosis can usually lead to the correct diagnosis of DID. Assessment for dissociation should be conducted as a part of every diagnostic interview, given the fact that dissociative disorders are at least as common as many other psychiatric disorders that are routinely considered in psychiatric evaluations. At a minimum, the patient should be asked about episodes of amnesia, fugue, depersonalization, derealization, identity confusion, and identity alteration. Additional useful areas of inquiry include questions about spontaneous age regressions; autohypnotic experiences; hearing voices; passive-influence symptoms such as "made" thoughts, emotions, or behaviors (i.e., those that do not feel attributable to the self); and somatoform dissociative symptoms such as bodily sensations related to strong emotions and past trauma. Clinicians should also be alert to behavioral manifestations of dissociation, such as posture, presentation of self, dress, fixed gaze, eye fluttering, fluctuations in style of speech, interpersonal relatedness, skill level, and sophistication of cognition.

Clinicians should bear in mind that some persons with DID do not realize (or do not acknowledge to themselves) that their internal experience is different from that of others. In keeping with the view that dissociation may serve as a defense against uncomfortable realities, the presence of alternate identities and other dissociative symptoms is commonly denied and disavowed by persons with DID. This kind of denial is consistent with the defensive function of disavowing both the trauma and its related emotions and the subsequent fragmentation of the sense of self.

The diagnostic process should include an effort to assess the patient's trauma history. Because of their dissociative amnesia, DID patients often provide a fragmented and incoherent history early in treatment; a more complete personal history typically emerges over time. Clinicians should use careful clinical judgment about how aggressively to pursue details of traumatic experiences during initial interviews, especially when those experiences seem to be poorly or incompletely remembered, or if remembering or recounting the trauma appears to overwhelm the individual's emotional capacities.

Epidemiology

DID and dissociative disorders are not rare conditions. Clinical studies have found that generally between 1% and 5% of patients in psychiatric programs may meet diagnostic criteria for DID. Many of the patients in these studies had not previously been clinically diagnosed with a dissociative disorder. The difficulties in diagnosing DID result primarily from lack of education among clinicians about dissociation, dissociative disorders, and the effects of psychological trauma, as well as from clinician bias. Most clinicians have been taught (or assume) that DID is a rare disorder with a florid, dramatic presentation. Instead of showing visibly distinct alternate identities, the typical DID patient presents a polysymptomatic mixture of dissociative and posttraumatic stress disorder (PTSD) symptoms that are embedded in a matrix of ostensibly non-trauma-related symptoms (e.g., depression, panic attacks, substance abuse, somatoform symptoms, eating-disordered symptoms). The prominence of these latter, highly familiar symptoms often leads clinicians to diagnose only these comorbid conditions. When this happens, the undiagnosed DID patient may undergo a long and frequently unsuccessful treatment for these other conditions.

DDNOS

A substantial proportion of the dissociative cases encountered in clinical settings receive a diagnosis of DDNOS. Many of these DDNOS cases are well described by the *DSM–IV–TR* Example 1 of DDNOS: "Clinical presentations similar to Dissociative Identity Disorder that fail to meet the full criteria for this disorder" (American Psychiatric Association, 2000, p. 532). There appear to be two major groupings of such DDNOS-1 cases: (a) full-blown DID cases whose diagnosis has not yet been confirmed (via the unambiguous manifestation of alternate identities) and (b) complex dissociative cases with some internal fragmentation and/or infrequent incidents of amnesia. Patients in this latter group of DDNOS-1 are "almost-DID." DDNOS-1 patients are typically subject to DID-like disruptions in their functioning caused by switches in self-states and intrusions of feelings and memories into consciousness. In terms of treatment, DDNOS-1 cases—whether they are as-yet-undiagnosed DID or "almost-DID"—benefit from many of the treatments that have been designed for DID.

Specialized Measures of Dissociation

The *Guidelines* describe several types of psychometric instruments for assessing dissociation:

1. Comprehensive clinician-administered structured interviews:

Structured Clinical Interview for DSM–IV Dissociative Disorders–Revised (SCID-D)
Dissociative Disorders Interview Schedule (DDIS)

2. Comprehensive self-report instruments:
   Multidimensional Inventory of Dissociation (MID)
3. Brief self-report instruments used for screening purposes:
   Dissociative Experiences Scale (DES)
   Dissociation Questionnaire (DIS-Q)
   Somatoform Dissociation Questionnaire-20 (SDQ-20) and its shorter form (SDQ-5)

Other Psychological Tests

Some commonly used personality assessment instruments (e.g., the Rorschach Inkblot Test, Minnesota Multiphasic Personality Inventory–2, Wechsler Adult Intelligence Scale–Revised, Millon Clinical Multiaxial Inventory–III) can provide understanding of the patient's personality structure and may yield information useful in making a differential diagnosis between DID and disorders with which it is often confused. However, these instruments were *not* designed to detect dissociative disorders and may lead to misdiagnosis if the evaluator (a) is not familiar with the typical responses of dissociative patients on these tests, (b) relies primarily on scoring scales not normed for a dissociative population, (c) does not administer additional dissociation-specific tests (such as structured clinical interviews), and (d) does not inquire specifically about dissociative symptoms during the clinical or testing interview.

Differential Diagnosis and Misdiagnosis of DID

Clinicians should be alert to both false positive and false negative diagnoses of DID. It is important that clinicians appreciate the similarities and differences between the symptoms of dissociative disorders and other frequently encountered disorders. Bipolar, affective, psychotic, seizure, and borderline personality disorders are among the common false negative diagnoses of patients with DID and DDNOS. False negative diagnoses of DID readily occur when the assessment interview does not include questions about dissociation and trauma or focuses on more evident comorbid conditions, and when evaluators have failed to attend to critical process issues such developing a sufficient sense of alliance and trust.

Conversely, clinicians who specialize in dissociative disorders must be able to recognize and diagnose nondissociative disorders so that they do not incorrectly diagnose DID or fail to identify the presence of true comorbid conditions. Dissociative symptoms are central in other dissociative disorders

and PTSD and can be prominent other disorders such as somatization disorder and even schizophrenia.

There has been heated debate in the professional literature concerning the so-called iatrogenesis of DID. Experts in the dissociative disorders field have argued strongly against the notion that clinical DID can be produced iatrogenically. No study in any clinical or research population has yet demonstrated that the full clinical syndrome of DID can be produced in this fashion.

As with any psychiatric condition, a presentation of DID may be factitious or malingered. Clinicians should be alert to atypical presentations of apparent DID, especially in situations where there is strong motivation to simulate an illness (e.g., pending legal charges, disability or compensation determinations).

TREATMENT GOALS

Integrated functioning is the goal of treatment for DID. The DID patient should be seen as a whole adult person with the identities sharing responsibility for daily life. Despite patients' subjective experience of separateness, clinicians must keep in mind that the patient is a single person and generally must hold the whole person (i.e., system of alternate identities) responsible for the behavior of any or all of the constituent identities, even in the presence of amnesia or the sense of lack of control or agency over behavior.

In most DID patients, each identity seems to have its "own" first-person perspective and sense of its "own" self, as well as a perspective of other parts as being "not self." Switches among identities occur in response to changes in emotional state or to environmental demands, resulting in the emergence of another identity that assumes executive control. Because different identities have different roles, experiences, emotions, memories, and beliefs, the therapist is constantly contending with their competing points of view. The identity that is in control usually speaks in the first person and may disown other parts or be completely unaware of them.

Helping the identities to be aware of one another as legitimate parts of the self and to negotiate and resolve their conflicts is at the very core of the therapeutic process. The therapist should foster the idea that all alternate identities represent adaptive attempts to cope or to master problems that the patient has faced. Thus, it is countertherapeutic to tell patients to ignore or "get rid" of identities or for the therapist to treat any alternate identity as if it were more "real" or more important than any other. The therapist should not "play favorites" among the alternate identities or exclude apparently unlikable or disruptive ones from the therapy. It is countertherapeutic to suggest that the patient create additional alternate identities, to

name identities when they have no names (although the patient may choose names if he or she wishes), or to suggest that identities function in a more elaborated and autonomous way than they already are functioning.

A desirable treatment outcome is a workable form of integration or harmony among alternate identities. Terms such as *integration* and *fusion* are sometimes used in a confusing way. *Integration* is a broad, longitudinal process referring to all work on dissociated mental processes throughout treatment. *Fusion* refers to a point in time when two or more alternate identities experience themselves as joining together with a complete loss of subjective separateness. *Final fusion* refers to the point in time when the patient's sense of self shifts from that of having multiple identities to that of being a unified self. Some members of the 2010 Guidelines Task Force have advocated for the use of the term *unification* to avoid the confusion of early fusions and final fusion.

The most stable treatment outcome is final fusion—complete integration, merger, and loss of separateness—of all identity states. However, even after undergoing considerable treatment, a considerable number of DID patients will not be able to achieve final fusion and/or will not see fusion as desirable. Many factors can contribute to patients being unable to achieve final fusion: chronic and serious situational stress; avoidance of unresolved, extremely painful life issues, including traumatic memories; lack of financial resources for treatment; comorbid medical disorders; advanced age; significant unremitting *DSM* Axis I and/or Axis II comorbidities; and/or significant narcissistic investment in the alternate identities and/or DID itself, among others. Accordingly, a more realistic long-term outcome for some patients may be a cooperative arrangement—that is, sufficiently integrated and coordinated functioning among alternate identities to promote optimal functioning. However, patients who achieve a cooperative arrangement rather than final fusion seem to be more vulnerable to later decompensation (into florid DID and/or PTSD) when sufficiently stressed.

Even after final fusion, additional work to integrate the patient's residual dissociated ways of thinking and experiencing may continue. For instance, the therapist and patient might need to work on fully integrating an ability that was previously held by one alternate identity, or the patient may need to learn what his or her new pain threshold is, or how to integrate all of the dissociated ages into one chronological age, or how to regauge appropriate and healthy exercise or exertion levels for his or her age. Traumatic and stressful material also may need to be reworked from this new unified perspective.

PHASE-ORIENTED TREATMENT APPROACH

Over the past two decades, the consensus of experts is that complex trauma-related disorders—including DID—are most appropriately treated

in sequenced stages. The phases of treatment discussed here describe the dominant focus of the therapeutic work during each stage; overall, they assist the DID patient in developing safety, stability, and greater adaptation to daily life.

Phase 1: Establishing Safety, Stabilization, and Symptom Reduction

In the initial phase of treatment, emphasis should be placed on establishing a therapeutic alliance, educating patients about diagnosis and symptoms, and explaining the process of treatment. The goals of Phase 1 treatment include maintaining personal safety, controlling symptoms, modulating affect, building stress tolerance, enhancing basic life functioning, and building or improving relational capacities. Maintaining a sound treatment frame in the context of a therapeutic holding environment is absolutely critical to establishing a stable therapy that maximizes the likelihood of a successful outcome.

DID patients vary widely in ego strength, commitment to treatment, social supports, life stresses, economic resources, and other factors that may make them more or less able to undertake a demanding, change-oriented treatment. Accordingly, some patients may continue in Phase 1 treatment for long periods of time—sometimes even for the entire course of treatment. These patients may make considerable improvements in safety and overall functioning but may not be able to participate in an extensive, emotionally intense, detailed exploration of their trauma history. In the case of chronically low-functioning patients, the focus of treatment should consistently be stabilization, crisis management, and symptom reduction (*not* the processing of traumatic memories or the fusion of alternate identities).

Safety issues and symptom management. Safety issues and symptom management should be addressed in a comprehensive and direct manner. Other treatment issues may need to be put on hold until safety is established. Interventions should include (a) education about the necessity for safety for the treatment to succeed; (b) an assessment of the function(s) of unsafe and/or risky behaviors and urges; (c) development of positive and constructive behavioral repertoires to remain safe; (d) identification of alternate identities who act unsafely and/or control unsafe behaviors; (e) development of agreements between alternate identities to help the patient maintain safety; (f) use of symptom management strategies such as grounding techniques, crisis planning, self-hypnosis, and/or medications to provide alternatives to unsafe behaviors; (g) management of addictions and/or eating disorders that may involve referral to adjunctive specialized treatment programs; (h) involvement of appropriate agencies if there is a question about whether the patient is abusive or violent toward children, vulnerable adults, or others (following the laws of the jurisdiction in which the clinician practices); (i) helping the patient with appropriate resources for self-protection

from domestic violence; and (j) insisting that the patient seek treatment at a more restrictive level of care, including hospitalization, as necessary to prevent harm to self or others.

DID patients usually give a history of having been abused or having had their safety disregarded throughout their early lives. They tend to reenact these behaviors in their lives, venting their aggression, shame, fear, horror, and other overwhelming affects onto themselves through self-injurious and destructive behaviors, often in identification with the aggressor. Accordingly, one major cornerstone of treatment is to help patients to minimize behaviors—such as suicidal or parasuicidal behaviors, alcohol or substance abuse, enmeshment in violent or exploitive relationships, eating disorder symptoms, violence or aggression, and risk-taking behaviors—that are dangerous to themselves or others (especially minor children) or that make them vulnerable to revictimization by others.

Safety problems often manifest as overt or covert behaviors that can best be understood as self-regulatory or even self-soothing strategies that are logically related to the patient's history of neglect and trauma and his or her attempts to cope with these. Accordingly, they are usually best acknowledged in therapy as acquired modes of coping with immense pain and best treated as adaptations to be shaped in a different direction rather than as "bad" behaviors to be eliminated. Nonetheless, the therapist must address these behaviors as currently dysfunctional and insist that the patient ally with a stance of "nonabusive values" to self or others.

The management and control of posttraumatic symptoms is also a priority of Phase 1 treatment. For example, if the patient has a spontaneous flashback or episode of intrusive recall of trauma during treatment, the therapist helps to teach skills to modulate the intensity of the experience. In this phase of treatment, the clinician would assist the patient to develop control of posttraumatic and dissociative symptomatology and to modulate psychophysiological arousal levels rather than encourage further exploration of the intrusive traumatic material.

Skills training is often an essential component of the safety and stabilization phase of DID treatment. These interventions address mental processes and deficiencies that undermine safety; they include enhancing emotional awareness and emotional regulation, decreasing affect phobia, building distress tolerance, and learning to optimize effectiveness in relationships.

Working with alternate identities. In learning about the nature of their disorder, DID patients must begin to understand, accept, and access the alternate identities that play an active role in their current lives. The patient's accountability for the conduct of all alternate identities—in the external world, in therapy, and internally—is usually discussed early in treatment. Strategies designed to improve internal communication may include techniques to encourage negotiation between the alternate identities, acknowledgement of the importance of all alternate identities, and

the establishment of commitments by all identities for safety from self-harm and/or suicidal behaviors.

In general, work with alternate identities should occur as they appear naturally in relation to current clinical issues. However, in situations involving significant safety problems, in times of repeated acting out by the patient, and/or at times of therapeutic impasse, it can be important to directly elicit or make contact with alternate identities, previously known or not, that are related to these difficulties.

The development of internal cooperation and co-consciousness between identities is an essential part of Phase 1 that continues into Phase 2. This goal is facilitated by a consistent approach of helping DID patients to respect the adaptive role and validity of all identities, to find ways to take into account the wishes and needs of all identities in making decisions and pursuing life activities, and to enhance *internal* support between identities. Early in the treatment process, some alternate identities deny or disavow past traumatic experiences and/or their associated affects. It is an important part of the therapy for these identities to progressively accept their disavowed memories and feelings, hence accepting the role and importance of the other identities that hold them. The therapist can facilitate the process of acceptance by helping the alternate identities to make internal agreements (e.g., "If you are able to acknowledge and accept some of the feelings that your 'angry part' experiences, perhaps that part can agree to stop some of the destructive behaviors that threaten your safety").

The successful treatment of DID almost always requires interacting and communicating in some way with the alternate identities. Ignoring alternate identities or reflexively telling identities to "go back inside" is frankly countertherapeutic. Early in the treatment, therapists and patients must establish safe and controlled ways of working with the alternate identities that will eventually lead to co-consciousness, co-acceptance, and greater integration. Identities can be accessed directly, by asking to speak to them. Experienced clinicians also develop a repertoire of skills to access alternate identities more indirectly. For example, the patient can be asked to "listen inside" to hear what the other identities have to say, or the clinician may suggest that the identities engage in inner conversations with one another to communicate information or negotiate important issues. The therapist may insist that "all parts who need to know should listen" when crucial matters are being discussed, or he or she can "talk through" to communicate with alternate identities relevant to the current clinical issues.

Trust and the therapeutic alliance. Clinicians should never underestimate the difficulties that DID patients have with establishing and maintaining a therapeutic alliance. Patients with extensive childhood histories of abuse and neglect often have major difficulties with trust. This mistrust frequently manifests itself in the therapeutic relationship and can play out in complex and shifting transference manifestations. Such "traumatic transference"

reactivity may be enacted in overt and covert ways (e.g., one identity appears to trust the therapist, whereas others feel vulnerable and mistrustful and work to sabotage the therapy). A gradual fostering of a real therapeutic alliance with the DID patient will occur as the clinician helps the patient to pace the therapeutic work, learn skills for mastering symptoms and crises, separate the traumatic past from the present, and change PTSD and DID-based cognitive distortions.

Phase 2: Confronting, Working Through, and Integrating Traumatic Memories

In this phase of treatment, the focus turns to working with the DID patient's memories of traumatic experiences. Effective work in this phase involves remembering, tolerating, processing, and integrating overwhelming past events. This work includes the process of *abreaction*—the release of strong emotions in connection with an experience or perception (usually a past experience or perceptions of a past experience). A body of clinical experience has demonstrated that abreactions, both spontaneous and those facilitated by psychotherapy, have helped many patients make major symptomatic and overall improvements. Modern approaches to abreaction involve cognitive change and mastery in addition to the intensive discharge of emotions and tensions related to the trauma; intense emotional discharge for its own sake may simply retraumatize.

It is optimal to carefully plan out and schedule work on traumatic memories. Patient and therapist should discuss and reach agreement upon which memories will be the focus, at what level of intensity they will be processed, which types of interventions may be used (i.e., exposure, planned abreactions, etc.), which alternate identities will participate, what steps will be taken to maintain safety during the work, and which procedures will be used to contain traumatic memories if the work becomes too intense. Patients benefit when therapists help them use planning and exploratory and titration strategies to develop a sense of control over the emergence of traumatic material. Specific interventions for DID patients in Phase 2 treatment involve working with alternate identities that experience themselves as holding the traumatic memories. These interventions help broaden the patient's range of emotions across alternate identities and assist the patient as a whole with tolerating the affects associated with the trauma, such as shame, horror, terror, rage, helplessness, confusion, anger, and grief.

In Phase 2, as the various elements of a traumatic memory emerge, they are generally explored rather than redissociated or rapidly contained—assuming that there is adequate time in sessions and that the patient can do this work without significant life disruptions. Over time, and often with repeated iterations, the material in these memories is transformed

from traumatic memory into what is generally termed *narrative memory*. A major mechanism of change is one of repeatedly re-accessing and re-associating and thus integrating fragmented and dissociated elements of traumatic memories into a comprehensible and coherent narrative.

Integrating traumatic memories refers to bringing together aspects of traumatic experience that have been previously dissociated from one another: memories and the sequence of the events, the associated affects, and the physiological and somatic representations of the experience. Integration also means that the patient achieves an adult cognitive awareness and understanding of his or her role and that of others in the events. Work on loss, grief, and mourning may be profound in this stage as the patient grapples with the realization of the many losses that the traumatic past has caused (some of which might continue in the present).

The process of Phase 2 work allows the patient to realize that the traumatic experiences belong to the past, to understand their impact in his or her life, and to develop a more complete and coherent personal history and sense of self. In addition, DID patients become able to recall the traumatic experiences across alternate identities, especially those who were previously amnestic or without emotional response to them. Thus, the patient gives the traumatizing event a place in his or her personal autobiography.

It is important to realize that even in this stage of treatment, intensive memory work should not be allowed to dominate session after session. Patients can be retraumatized and/or destabilized if the treatment does not allow for adequate time to deal with the impact of the trauma or if it fails to allow periods of time for the patient to pause and regroup. Even with careful therapeutic planning, destabilization can and may require that the therapy return to Phase 1 issues such as stabilization, internal communication, containment, and symptom management. The therapist may need to address any resistance and reluctance among alternate identities to the integration of the traumatic memories.

As traumatic experiences are integrated, the alternate identities may experience themselves as less and less separate and distinct. Spontaneous and/or facilitated fusions among alternate identities may occur as well. Facilitated fusions often involve "fusion rituals." These therapeutic ceremonies usually involve imagery or hypnosis. Fusion rituals are useful when, as a result of psychotherapeutic work, separateness no longer serves any meaningful function for the patient's intrapsychic and environmental adaptation. At this point, if the patient is no longer narcissistically invested in maintaining the particular separateness, fusion is ready to occur. However, clinicians should *not* attempt to press for fusion before the patient is clinically ready for this. Premature attempts at fusion may cause significant distress for the DID patient or, alternatively, a superficial compliance wherein the alternate identities in question attempt to please the therapist by seeming to disappear.

Phase 3: Integration and Rehabilitation

In Phase 3 of DID treatment, patients make additional gains in internal cooperation, coordinated functioning, and integration. They usually begin to achieve a more solid and stable sense of self and sense of how they relate to others and to the outside world. In this phase, DID patients may continue to fuse alternate identities and improve their functioning. They may also need to revisit their trauma history from a more unified perspective. As patients become less fragmented, they usually develop a greater sense of calm, resilience, and internal peace. They may acquire a more coherent sense of their past history and deal more effectively with current problems. The patient may begin to focus less on the past traumas, directing energy to living better in the present and to developing a new future perspective. With a greater level of integration, the patient may be more able to review traumatic "memories" and decide that some are more symbolic—that they seemed "real" at the time but did not occur in objective reality.

Many tasks of late-phase treatment of DID are similar to those in the treatment of nontraumatized patients who function well but experience emotional, social, or vocational problems. In addition, the more unified DID patient may need specific coaching about dealing with everyday life problems in a nondissociative manner. Similarly, the patient may need help in tolerating everyday stresses, petty emotions, and disappointments as a routine part of human existence. Eventually, many patients experience this treatment phase as one in which they become increasingly able to realize their full potential in terms of personal and interpersonal functioning.

TREATMENT MODALITIES

Framework for Outpatient Treatment

The primary treatment modality for DID is individual outpatient psychotherapy. The frequency of sessions and duration of treatment may depend on a number of variables, including the patient's characteristics, the abilities and preferences of the clinician, and external factors such as insurance and other financial resources and the availability of skilled therapists. As with treatment for other patients with complex posttraumatic disorder, treatment for DID patients is generally long term, usually requiring years, not weeks or months.

The frequency of sessions may vary depending on the goals of the treatment and the patient's functional status and stability. The minimum frequency of sessions for most DID patients is once a week, with many experts in the field recommending twice a week. For high-functioning patients, once

a week is often enough. However, for those whose symptoms are florid and whose lives are chaotic, once per week is likely to be insufficient. In certain circumstances, a greater frequency of sessions (three or more times per week) can be scheduled on a time-limited basis to enable the patient to sustain adaptive functioning and/or (as an alternative to hospitalization) to contain self-destructive and/or severely dysfunctional behavior. Frequent outpatient sessions for restabilization should generally be limited to brief periods to minimize regression and overdependence on the therapist.

Although the 45- to 50-min session remains the norm for most therapists, many therapists have found extended sessions (e.g., 75–90 min) to be useful (e.g., for preplanned work on traumatic memories). Therapists must attempt to help patients reorient themselves to the external reality well before the scheduled end of each session so patients do not leave sessions in a decompensated or dissociated state. The therapist can develop interventions with the patient for the purposes of becoming grounded in the present and ending the session (e.g., alerting the patient some minutes before the end of the session to initiate the process of reorientation).

Types of treatment for DID. The most commonly recommended treatment orientation is individual psychodynamically oriented psychotherapy, which often eclectically incorporates other techniques. For example, cognitive-behavioral therapy techniques can be modified to help patients explore and change dysfunctional trauma-based beliefs or cognitions or manage stressful experiences or impulsive behavior. Many therapists use hypnosis as an adjunctive modality of DID. The most common uses of hypnosis are for calming, soothing, containment, and ego strengthening. In addition to individual psychotherapy, patients may benefit from specialized interventions such as family or expressive therapy, dialectical behavior therapy, eye-movement desensitization and reprocessing (EMDR), sensorimotor psychotherapy, and other treatments. Some of these specialized interventions should be modified (as detailed in the full *Guidelines*) when working with DID patients to help them maintain stability and avoid the risk of decompensation due to flooding with emergent memories and intense emotions. Some patients additionally require specialized substance abuse or eating disorder treatment.

Treatment for DID is typically provided by an individual psychotherapist. However, additional clinicians may be helpful in making up a treatment team. Depending on individual circumstances, treatment teams may include representatives from a variety of professional disciplines, including psychopharmacologists, case managers, family therapists, expressive therapists, sensorimotor psychotherapists, and medical professionals. It is vital that members of the treatment team coordinate their treatment of the DID patient and that there be clarity about which clinician is responsible for overall treatment management and decision making.

Inpatient Treatment

Treatment of DID typically occurs on an outpatient basis, even during the processing of traumatic material. However, inpatient treatment may be necessary at times when patients are at risk for harming themselves or others and/or when their posttraumatic or dissociative symptomatology is overwhelming or out of control. Inpatient treatment should occur as part of a goal-oriented strategy designed to restore patients' functioning so that they are able to resume outpatient treatment expeditiously. Efforts should be made to identify the factors that have destabilized or threaten to destabilize the DID patient, such as family conflicts, significant losses, and so on, and to determine what must be done to ameliorate these. Inpatient treatment is often used for crisis stabilization and the building (or restoring) of skills and coping strategies.

Given the current constraints of third-party payers, most hospitalizations are brief and only for the purpose of safety, crisis management, and stabilization. In some cases, the structure and safety of a hospital setting can facilitate therapeutic work that would be destabilizing or even impossible in an outpatient setting. When resources are available to support a more prolonged length of stay, inpatient treatment can include planned and judicious work on traumatic memories and/or work with aggressive and self-destructive alternate identities and their behaviors.

Specialized inpatient units dedicated to the treatment of trauma and/or dissociative disorders may be particularly effective in helping patients develop the skills they need to become more safe and stabilized. These programs provide services that are not usually provided in general hospital psychiatric programs: specialized diagnostic assessments, intensive individual psychotherapy, psychopharmacological interventions, and specialized trauma-focused work on symptom management and skill building.

During inpatient treatment, seclusion and physical or chemical restraints may be indicated for the DID patient who is acting out violently and who has not responded to verbal, behavioral, or pharmacological interventions. However, these restrictive measures often can be avoided by careful planning in advance for symptom management and containment strategies to help in times of crises. For example, these interventions might include accessing helper alternate identities, using imagery to find an inner "safe place" for overwhelmed or self-destructive alternate identities, and using imagery to "dial down" or otherwise attenuate strong affects. Medications for anxiety and/or agitation such as benzodiazepines or neuroleptics may also help to reduce agitation and to avoid a crisis.

The use of "voluntary" physical restraints to control a violent alternate identity while working through trauma is no longer considered an appropriate intervention.

Partial Hospital or Residential Treatment

DID patients may be able to gain some assistance from generic partial hospital programs as a step down from inpatient treatment. Programs that allow an individualized focus for the trauma survivor and that are cognizant of trauma-related issues may be most helpful for this purpose.

Specialized partial hospital or residential treatment for DID patients and others with severe trauma can be very helpful as either a step down from inpatient care or as a more intensive outpatient modality to prevent inpatient hospitalization and/or to provide intensive skills training. In general, these specialized programs use multiple daily groups to educate about trauma-related disorders, to teach symptom management skills, and to provide training in relationships and other life skills. Dialectical behavior therapy or other more formal, structured techniques for symptom management may be incorporated into these programs. Unfortunately, few of these specialized programs are in operation at this time.

Group Therapy

Patients with DID generally do poorly in generic therapy groups that include individuals with heterogeneous diagnoses and clinical problems. Many DID patients have difficulty tolerating the strong affects elicited by traditional process-oriented psychotherapy groups or those that encourage discussion, even in a limited way, of participants' traumatic experiences. Some such therapy groups have resulted in symptom exacerbation and/or dysfunctional relationships among group members.

Group psychotherapy is not a viable *primary* treatment modality for DID. However, certain types of time-limited groups for selected patients with DID or complex PTSD can be valuable adjuncts to individual psychotherapy. These types of groups can help educate patients about trauma and dissociation, assist in the development of specific skill sets (e.g., coping strategies, social skills, and symptom management), and help patients understand that they are not alone in coping with dissociative symptoms and traumatic memories. These task-oriented groups should be time limited, highly structured, and clearly focused.

Some clinicians have reported that carefully selected DID patients may benefit from longer term, homogenous, more process-oriented groups for DID and complex PTSD patients. These groups provide ongoing support, focus on improvement of interpersonal functioning, and buttress the goals of individual therapy. Successful groups of this type require an explicit treatment frame with set expectations and boundaries for the participants' actions inside and outside the group (e.g., limitations on discussion of trauma memories in group, no socializing between members outside the group).

Some patients may make good use of 12-step groups such as Alcoholics Anonymous, Narcotics Anonymous, or Al-Anon when addressing substance abuse problems. However, 12-step "incest survivor" groups or nonprofessionally led "self-help" groups may be inadvisable for DID patients, as their typical format is unregulated and may result in emotional flooding and other psychological distress. In addition, there is the potential for poor boundaries among group members, including disturbed, overdependent, and/or exploitive behavior.

Pharmacotherapy

Specific information regarding the use of classes of psychotropic medications and individual agents can be found in the full *Guidelines*.

Psychotropic medication is not a primary treatment for dissociative processes, and specific recommendations for pharmacotherapy for most dissociative symptoms await systematic research. However, it is very common for practitioners to use medication as one element of DID treatment. Pharmacotherapy for dissociative disorder patients typically targets the hyperarousal and intrusive symptoms of PTSD, and comorbid conditions such as affective disorders and obsessive-compulsive symptoms, among others. Informed consent concerning medication protocols for DID should include an understanding that prescribing is mostly empirical in nature.

Psychopharmacologic management of DID requires careful attention to boundaries and active lines of communication between treating therapists, nonpsychiatric treatment team members, and the medicating psychiatrist to avoid "splitting" the treatment team (especially when the psychiatrist is not also the primary therapist). It is essential that the functions of the therapist and the medicating psychiatrist be clearly defined. The regular exchange of significant information between treatment team members is important to provide an ongoing context for interventions and adjustments to the treatment.

Alternate identities within the DID patient may report different responses to the same medication. This may be because of the different levels of physiologic activation in different identities, somatoform symptoms that can realistically mimic all known medication side effects, and/or the identities' subjective experience of separateness rather than because of any actual differential biological effects of the medications. In general, medications are likely to be effective only when the targeted symptoms are reported across "the whole human being." DID patients may have many day-to-day symptom fluctuations that are due to the modulation of dissociative defenses as well as their personal predicaments and life stresses. Thus, it is most helpful in changing or adjusting medications to attend to the overall "emotional climate" of the patient's presentation rather than trying to medicate the day-to-day psychological changes in "weather."

Medications for DID are usually best conceptualized as "shock absorbers" rather than as curative interventions. Nearly all classes of psychotropic medications have been used empirically with DID patients. Partial responses to many different medications are common with DID and other complex posttraumatic disorder patients. Thus, prescribers should be especially alert to the potential negative effects of polypharmacy in this patient population. In times of crisis, the psychiatrist may choose to adjust doses of medications for increased problems with sleep, anxiety, and/or increased PTSD symptoms, among others, either as standing or as "as needed" doses. Often this is a more parsimonious and helpful intervention than initiating new trials of medications.

Hypnosis as a Facilitator of Psychotherapy

Several powerful rationales support the use of hypnotic strategies as an adjunct to the treatment of DID: (a) DID patients are more hypnotizable than other clinical populations, and higher hypnotizability correlates with the likelihood of therapeutic success with hypnosis; (b) hypnotic work can potentiate various therapeutic strategies; (c) because hypnosis can take the form of spontaneous trance, autohypnosis, or heterohypnosis (trance induced by another person), some form of hypnosis inevitably takes place in therapeutic work with this highly hypnotizable group of patients. Dissociative clients, usually unwittingly, use a variety of self-hypnotic strategies in an unbidden, uncontrolled, and disorganized way, and teaching them to exert some control over spontaneous hypnosis and self-hypnosis may allow them to contain certain distressing symptoms and to use their hypnotic talents to facilitate constructive self-care strategies.

Many techniques that rely upon the DID patient's autohypnotic skills—used with or without formal trance induction—have earned a place in DID treatment. These techniques include accessing alternate identities not immediately available, an intervention that can facilitate the emergence of identities critical to the therapeutic process or that can resolve the situation of having a child-like, disoriented, or dysfunctional identity that is "stuck" at the end of the therapy session. Reconfiguration is a related technique in which a system of alternate identities in a dysfunctional disequilibrium can be rearranged by requesting that different identities assume important roles in a more safe and stable constellation.

Other hypnotherapeutic techniques have been designed to contain flashbacks and control the processing of abreactions and traumatic memories, to modulate affect, to explore and resolve distressing psychological and somatoform symptoms, to place unsettled identities in settings away from the mental mainstream to protect function and safety, to put identities in a therapeutic "sleep" between sessions, to promote general restabilization, to encourage identities to communicate and to engage with one

another constructively, and to promote or bring about integration (e.g., fusion rituals).

DID patients' autohypnotic abilities allow many hypnotic techniques to be used effectively throughout DID treatment without formal trance induction. Patients can be taught to use at least some of these techniques outside of the therapist's office. In Phase 1 treatment, autohypnotic techniques may be especially helpful to induce relaxation, to allow the patient to use an imaginary safe place for self-soothing, to alleviate various symptoms, to help with dysphoric moods through the use of ego-strengthening suggestions, to provide better coping skills, to create skill in "grounding" into the present through the use of active-alert hypnosis, and so on. During subsequent phases, additional autohypnotic skills may be taught, such as containing traumatic memories and using an internally visualized location as a meeting place to permit identities to discuss issues and day-to-day concerns and to problem solve.

Clinicians should be aware of current controversies concerning the use of hypnosis in trauma treatment, particularly the use of hypnosis-facilitated techniques to explore areas of amnesia or to further explore fragmentary images or recollections. Authorities who support the use of hypnosis for these indications point to the recovery of material that has been confirmed at a later date and to the therapeutic progress that is often achieved through hypnotic techniques. Detractors argue that hypnosis-facilitated memory work will increase the patient's chances of mislabeling fantasy as real memory and may leave patients with an unwarranted level of confidence in what has been recalled in hypnotic states. However, it is likely that the untoward clinical outcomes attributed to hypnosis reside more in misleading cues and other misuses of hypnosis than in the modality of hypnosis itself. Like other interventions, hypnotherapy should be used only with adequate training both in the modality itself and in its specific use with traumatized and dissociative patients.

EMDR

EMDR was developed in 1989 and became known for facilitating the rapid resolution of traumatic memories in uncomplicated PTSD, among other uses. However, early use of standard EMDR for patients with unrecognized DID resulted in serious clinical problems, including unintended breaches of dissociative barriers, flooding, abrupt emergence of undiagnosed alternate identities, and rapid destabilization. Current expert consensus is that the original EMDR protocols must be modified for safe and effective use with DID patients.

Modified EMDR procedures, when imbedded into an overall phase-oriented framework, can be used for specific work on particular traumatic material, symptom reduction and containment, ego strengthening, and

working with alternate identities. EMDR procedures should be used only by clinicians knowledgeable in the treatment of dissociative disorders, and only when the patient is generally stable and has adequate coping skills, enough internal cooperation among alternate identities, and the ability to maintain a dual focus of awareness that is necessary in EMDR procedures. Ongoing abusive relationship(s); strong opposition from alternate identities to processing; and serious comorbid diagnoses such as schizophrenia, active substance abuse, or severe character pathology are contraindications to the use of EMDR.

It is essential to reduce the risks of breaching dissociative barriers and flooding when using EMDR with DID patients. Unlike in the usual EMDR procedure, associative processing (i.e., allowing the processing to bridge to associated memories) is discouraged with DID patients. Instead, the target memory should be procedurally isolated as much as possible. Various techniques have been developed to modulate the intensity of EMDR work, including fractionated abreaction and serial desensitization, which involves processing the different elements of a memory held by separate ego states. Other protective modifications of EMDR for DID involve the pacing and the use of shorter alternating bilateral stimulation sets and/or audio or tactile alternating bilateral stimulation.

Expressive and Rehabilitation Treatment Modalities

Expressive and rehabilitation therapies are often an integral part of treatment for patients with DID. Modalities such as art therapy, horticulture therapy, journaling, music therapy, movement therapy, occupational therapy, poetry therapy, psychodrama, and therapeutic recreation provide the patient with unique opportunities to address a wide range of treatment issues within a structured and supportive context.

The creative arts or expressive therapies may take place within a therapeutic dyad or a group setting. The nonverbal process and products (i.e., artwork, musical expression, movement sequences, writing, etc.) can serve as a visual or written record of the experiences of the internal system of alternate identities and may be examined at any point in treatment. As vital information about current stressors, triggers, safety issues, past traumatic experiences, and coping strategies is often articulated nonverbally long before it can be vocalized, expressive therapies are particularly helpful in the healing process. Subsequent discussion of artwork, writings, music, and so on can then be used to work toward a variety of treatment goals. In conjunction with verbal associations, nonverbal psychotherapeutic approaches bridge the communication gap among split-off parts of the self as well as between the patient's inner world and external reality.

In addition, expressive therapy group and individual treatment also facilitate improved concentration, reality-based thinking, internal

organization and cooperation, problem-solving skills, and utilization of containment techniques. Creative therapies may promote insight, the sublimation of rage and other intense feelings, and the working through of traumatic experiences and can assist with integration goals. Many psychotherapists find the drawings and journal entries of patients useful in ongoing psychotherapy, in addition to their role in clarifying diagnostic issues.

Rehabilitation therapies, including occupational therapy, horticulture therapy, and therapeutic recreation, are especially helpful in improving overall functioning in patients with DID. Through ongoing functional assessments and the provision of structured, reality-based crafts or tasks, the patient's ability to execute activities in a consistent and age-appropriate manner is recorded. Occupational therapy evaluations can also reveal data about how daily living, personal hygiene, meal preparation, money management, work, school, leisure/unstructured time, and social life may be adversely affected by dissociative symptoms.

Although patients may bring artwork into sessions and/or clinicians may occasionally ask individuals to create art as part of a therapy assignment, the formal use of expressive and rehabilitation therapies should be practiced by clinicians with appropriate training and certification.

SPECIAL TREATMENT ISSUES

Informed Consent

Clinicians should be aware of the ethical, legal, and clinical issues that are related to informed consent for mental health treatment—and for DID treatment in particular—and should take care to obtain informed consent in a manner consistent with prevailing standards of care. Furthermore, clinicians should educate themselves about the specific issues that have become heightened concerns because of recent controversies around trauma treatment and should consider discussing them with patients early in treatment. These controversial issues include the traumatic versus "sociocognitive" etiology of DID, the debate over the existence of delayed recall for traumatic experiences, the possibility that therapy can produce confabulated "memories" of events that did not occur, the potential distortions and undue certainty concerning memories accessed through hypnosis, and regression and increased dependency in treatment. Even the properly conducted treatment of DID can cause temporary regressions while patients grapple with understanding their symptoms, limits and boundaries in treatment, relational issues, and the memories and emotions concerning traumatic experiences. Experienced therapists attempt to limit the duration and severity of these temporary regressions and inform patients of this possibility before addressing recollected trauma.

Boundary Issues in the Psychotherapy of DID

Victims of child abuse or neglect—including persons with DID—have often grown up in situations in which personal boundaries were breached. In the therapy of this population, there is a significant potential for reenactments of boundary violations. It cannot be overemphasized that clinicians need to be exceedingly prudent, cautious, and thoughtful about the issue of boundaries, including the need to clearly define roles, rules, expectations, rights, and other elements of the treatment frame and the therapeutic relationship.

Boundary issues can arise at every stage in the treatment of DID, and negotiation and discussion of these issues should occur as needed. Most experts agree that the patient needs a clear statement near the beginning of treatment concerning therapeutic boundaries that might include some or all of the following issues: length and time of sessions, fee and payment arrangements, the use of health insurance, confidentiality and its limits, therapist availability between sessions, the respective roles and responsibilities of the patient and therapist, management of inter-session crises, procedures if hospitalization is necessary, patient charts and who has access to them, physical contact between the therapist and patient, and involvement of the patient's family or significant others in the treatment, among other topics.

Requests or attempts by DID patients to extend or alter the parameters of therapy are very common, especially from "young" alternate identities; therapists need to carefully evaluate the implications and potential effect of such requests before making any changes to the usual and customary boundaries of treatment. Rather than actually altering the treatment structure, clinicians should see these situations as opportunities to explore important clinical material, such as unconscious urges to reenact earlier boundary violations by significant others, conflict among alternate identities wishing to test the therapist's trustworthiness, or an attempt to compensate for unmet childhood needs.

Physical contact with a DID patient is generally not recommended as a treatment "technique." Therapists generally need to explore the meanings of a patient's requests for a hug or hand holding, for example, rather than reflexively complying with the requests. Some therapists believe that limited physical contact may be appropriate when a patient is highly distressed or overwhelmed, such as when the patient is intensely reliving a very disturbing experience in Phase 2 therapy. If previously and specifically discussed with the patient—that is, by full exploration with the whole alternate identity system—limited physical contact, such as briefly holding the patient's hand or resting a hand on the patient's arm, may help the patient stay connected to present-day reality.

Validity of Patients' Memories of Child Abuse

DID patients frequently describe a history of pervasive abuse beginning in childhood. Although many enter therapy remembering some abusive childhood experiences, most also recover additional previously unrecalled memories of abuse and/or additional details of partially recalled memories. Such memory recall occurs both within and outside of therapy sessions. Newly recalled trauma memories frequently precede or precipitate the patient's entry into psychotherapy. Memories that are "recovered" (i.e., forgotten and subsequently recalled) can often be corroborated and are no more likely to be confabulated than memories always recalled.

A number of reports from professional societies have all concluded that it is possible for accurate memories of abuse to have been forgotten for a long time, only to be remembered much later in life. They also indicate that it is possible that some people may construct pseudomemories of abuse and that therapists cannot know the extent to which someone's memories are accurate in the absence of external corroboration—which may be difficult or impossible to obtain, especially given the passage of time. As with all memories, recall of child abuse experiences may at times mix recollections of actual events with fantasy, confabulated details, abusers' rationalizations of the events, or condensations of several events.

A respectful neutral stance on the therapist's part, combined with care to avoid suggestive and leading interview techniques, along with ongoing discussion and education about the nature of memory seems to allow patients the greatest freedom to evaluate the veracity and import of their memories. Therapy does not benefit from clinicians automatically telling patients either that their memories are likely to be false or that they are accurate and must be believed. The therapist is not an investigator, and there are ethical, boundary, and countertransference considerations related to his or her role in attempting to prove or disprove the patient's trauma history.

The therapist can help educate the patient about the nature of autobiographical memory (e.g., that it is generally considered reconstructive, not photographic) and about factors that can confuse memory and how these might impact a given memory report. In the early stages of treatment, when there may be greater confusion about memories, the therapist should foster a therapeutic atmosphere that encourages patients not to arrive at premature closure about the memory material, assuring them that the issues can always be reviewed again, for example after progressive integration improves the patients' access to previously dissociated information.

Organized Abuse

A substantial minority of DID patients report sadistic, exploitive, and coercive abuse at the hands of organized groups. This type of organized abuse victimizes individuals through extreme control of their environments in

childhood and frequently involves multiple perpetrators. It may be organized around the activities of pedophile networks, child pornography or child prostitution rings, various "religious" groups or cults, multigenerational family systems, and human trafficking/prostitution networks. Organized abuse frequently incorporates activities that are sexually perverse, horrifying, and sadistic and may involve coercing the child into witnessing or participating in the abuse of others.

Organized abuse is typically described as long standing, and it is not unusual for its victims to report in treatment that they are still being exploited by one or more primary perpetrators. Particularly with this population, the clinician should consider the possibility that the patient may be currently being abused or may have renewed contact with abusers in the course of the treatment, which is often signaled by an unexplained shift in the therapeutic alliance or an abrupt change in the trajectory of improvement.

There is a divergence of opinion in the field concerning the origin of patients' reports of seemingly bizarre abuse experiences such as involvement in occultist or Satanic "ritual" abuse and covert government-sponsored mind control experiments. Clinicians who reflexively regard all such patient reports as historically true or historically false may diminish the likelihood of the patient's own exploration of such memories. As patients become more integrated, they may become more able to clarify for themselves the relative accuracy of their memories.

CONCLUSIONS

The information in these *Guidelines* represents current and evolving principles that reflect current scientific knowledge and clinical consensus developed over the past 30 years with regard to the diagnosis and treatment of DID. Given that ongoing research on the diagnosis and treatment of dissociative disorders and other related conditions such as PTSD will lead to further developments in the field, clinicians are advised to continue to consult the published literature to keep up with important new information. It is strongly recommended that therapists treating DID and other dissociative disorders have proper training in their diagnosis and treatment, for example through programs available through the International Society for the Study of Trauma and Dissociation.

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