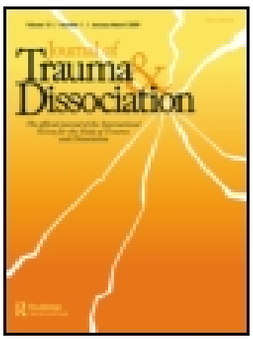

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Contextual Treatment of Dissociative Identity Disorder: Three Case Studies

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The authors wish to thank the clients whose treatment is described here for their willingness to have their cases presented in order that other survivors of child maltreatment might benefit and for their generous cooperation in completing assessment measures. Their names have been changed to protect their anonymity. The authors would also like to express their appreciation to Heather Kimmel, who helped prepare the manuscript and figures.

Some of the material from this article appeared in presentations made at the 16th Fall Conferences of the International Society for the Study of Dissociative Disorders, and the 15th Annual Meeting of the International Society for Traumatic Stress Studies, both held in Miami, Florida in November, 1999, and at the 17th Fall Conferences of the International Society for the Study of Dissociative Disorders in November, 2000 in San Antonio, Texas.

ABSTRACT. Evidence for the effectiveness of contextual therapy, a new approach for treating adult survivors of prolonged child abuse (PCA), is provided via case studies of three women with Dissociative Identity Disorder (DID). Contextual therapy is based on the premise that it is not only traumatic experiences that account for PCA survivors' psychological difficulties. Even more fundamentally, many survivors grow up in an interpersonal context in which adequate resources for secure attachment and acquisition of adaptive living skills are not available. As a result, they are left with lasting deficits that undermine not only their current functioning, but also their ability to cope with reliving their traumatic memories in therapy. The primary focus of this treatment approach, therefore, is on developing capacities for feeling and functioning better in the present, rather than on extensive exploration and processing of the client's trauma history or, in the case of DID, of identity fragments. Treatment of the three cases presented ranged from eight months to two and one-half years' duration, and culminated in very positive outcomes. The women's reports of achievements, such as obtaining and maintaining gainful employment, greater self-sufficiency, and the establishment of more intimate and gratifying relationships, indicated marked improvements in daily functioning. Objective test data obtained at admission and discharge, and in one case, at follow-up, documented substantial reductions in dissociative, posttraumatic stress, depressive, and other symptoms.

KEYWORDS. Dissociation, child abuse, case study, contextual therapy, treatment

The prevailing etiological model of pathological dissociation in the late twentieth century has been that it is primarily a reaction to exposure to traumatic events. Dissociation is conceptualized as an escape from trauma or physical threat (Bliss, 1986; Putnam, 1991, 1997) through the mental compartmentalization of traumatic experiences (van der Kolk, van der Hart, & Marmar, 1994). Although the capacity for dissociation may be common among children in general, exposure to trauma in childhood is thought to foster reliance on this capacity (Putnam, 1991). Originally an adaptive and reinforcing survival strategy (Ludwig, 1983), it has been suggested that dissociation becomes maladaptive when, through repeated evocation, it comes to be automatically triggered by low-level stressors (Bloch, 1991; Putnam, 1991).

On the basis of this conception, most models of treatment for dissociation construe identifying, confronting, and processing disowned traumatic material as the essential core of the therapeutic process. Experts in the field have progressively moved toward endorsing phase-oriented treatment in which explicit processing of traumatic material is preceded by an extended period of preparation and stabilization (see, e.g., Herman, 1992a; Phillips & Frederick, 1995; Putnam, 1989). A continuing shift in this direction is reflected by the fact that a number of authorities (e.g., Barach, 1999; Courtois, 1999; Gold, Silberg, Beere, & Rivera, 1999; van der Kolk, 1999) are concluding that primarily trauma-focused treatment approaches, while highly effective for more circumscribed forms of catastrophic experiences, are often contraindicated for survivors of the type of trauma most commonly associated with dissociative symptoms: prolonged childhood abuse (PCA). In fact, undue emphasis on recovering and addressing traumatic memories is likely to lead to marked deterioration in clients with an extensive history of childhood maltreatment (Gold & Brown, 1997).

A crucial conceptual distinction that has emerged in the literature is that between posttraumatic stress disorder (PTSD) and Complex PTSD (Herman, 1992a, 1992b), also referred to as Disorders of Extreme Stress, Not Otherwise Specified (DESNOS; Pelcovitz, van der Kolk, Roth, Mandel, Kaplan, & Resick, 1997; Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997). Trauma-centered therapies are often highly effective for PTSD (Foa, Keane, & Friedman, 2000). However, for the Complex PTSD symptomatology commonly associated with a PCA history, these same approaches can exacerbate rather than resolve clients' difficulties. Phase-oriented treatment that begins with a protracted period of stabilization (Chu, 1998; Herman, 1992a; Phillips & Frederick, 1995) was developed in large part in recognition of and response to this observation.

Contextual therapy (a comprehensive description of which can be found in Gold, 2000) "builds upon . . . and considerably extends the Complex PTSD treatment model" (Courtois, 2000, p. xvi). A central observation underlying contextual treatment is that many of the difficulties experienced by individuals with a PCA history, including pathological dissociation, are not exclusively attributable to the traumatic impact of discrete experiences of abuse. A substantial, but yet to be widely cited body of empirical findings suggests that ineffective family of origin environment makes an appreciable contribution to the long-term symptomatology of PCA survivors, over and above that accounted for by the abuse itself (e.g., Alexander, 1993; Fromuth, 1986; Mullen, 1993; Mullen, Martin, Anderson, Romans, & Herbison, 1996; Nash, Hulsey, Sexton, Harralson, & Lambert, 1993; Widom, 1999).

Many persons subjected to PCA grow up in chaotic, detached, or otherwise ineffective familial and social contexts that fail to adequately transmit to them

the numerous capacities required to negotiate the complex demands of daily functioning. For example, basic qualities frequently associated with PCA survivors' families such as interpersonal conflict, inconsistent parenting, lack of warmth or reinforcement, and profound neglect have consequences that rival and greatly exacerbate the effects of abuse itself. In turn those lasting consequences such as tenuous interpersonal attachment, unstable sense of self, and poor ability to maintain concentration on the here-and-now promote the dissociative absorption, amnesia, and identity disintegration commonly ascribed to trauma (Alexander, 1992; Barach, 1991; Gold, 2000). Similarly, in the absence of modeling of basic adaptive capacities, many PCA survivors never learn to effectively manage even routine stressors encountered in daily living. It is not surprising to observe, therefore, that treatments emphasizing confrontation of the extraordinary stressor of recollecting traumatic events frequently induce deterioration rather than improved functioning in PCA survivors.

In contrast, the guiding strategy of contextual treatment is to facilitate remediation of deficits that stem from having grown up in an inadequate interpersonal context. These deficits can be conceived of as falling into the three major areas: (a) interpersonal relating, (b) conceptual understanding, and (c) instrumental functioning. Contextual therapy thus consists of three primary components corresponding to each of these three spheres of difficulty: (a) *collaborative relating,* (b) *collaborative conceptualization,* and (c) *skills transmission*.

As a consequence of repeated experiences of failure due to inadequate preparation for effective living, PCA survivors frequently believe that their difficulties stem from their own inherent badness, weakness, and incompetence. In response to this conviction, and as a result of a myriad of past instances of being derided, rejected, ignored, and maltreated, they also harbor a deeply entrenched expectation of disdain and abandonment by others. Consequently, most survivors of PCA are tragically lacking in the types of interpersonal experiences that would allow them to imagine that anyone could be genuinely interested in their welfare, or that would teach them how to work cooperatively with another person toward a common goal. Interpersonal histories that failed to provide them with adequate attachment experiences, and that instead created severe dependency and mistrust, produce tremendous obstacles to the development of the type of interaction required for effective therapy. *Collaborative relating* refers to a set of specialized strategies aimed at surmounting these obstacles. *Collaborative conceptualization* refers to the process by which the PCA survivor's convictions of personal inadequacy and reprehensibility are disputed and dispelled, promoting recognition that most current problems in adjustment are attributable to the twin contexts of family (inadequate preparation for effective living) and trauma (the debilitating conse-

quences of abuse). The remaining of the three components of contextual therapy, *skills transmission*, consists largely of structured interventions similar to, and in some instances directly borrowed from, existing cognitive-behavioral treatment approaches such as Dialectical Behavior Therapy (DBT; Linehan, 1993a, 1993b) and narrative constructivist therapy (Hoyt, 1996).

Where contextual therapy differs most markedly from other forms of treatment is in its contextual theoretical framework, and in the way in which this perspective informs, structures, and integrates the three treatment components. From a contextual vantage point, the components designed to actively promote a working alliance with the therapist (*collaborative relating*), and to dispel deeply held beliefs of being undeserving and incapable (*collaborative conceptualization*), are essential. Without them, it is unreasonable to expect that the client with a PCA history will be disposed to actively participate in and benefit from the *skills transmission* component.

From the perspective of contextual therapy, the identity fragmentation integral to dissociative identity disorder (DID) is not viewed exclusively as a reaction to circumscribed trauma that is later invoked as a defense. Instead, it is seen in large measure as a reflection of the chaotic and inconsistent interpersonal environment in which the individual with DID was reared. In the absence of predictable treatment and reactions from others, it becomes difficult or impossible for a child to develop a self-concept that is stable and integrated. This conception suggests that, to a considerable extent, identity fragmentation is a consequence of deprivation of the conditions needed to develop a cohesive sense of self. Consequently, the primary tactic for addressing identity fragmentation in contextual therapy is the remediation of these deficits, rather than the evocation and exploration of identity fragments. Significant changes in their approach to interpersonal relationships (through *collaborative relating*), self-understanding (through *collaborative conceptualization*), and daily living (through *skills transmission*) foster the process of integration of identity fragments.

This is one example of how contextual therapy differs from phase-oriented approaches: helping clients develop greater distress tolerance and more effective coping abilities is not viewed as a precursor to trauma-focused treatment, but as the primary thrust of the treatment process. This does not mean that clients are dissuaded from addressing traumatic material or from acknowledging and addressing identity fragmentation. However, these aspects of treatment are integrated into a conceptual framework that construes explicitly traumatic incidents and identity fragmentation as specific features of a much broader landscape. They are seen and dealt with as part of the larger context of having grown up in chaotic and unpredictable familial and social circumstances that did not allow for the development of secure interpersonal attachment or effective daily functioning. This perspective promotes awareness that for most PCA

survivors, unlike for survivors of many other forms of trauma, incidents of abuse and dissociative phenomena are not anomalous, but entirely consistent with the broader scope of their experience.

The aim of this article is to illustrate via three detailed case studies how contextual therapy is applied to DID, one of the most challenging syndromes associated with PCA, and to evaluate treatment outcome in these cases on the basis of self-reported changes in functioning and standardized test data. In each of the cases the PCA history was extreme and the level of impairment at admission was severe. Each of the clients reported ongoing sexual and physical abuse throughout her childhood. All three met DSM-IV (American Psychiatric Association, 1994) diagnostic criteria for DID, posttraumatic stress disorder (PTSD), and major depressive disorder (MDD).

The three women whose cases are presented here were all treated at the Trauma Resolution Integration Program (TRIP), an outpatient treatment program for clients with trauma-related and dissociative difficulties. TRIP is housed within a university-based, government funded community mental health center, and is staffed entirely by doctoral students in clinical psychology in advanced practicum or internship. TRIP (formerly SASP, Survivors of Sexual Abuse Program) provides extensive organized training and supervision in treating individuals with dissociative and trauma-related disorders (described in Gold, 1998). Contextual therapy was, in large measure, developed at TRIP, and is the primary approach employed there in the treatment of PCA survivors.

While the outcomes reported here were generally positive, the cases were not randomly selected. These outcomes, therefore, can not be assumed to be representative of DID cases treated with contextual therapy. Moreover, it should be emphasized that since contextual therapy is primarily conceptually driven rather than protocol driven, the way in which it is implemented can vary considerably from one case to another based on the individual circumstances and needs of the particular client. Our hope is that the cases presented here help to illustrate some of those variations in application.

CASE STUDIES

Case 1: Alison

At admission, Alison was 48 years old, married, and had a 16 year-old daughter. She was referred to TRIP upon discharge from a hospital following a suicide attempt in response to the onset of hearing voices. She reported hearing eight distinct voices and indicated that each had taken control of her behavior at some point. She also complained at intake of nightmares, panic attacks, and amnestic episodes. Alison stated that her symptoms had exacerbated following her father's death a few months prior to her hospitalization. The severity of her

anxiety and dissociative episodes made it impossible for her to maintain her employment as a nurse. She therefore had to rely financially on her husband, who she alleged was alcoholic and verbally abusive.

Alison revealed an extensive history of childhood sexual abuse (CSA) committed by her father several times a week from the time she was five until age twelve. She described her mother as having been cold and demeaning and the family in general as wrought with mixed messages and double binds. Her symptom picture was consistent with diagnoses of DID, PTSD, MDD, and Panic Disorder.

Course of Treatment by First TRIP Therapist. The treatment goals Alison initially established were reduction in severity and frequency of panic attacks, dissociative "switching" and accompanying amnesia. As a foundation for achieving these objectives, she was taught to use and regularly practice diaphramatic breathing to reduce her baseline level of distress. To further bolster her sense of control and reduce her level of distress, functional behavioral analysis was employed to aid Alison in identifying triggers of episodes of panic attacks and switching. This enabled her to be proactive in preventing them.

Concurrent with individual treatment, Alison participated in a Dialectical Behavior Therapy (DBT; Linehan, 1993a, 1993b) skills group. In this group she learned additional strategies for modulating and tolerating distress and maintaining concentration. Consistent practice of these skills and the reinforcement provided by the group experience augmented Alison's confidence in her capacity to cope and to interact with others effectively.

On several occasions Alison experienced episodes of switching in session. One of these instances occurred while discussing having recently "lost time" for a two day period. Her therapist asked her to focus internally in an attempt to access awareness of what had transpired during those two days. At this point an identity fragment presented, claiming to have assumed executive control during that time and obscured recollection of that period because Alison "needed a rest." The therapist discussed how distressing the lost time had been to Alison, and it was agreed that in the future she would be informed before an action such as this was taken.

Alison began expressing anxiety that returning to work too soon might lead to a recurrence of panic and switching. She mentioned that it was as if she had a box in her mind that contained all the painful feelings and memories in her life, which sometimes overflowed, overwhelming her. She contended that coming to treatment stirred up these agonizing emotions, raising fears that they would interfere with her functioning at work or in other situations outside of therapy.

Building on her metaphor, her therapist asked her to describe the box in detail, and suggested to her that it might be possible to place a lock on it. This would allow her to open it when she came in for treatment, while keeping it

locked at other times when these emotions might be disruptive. Alison immediately responded positively to this idea, and took the initiative to inform the various identity fragments of this plan and secure their cooperation. This development further promoted communication between parts, contributed to the eventual obsolescence of maintaining separateness between parts, and provided a greater sense of control.

In the wake of this accomplishment, Alison was able to return to work with no adverse effects. As she became confident in her ability to remain calm and focused, she grew more assertive and independent. When her husband, upon whom she had previously been dependent, became physically and verbally abusive toward both her daughter and herself, Alison was successful in insisting that he move out of the house. This action, which she took without episodes of panic or dissociation being triggered, strengthened her conviction that she could rely on her newly acquired skills.

As this was occurring, Alison's first TRIP therapist's training year was nearing an end, necessitating the termination of their treatment relationship and the transfer of her case to another trainee. This transition was difficult for her. It engendered several panic attacks and one dissociative episode. These instances were framed as remnants of past habitual behaviors that were understandably evoked in response to the distress aroused by relinquishing her connection with her current clinician and the anticipation of learning to trust another therapist. Nevertheless, Alison was certain that she wanted to continue treatment as recommended in order to stabilize and build upon the gains she had made.

Course of Treatment by Second TRIP Therapist. The initial phases of Alison's treatment with her new therapist focused on re-establishing stabilization and solidifying previous gains. Central to this task was demonstrating to Alison that she already had many of the tools needed for self-care. From the beginning of their work together, her new TRIP clinician set out to reinforce her sense of mastery and independence, essential elements of a burgeoning sense of self. While this goal was rarely discussed explicitly, it guided the implementation of several early interventions as well as constituting a basic stance underlying the remainder of treatment.

For example, at the outset of one session Alison presented in a state of anxiety nearing panic. She was distressed because her therapist had been detained, delaying the start of the meeting. Rather than attending to Alison's anxiety about the abbreviated length of the meeting, he encouraged her to express her anger about it. Once this was processed, he underscored her competency by asking her to select any relaxation technique she had previously learned in treatment, and to walk *him* through it. She chose to use diaphramatic breathing, which quickly and effectively reduced both her and her clinician's level of distress. She was warmly praised for her obvious skill in anxiety reduction. These

and similar interventions implicitly: (a) reduced the hierarchical qualities of the treatment relationship; (b) gave Alison license to interact with her therapist from a position of strength rather than of the dependence and deference that characterized her childhood relationships; and (c) affirmed her own responsibility for her growth as well as for her notable treatment gains up until that point. The unexpected quality of these interventions appears to have enhanced their value for Alison by directing her focus on the present rather than reinforcing old expectations about treatment and herself.

Alison was simultaneously beginning a second year of DBT skills group with new members. She quickly regained her proficiency at the DBT skills, which, other than a few brief setbacks, she maintained throughout the remainder of treatment. It was apparent to her that these skills were far more effective than the defenses, such as dissociation and avoidance, that she had learned as a child. However, her newly acquired capacity to modulate distress only reinforced Alison's habitual pattern of minimizing her feelings of fear, anger, and even happiness at any cost. Her episodes of dissociative amnesia and identity fragmentation were conceptualized as having resulted from this general tendency. Some feelings (such as rage, vulnerability, or sexual passion) had constituted such a dire threat to her in her family of origin that she had learned to keep them compartmentalized as disowned aspects of self. Mastery of more effective methods of managing affect, while helpful, did not negate Alison's core conviction that life was a joyless exercise in maintaining control.

Therefore, once stabilization had been achieved, therapy shifted toward helping Alison to access a greater breadth of emotional experience. This therapeutic focus was comprised of a number of overlapping and interrelated components. One of these elements was subtly and gradually raising the possibility that life might be *lived*, not merely survived. This notion was introduced by changing the Subjective Units of Distress Scale (SUDS; Wolpe, 1969) format that Alison had previously learned in TRIP to rate her level of distress. The use of a 0 (no distress) to 10 (maximal distress) scale, implying that her experience could be measured only in terms of the presence or absence of misery, was abandoned. Instead, use of a scale ranging from −10 (maximal distress) through 0 (no distress) to +10 (maximal pleasure or contentment) was proposed. This suggestion alone had a dramatic impact on Alison. She stated much later in treatment that this simple change had been instrumental to her progress.

A second element of Alison's expanding range of affective experience entailed addressing her dissociative experiences of identity fragmentation. Her therapist deliberately adopted language that recognized and honored her experience of having multiple "selves," while avoiding affirming that she was in reality fractured. Phrases such as "the Alison part of you" or "the Alisa part of you" were used, rather than referring to those aspects of self solely by proper

names, by addressing them directly, or by requesting that they appear, as if they were separate entities. In one session, Alison arrived presenting as Alisa, who had come "to check out the new therapist." In response, the therapist decided to straightforwardly answer a series of appropriate questions. As the Alisa aspect of Alison became more comfortable, the therapist began asking questions designed to gain insight into its function for Alison. It was established that Alisa's mission was to introduce some fun into Alison's life. Her therapist was able to persuade the Alisa aspect to teach Alison how to be more playful and carefree.

Toward the end of this interchange, the client "switched," presenting as Alison. She was asked to describe incidents of having fun, instances with which it was presumed the Alisa aspect would be well acquainted. Alison insisted that she could not recall a single instance in her life when she felt carefree. Consequently, it was suggested that "perhaps the Alisa side of you could share a memory or two." To Alison's delight, this occurred, initiating a "coaching" relationship whereby previously disowned capacities, emotions, and experiences were appropriated at her own pace. Over the course of the next two to three months, Alison developed tolerance for increasingly more intense feelings. Gradually, one by one, she reported first feeling present simultaneously with each of her identity fragments, then feeling "merged" with each of them, and finally experiencing them merely as various facets of herself.

A third approach to extending Alison's emotional experience was discussion of her family of origin. Exploring the family context of her emotional development proved to be quite liberating for her. She came to realize, for instance, that sadness was the only feeling that was deemed acceptable in her childhood home. Consequently, much of the anxiety that she had previously viewed as a response to feeling vulnerable was instead related to feeling angry and anticipating retribution before she even registered the anger consciously. These discoveries and many similar ones helped free Alison to examine situations with much less guilt and conflict, facilitating substantial changes in self-awareness and self-acceptance.

Alison reached a point a few months prior to termination of feeling comfortable almost all the time. She had not switched or had a panic attack in over six months. She thoroughly knew the DBT skills, and used them regularly and spontaneously. She was discovering her capacity to enjoy life rather than to merely survive. However, she reported that thinking about the abuse itself, seeing pictures of her father, and other related stimuli were still extremely troubling to her. She was disturbed that she still felt she had to live in fear of something that happened long ago. In collaboration with her therapist, Alison decided to undergo Traumatic Incident Reduction (TIR; French & Harris, 1999), a client-directed method of exposure, to neutralize the impact of her memories of abuse. Within a single four-hour TIR session, she indicated that

on a 0 to 10 scale her SUD related to childhood emotional, physical, and sexual abuse recollections dropped from levels of 9 or 10 to 1 or 0. In subsequent sessions, she reported that this reduction in SUD was maintained.

Alison stated in the last month of treatment that she felt remaining in therapy would only hinder her further growth and social involvement because of the temptation to use therapy as a "crutch" instead of challenging herself to form new relationships. She reported that she was delighted to discover that she now found therapy "boring." Termination proceeded smoothly after 18 months of treatment.

Case 2: Blanche

Blanche, a 54-year-old, divorced woman, was referred to TRIP by a former therapist, a private practitioner in the community who had seen her for nine months, so that she could obtain more affordable treatment. Blanche's private therapist indicated that she had been referred to her by a mutual Narcotics Anonymous (NA) peer, that "her Borderline tendencies . . . sabotaged her own earnest efforts and treatment under my care," and that termination occurred ". . . not under pleasant circumstances." A course of treatment was described in which Blanche vacillated between marked improvement and drastic deterioration. She concluded that Blanche ". . . is true Dissociative Identity Disorder (DID) with a Borderline Personality Disorder, in remission from her Polysubstance Abuse." Prior to initiating treatment with her first TRIP therapist Blanche was seen by a crisis clinician within the community mental health center due to severe depressive symptoms and suicidal ideation.

Blanche reported that she was an adult survivor of prolonged childhood sexual and physical abuse, cult abuse, and neglect. Her symptoms included depression, suicidal ideation, anhedonia, insomnia, fatigue, feelings of worthlessness, excessive guilt, diminished concentration, flashbacks, nightmares, avoidance of trauma-related thoughts and triggers, inability to recall aspects of her traumatic experiences, feeling detached from others, exaggerated startle response, and hypervigilance. Based on clinical observations and test data, Blanche met DSM-IV diagnostic criteria for MDD, Dysthymic Disorder, PTSD, and Borderline Personality Disorder. She was also given a provisional diagnosis of DID.

Blanche was an only child. Her biological mother died giving birth to her. Her biological father was unavailable to care for her since he served active duty in the military. She grew up with her maternal grandparents, who legally adopted her when she was five years old. Also at age five, a religious leader began sexually abusing Blanche and threatened that she would be condemned to hell if she ever disclosed the abuse. At age 12, he convinced her grandmother to allow him to take Blanche to live in a different state, in what she described as

a Pentecostal "Jim Jones" style religious cult. Blanche remained in the cult for 15 years, until age 27, throughout which, she contended, she was physically and sexually abused by male cult members. The cult allegedly controlled every aspect of her life. For example, she was forced to marry and deprived of sleep and food.

At age 30 Blanche relocated to where her elderly grandparents resided, caring for them for over 10 years until they died. She moved to another state at age 50 and rented a room from a friend she had known for over 20 years. Although Blanche generally had a good relationship with this roommate, she often felt uncomfortable in the home when there were male visitors. She reported never to have had any consensual intimate relationships as an adult.

Blanche mostly maintained full-time employment as a health care professional since leaving the cult, even though she was actively abusing substances. At the time of the initial evaluation, Blanche was attending an accounting program. She was supporting herself with school loans and with money inherited from her grandmother.

Course of Treatment by First TRIP Therapist. In her initial TRIP session Blanche expressed suicidal ideation, without plan or intent. Toward the end of the interview she appeared childlike in speech and posture and referred to herself by the name "Blaire." After some inquiry, "Blaire" expressed concern that Blanche would attempt suicide, and wanted her to agree not to do so. By the end of the interview Blanche resumed her adult composure and signed a written agreement not to harm herself during the coming week.

As is standard practice in contextual therapy, appearances of and references to identity fragments were accepted and taken in stride. Discussions of manifestations such as these, however, were not initiated by the therapist, but were responded to when raised by Blanche. Without explicitly verbalizing it to her, Blanche's therapist worked from the basic assumption that her identity fragments were rooted in feelings that remained disconnected from each other in subjective experience, but that were on a more fundamental level components of a larger, coordinated system. Addressing these feelings soon led to a decrease in the frequency with which Blanche manifested identity fragments, both in session, and, according to her report, elsewhere. As a result, it was not necessary in treatment with this or subsequent therapists to extensively focus on identity fragments.

The next few sessions focused on building rapport, collaborative development of a treatment plan, processing her feelings of abandonment by her private therapist, establishing the limits of the therapeutic relationship, referral for a psychiatric evaluation, and developing a safety plan. In her prior treatment Blanche had received two sessions of therapy per week and had unlimited phone access to her therapist. Thus, establishing limits was difficult. However, this was done to avoid increasing dependency and decreasing

Blanche's sense of self-efficacy, to prevent therapist burnout, and to minimize splitting among clinic staff.

During these initial sessions, Blanche reported taking three Benadryl and three Dramamine pills in an attempt to sleep, but denied this was a suicide attempt. She was provided with information on sleep hygiene and compliance with these suggestions was encouraged and monitored on an ongoing basis. Although Blanche was hesitant to take psychotropic medication due to her history of substance abuse, after the pros and cons were evaluated she chose to attend a psychiatric evaluation. She was prescribed fluoxetine (Prozac) and trazodone (Desyrel). During these sessions, Blanche expressed suicidal ideation, with a plan to drive into a canal or turn the gas on in her car. A behavioral no self-harm contract and safety plan were developed and implemented during each session. The act of contracting not to hurt herself, combined with the hope fostered in the developing relationship with her therapist, soon resulted in reduced suicidal ideation.

By the fifth session, Blanche was no longer preoccupied by fears of abandonment and made a commitment to working with her TRIP therapist. She reported a decrease in suicidal ideation and depressive symptoms. The pros and cons of attending a DBT skills group were explored. Although Blanche was reluctant to attend the DBT group due to previous negative experiences with groups both in therapy and in the cult, she agreed to try it.

Treatment then focused on increasing her social support by renewing contact with her NA sponsor and attending the DBT skills group. A list of pleasurable activities, to be used as a means of moderating distress, was jointly constructed between Blanche and her therapist. This was particularly challenging since she felt guilty for engaging in enjoyable activities. Blanche was also taught a visualization technique as a tool for stress reduction. She reported consistent practice of this exercise and a consequent reduction in her baseline SUDS level. Next, cognitive techniques, especially Socratic questioning (see Hoyt, 1996), were used to address Blanche's unrealistic expectations of herself, many of which were attributable to her experiences in the cult. Grounding techniques (Simonds, 1994) were also taught at this time to help reduce episodes of dissociation.

Within four months of beginning treatment Blanche was actively planning to search for a job, since she was nearing the completion of school. She reported utilizing deep breathing, progressive muscle relaxation, skills learned in DBT group, and methods for being non-judgmental of herself, with positive results. She increased pleasurable activities and social support. She reported improved sleep and no suicidal ideation. Despite the fact that she had overtly manifested alters in previous sessions, she now experienced such a great decrease in dissociation that she wondered, "Where did my parts go?" She was also utilizing interpersonal effectiveness skills. For example, she became de-

pressed when a friend did not call her as scheduled. Previously Blanche would have internalized this as she would have been "down" on herself and felt "unimportant." However, she utilized assertiveness skills to contact her friend, and learned that her friend simply did not have her correct phone number.

Blanche expressed fears about searching for employment, and worry that she would be incompetent on the job. She felt as if she was "putting on a front" to employers when they perceived her as being capable. Her therapist guided her in developing a list of qualities that made her a desirable employee; she cited her responsibility, dependability, trustworthiness, conscientiousness, past successes, and personality. A fear hierarchy regarding the job search process was developed. Examination of the question "What will it take for me to have confidence?" helped her recognize her unrealistic expectations, and how her anticipation of failure contributed to suicidal ideation.

At approximately six months into her course of therapy Blanche went on several job interviews. She drew on assertiveness skills learned in DBT group, calling a potential employer to ask the salary and if her qualifications matched the position, and succeeded in obtaining her first-choice job. Soon afterward she reported that she would no longer be able to attend DBT skills group due to her work schedule. She began to show a marked decrease in dependency, requesting that her sessions be reduced to every other week. By this point, Blanche denied depressive symptoms, stating that for the first time ever "I'm real happy" and "I love my job." She was able to credit herself for her successes, noting that she made few mistakes compared to her co-workers.

Four sessions before her final meeting with her first TRIP therapist, Blanche expressed suicidal ideation in response to their impending termination as well as to financial pressures. She decided that she was unable to pay rent to her roommate because it would render her unable to save enough money to move out on her own, and she tried to assertively discuss this with her roommate. However, she did not get the desired response, and claimed she could no longer trust anyone except her therapist. She fantasized about cutting her wrists in front of her roommate "to show her." However, instead she contracted to implement a safety plan. It was also agreed that Blanche would be transferred to a crisis clinician after transfer due to her ongoing suicide risk.

Course of Treatment by Second TRIP Therapist. Blanche was initially ambivalent about starting with a new therapist, a focal topic during the first two sessions. She soon recognized that her hesitancy was related to fear of again becoming attached. Once rapport was established, and she discussed the progress she had made with her previous therapist and the new goals she hoped to achieve in treatment, ambivalence about continuing subsided.

Within a few sessions of starting treatment with this therapist, Blanche stated that she would like to begin discussing her history of sexual abuse. It was her belief that discussing the trauma would make her feel "stronger."

Blanche's need to express her feelings was validated, but her therapist encouraged her to continue learning effective coping skills before specific traumatic events were discussed in session. She agreed that this approach to addressing her trauma history would help her to feel protected. The wisdom of her decision to delay discussion of her abuse was confirmed when Blanche began to express difficulty in handling pressure at work and complained of suicidal ideation. Stress reduction techniques were used to help her remain effective in the workplace. Blanche also reported the successful application of DBT skills to help reduce her anxiety at work.

Over the next five months she often initiated the use of no self-harm contracts to help her feel safe. Although increasing her sense of autonomy was important to her, she felt she needed the support represented by accountability to her therapist when her suicidal thoughts intensified. She never acted upon her suicidal ideation, and over time her need for the contract diminished.

Identification of the antecedents of her flashbacks played a central role over the next few months of therapy. Blanche was able to track both internal (e.g., ruminating about stressful events at work) and external (e.g., watching and reading news of sexual abuse) triggers for the flashbacks that caused her distress. She reported that identifying specific events that triggered memories of abuse provided her with greater control over her flashbacks. Feelings associated with the flashbacks were frequently discussed, and eventually her fear of having flashbacks and the frequency of the flashbacks themselves diminished.

When Blanche moved into her own apartment her increased independence constituted a significant source of pride for her. As her self-reliance expanded she began to take more responsibility for herself at work and in her relationship with a long-time friend. In addition, Blanche began to assert herself with another employee who often attempted to take advantage of her willingness to help others.

A significant amount of time was spent discussing Blanche's self-esteem. Initially, her struggle with self-esteem was apparent in her difficulty believing she "deserved" therapy. In individual and group sessions Blanche was encouraged to entertain the idea that her needs had value. Soon she began acting on this belief. She reported instances, such as choosing not to baby-sit for a friend when she felt tired, in which she decided to take her own needs into account before reflexively attending to the needs of others.

As a result of Blanche's severe trauma history, her sense of control and ability to protect herself had been compromised. Therefore, therapy sessions often focused on ways to improve her ability to assert her needs and tolerate distress. This facilitated acceptance and integration of her identity fragments. For example, Blanche often referred to a child part that felt all of her anger for her in order to protect her from directly experiencing it. This was readily apparent in session when a regressed identity fragment expressed anger toward

her therapist. Blanche described what she perceived as the therapist's disinterest during a phone contact prior to this session. The remainder of the session focused on exploring her experience of feeling slighted, and reviewing grounding techniques to help her reduce her anxiety. In subsequent sessions, Blanche and her therapist addressed her difficulty expressing anger directly, and eventually she reported an increased ability to tolerate and express her emotions rather than compartmentalize them. This was demonstrated when she proved able to discuss her sadness about ending her work with her therapist, while also stating that she felt she could tolerate the break in treatment until she was assigned a new therapist. The ability to successfully negotiate this termination better than the previous one was representative of the progress she had made developing her independence, security, and sense of mastery.

Course of Treatment by Third TRIP Therapist. Soon after beginning treatment with her third and final TRIP therapist Blanche revealed that she had begun to explore the Internet and was tempted on occasion to view a site that apparently offered suggestions on how to successfully commit suicide. After all, she said, "I'm 55 years old so why should I even try to make things better?" Blanche contracted not to act on her suicidal thoughts, which included a self-imposed ban on visiting the Internet site. Over the course of treatment, Blanche only called a few times in order to "check in" and restate her commitment to the contract. The duration of the phone calls was only one to two minutes and, over time, became less frequent. Eventually, the need for the phone calls, contract, and suicidal thoughts subsided entirely.

The majority of session time was spent discussing Blanche's present occupational and social life, as these were newly developed areas for her. Although she had been working as a full time billing clerk for more than one year, she remained a temporary employee without the benefits associated with a permanent position. She was beginning to expand her social circle and learning how to establish boundaries in a variety of relationships. In broader terms, she was learning to identify the characteristics of social situations and interpersonal interactions in which she felt safe and to experiment with expanding those limits. She was able to approach new situations and conflicts in her daily life with increased ease as she came to realize that she had the ability to talk herself through any situation in the manner she had learned in therapy.

One of the things that sustained and comforted Blanche throughout difficult times was her love for her numerous pets. She had often stated that her animals were the reason she did not kill herself. This caused her therapist to be alarmed when Blanche casually stated that she had begun to give some of her animals away to other people. This would previously have been an indicator that she was preparing for death. However, as Blanche went on, it became apparent that as she expanded her social circle, she not only no longer needed the pets for companionship, but she actually did not have enough time to care for them ad-

equately. Significantly, she had begun to establish a reliable social support network with whom she socialized after work.

Blanche set a new goal of losing weight and was getting depressed over her failed attempts at exercise and proper diet. The relationship between depressed mood and lack of activity was addressed in therapy. Blanche understood the concept and agreed to begin walking her pets for increasing periods of time before and after work. Within a few weeks, she was also walking with a friend from work. She and her friend supported each other in their efforts and she also began to control her diet. However, dieting was equated with deprivation in Blanche's mind, since it readily reminded her of experiences in the cult. Grounding techniques to reinforce awareness of being an adult in the present helped somewhat, but she reported that the most effective coping mechanism was reassuring herself that she was the one in control.

The therapeutic relationship was tested when DBT groups were beginning again and it was explained to Blanche that it was the policy of TRIP to participate in both individual therapy and skills group on a weekly basis. Although she acknowledged the benefits of skills group, she felt as though she had gained a full understanding of the skills after participating in the full sequence of modules twice and utilizing the skills on a daily basis. The therapist was glad to see Blanche express confidence and assert herself appropriately, but had not known her long enough to determine whether or not she would benefit from continued group participation. As a compromise, Blanche agreed to attend the first meeting and then discuss her experience with the therapist. Blanche did attend the first group and reported to the therapist that by listening to the other group members she could see how much she had progressed over the past two years. After careful consideration, she had decided that she did not need the group any longer. Blanche expressed appreciation to the therapist for her support in what she said was an important learning process about how to make a decision in her own best interest.

A major issue early in the final phase of treatment was whether to reconcile with her friend and former roommate, who she felt had betrayed her by essentially throwing her out of her home several months earlier. She often discussed how she missed her friend and that her friend had repeatedly called to apologize and try to repair the friendship. She realized that the loss of her friend was symbolic of the abandonment she suffered by her grandmother and consequently understood why her emotions had seemed so out of proportion with the event. Nevertheless, she also recognized that it was this incident that prompted her to obtain her own apartment and maintain independent living. Eventually, Blanche proudly announced that she had called her friend and reconciled with her. She had once again experimented with relationship boundaries and with establishing a relationship based on equality rather than on a maternal type of interaction.

The strength of the therapeutic relationship did not prevent Blanche from experiencing severe anxiety when the therapist informed her that she would be out of town for two weeks for vacation. Blanche expressed intense fear that the therapist would not return. Although she realized and stated that this was irrational, she nonetheless admitted that she feared she would be abandoned. Two weeks later, she triumphantly declared that she had been "okay" while the therapist was away. She hinted at termination issues and then expressed some vague concern about "different relationships." As this was explored, Blanche explained that she had addressed everything but the deepest, most intimate area of her life: her sexuality.

Blanche was not at all clear about her sexual preference. She often stated that she felt ridiculous as a 55-year-old woman with so many questions about sex. She revealed that not only had she been married in the cult to a man she did not choose or like, she had been sexually abused by females as well as males in the cult. As these issues about sexuality were being discussed in therapy, Blanche had begun to socialize with a female member from her last DBT group, and she wasn't sure what her friend wanted or expected of her. The therapist shifted attention to what Blanche wanted. She stated she was not attracted to her friend. She began to establish boundaries in the friendship with which she was comfortable. It did not take long before her friend eased up on the intensity of their relationship. They subsequently provided support for each other and socialized frequently.

The theme of sex caused an increase in flashbacks, and grounding techniques were again employed to moderate them and to allow Blanche to remain experientially present. She found holding onto her car keys and typing on her computer keyboard to be especially effective means of staying oriented to the present. She did not have access to car keys as an adolescent and therefore did not have an immediate means of escape, nor did she have knowledge about computers at the time she was being abused. This quickly reminded her that she was in the present and was an adult who was safe from her past perpetrators. Although she preferred the computer as a grounding technique, keys were portable, less conspicuous, and more readily available.

At the outset of discussions about sex, Blanche talked about sex in terms of "performing." Her use of the word "performing" seemed to indicate that Blanche perceived sex as an unequal act of one person performing for the other without any reciprocation. Clarification of this issue eased Blanche's mounting worry about being able to perform, and led to the realization that she had many steps to take before actively entering a sexual relationship. She came to realize that she first had to be able to meet people and sustain friendships before she would be ready to become sexually active. This also alleviated some of the pressure of needing to identify her sexual preference, although she re-

peatedly stated that "this sexual thing will just not go away," as if she wished sexuality did not exist for her.

Blanche referred to her "parts" several times during the course of therapy. The therapist replied with "you," emphasizing the whole person. Blanche later stated that regardless of whether she had had parts or not, she did not need them anymore because she was learning how to cope with life. She acknowledged that she has different aspects of her personality, and said she no longer felt that she had multiple identities.

At the final session, Blanche described many examples of how she had been establishing clear, comfortable boundaries in relationships. She also explained that for the first time in her life, she didn't feel as though she was looking for a "mother" in social relationships or in therapy. She no longer needed others' permission or validation, because she had the ability to do this for herself. When asked to reflect on her therapy experiences in TRIP and to identify what aspects of the therapy she felt were most helpful, Blanche immediately identified the trusting relationships she had with her therapists, describing them as "good listeners." She added that the DBT group certainly helped. She stated that therapy taught her to recognize the existence of options between polar extremes. She was now able to see that she had choices, select among them, and feel competent making decisions. She commented that as therapists began to believe and communicate to her that she could accomplish various things, she began to believe this as well. Although she had hinted at termination, she didn't feel she would have taken the leap had her therapist not followed through by discussing it with her. She assertively stated that she could end therapy because she simply did not need it any longer.

Before she left, she informed the therapist that she had just revised her resume and was going to apply for a better paying job now that she had work experience and confidence. Additionally, she was completing the papers to obtain health insurance (for the first time) from her employer so that she could begin to take care of herself. The therapist called Blanche two weeks after her final session to inform her that her psychiatrist would be leaving the community mental health center. She took the news in stride and communicated that she had just been made a permanent employee and would be receiving benefits.

Case 3: Cassandra

Cassandra, a 48-year-old widow, was referred to TRIP by her previous therapist following four years of psychotherapy at an outpatient treatment center that specialized in sexual assault. She indicated that as a result of this course of treatment she had successfully stopped engaging in self-mutilating behavior, a substantial accomplishment that she clearly valued highly. However, despite

the gains that had been achieved in treatment up to that point, her therapist, who did not consider herself to be well-versed in dissociation, had encouraged Cassandra to seek treatment at TRIP as it became increasingly apparent that dissociation figured prominently in the clinical picture.

Cassandra alleged having been sexually abused by her mother. She reported that her mother repeatedly took her into the basement of their home with people (mostly women) her mother knew, where she was subjected to sexual and physical abuse accompanied by Satanic rituals. This continued, she stated, until she was eight years old, after which her mother continued to physically and sexually abuse her on an ongoing basis until she was 14 years old. During these years, she stated, her mother would make Cassandra sexually available to people such as the milkman, diaper man, and repairmen in exchange for business services.

Cassandra described her father as "oblivious to the world." She believed he did not know how to care for the children emotionally, referring to them generically, as might a professor unaware of her or his students' names. She described her mother as being a cold, "evil monster."

Cassandra married at age 19, one month after meeting her husband. He allegedly beat, cut, and burned her, would only have sex with her if she was tied up or hurt in some way, and forced her to have sex with other people while he watched. She and her husband had two daughters together, the first when she was 21. She left him when she was 22, during a physical fight. He periodically visited and continued sexually and physically abusing her until she was 24 years old. He also, unbeknownst to her at the time, sexually abused their daughters.

Cassandra pursued a college education, began employment as a social worker at age 23, and completed her B.A. in social work at age 31. She and her daughters moved in with a very supportive man when she was 24 years old, whom she married at age 30. She stated that he would "protect" her from abuse by anyone else, including her ex-husband, by making sure she was constantly supervised and encouraging her to lock herself in the house when alone without ever answering the door. Cassandra and this husband had one son when she was 35. She first received outpatient psychotherapy beginning at age 36 for four years after a suicide attempt precipitated by finding out that one of her daughters had been molested by her ex-husband, which brought back memories of her own abuse. Her husband died of pneumonia when Cassandra was 39, after which, she claimed, she cried every day, unable to speak much of the time, and constantly afraid that the "windows would get crashed in."

At age 42 Cassandra found out about her son's molestation by his school principal when a jealous peer also molested by the principal shot her son in the leg. In her words, "my life ended that day," as she felt unable to protect her children. She moved to New England for one year to work for a friend and then

to Florida to be with her son, who was living with his uncle there while being treated for his gunshot wound.

Cassandra reported lifelong problems with dissociation, posttraumatic stress, and panic attacks. Her chief complaint was dissociation, which included such symptoms as: loss of time many times a day; finding objects, often childish in nature, that she could not remember acquiring; and having "out of body" experiences. Her previous therapist told her TRIP therapist that she had observed at least one alter personality in treatment, and presented him with writings and drawings created by Cassandra. Cassandra experienced daily panic attacks, often following amnestic episodes. Since the death of her husband nine years before she entered treatment at TRIP, she had avoided situations such as driving and going into public places alone. She indicated that her posttraumatic symptoms also exacerbated considerably after his death. Cassandra was judged to meet criteria for diagnoses of DID, PTSD, MDD and Panic Disorder with Agoraphobia. She did not meet diagnostic criteria for or manifest appreciable features of any type of personality disorder.

Course of Treatment by TRIP Therapist. Treatment at TRIP began with the exploration of Cassandra's recent dissociative episodes. The major strategy used to accomplish this was functional behavioral analysis of particular recent incidents of amnesia, conducted over several sessions. Detailed information was elicited about the circumstances, thoughts, and feelings preceding each dissociative episode. Cassandra was asked to relate the last thing she remembered before the onset of the episode, and then guided to work backward in time from there. Through this process it was deduced that each amnestic period discussed was preceded by an unexpected occurrence, such as an unannounced visit by someone to her house, or the car she was riding in hitting a bump in the road.

Practice of a "safe place" imagery-based relaxation technique (Shapiro, 1995) was then introduced. This technique involved asking Cassandra to vividly imagine a place where she would feel particularly safe. She was instructed to practice this exercise at least once a day. The next several sessions were devoted to monitoring her practice and teaching her additional methods of reducing distress. She was taught another imagery technique: picturing her anxiety draining from her body, allowing the anxiety to enter and inflate an orange ball floating in front of her, and then shrinking the ball.

These anxiety reduction methods were supplemented with grounding techniques (Simonds, 1994) aimed at countering the dissociative tendency to lose focus on the here and now. These strategies included attending to and describing aspects of her surroundings and of her experience. For example, she was asked to describe both the painting and the lamp in the therapy office, and the tactile sensations of the sofa pillow in her hand and of the sandals on her feet.

Functional behavioral analysis of amnestic episodes was continued throughout this same series of sessions. Soon Cassandra began reporting that she was "taking apart" the dissociative episodes by applying functional behavioral analytic methods outside of session. In session 10 she reported that during the week she recognized a dissociative trigger: her son surprised her by tapping a pencil on the kitchen table behind her. She stated that, using imagery, "I pushed the tapping pencil (a stimulus that usually brought on dissociation) into the orange ball, and sent him up to his room," preventing the onset of a dissociative episode. In the same session she reported unexpectedly being hugged by an acquaintance during the previous week, which (to her surprise) did not lead to the loss of time. She stated that she was practicing relaxation exercises once or twice daily.

Over the next several sessions Cassandra indicated that she had begun driving, something she had not done in years, and had also seen a medical doctor, which she claimed never to have done other than when her children were born. She described a tremendous reduction in panic and hypervigilance, which she attributed primarily to her practice of relaxation imagery exercises. She had begun to volunteer at a homeless shelter, and related that she had been consistently sleeping four hours per night, improved from 1 to 2 hours per night previously. By the thirteenth session, she indicated that she was regularly sleeping 6 to 7 hours a night.

As her emotional distress was being well managed by the relaxation exercises, the focus of treatment shifted to cognitive intervention. Her therapist began helping her identify and question her erroneous beliefs. Initially largely under his direction, Cassandra gradually took increasing stewardship over the process of challenging and restructuring her own faulty beliefs both within and between therapy sessions. For example, she was able to reach the conclusion that her periods of dissociation were "not the end of the world," as she had previously viewed them. She also recognized that her therapist had difficulty remembering details of an early session, and that it was therefore not only her own memory that was fallible. Cassandra shared that this observation was comforting because it helped to make her feel more "normal." Evidence of specific feared consequences of dissociation and the likelihood of their occurrence was also examined. With time, Cassandra increasingly generated her own rebuttals to her previously held convictions without prompting from her therapist. These cognitive techniques resulted in considerably less anxiety and panic when forgetfulness and other dissociative phenomena did occur.

In response to Cassandra's request to work on alleviating her fear of particular situations, *in vivo* systematic desensitization was introduced. A fear hierarchy, ranging from the least to most fearful stimuli that precipitated dissociation, was collaboratively constructed with her therapist. Items on the hierarchy in-

cluded driving by herself to session, cashing a check at the bank, and visiting the doctor.

During session 22 Cassandra mentioned that her father arrived at her house that week, and asked to stay for a while because his current girlfriend had left him. Having him present facilitated her understanding of her childhood circumstances and how they had continued to shape her experience in the present. For example, when she asked her father if he knew about how her mother treated her, he replied that he never wanted to have children and felt as if they had stolen his life from him. Cassandra realized through this experience that it was her father's "lack of caring for human beings," rather than her being inherently unlovable, that was responsible for his failure to be supportive of her in childhood. She described feeling a greater sense of freedom as a result of this realization, and concluded that she loved him despite his characterological limitations. She also mentioned that as of that day she felt as if she were graduating from treatment.

Cassandra continued employing the relaxation techniques, albeit in an elaborated and creatively modified fashion. For example, she modified the orange ball technique, instead imagining her anxiety in small garbage bags emptied by an "emotional cleaning lady," emptying these garbage bags of anxiety into a canvas cart. The techniques were still helping her tremendously, as she claimed to be able to invoke them automatically and effortlessly. It was at about this point in treatment that she began expressing the recognition that it was she, rather than something or someone outside her control (i.e., disowned identity fragments), who had been responsible for the things that happened to her while she had dissociated.

During the last few sessions, Cassandra reported that she was moving toward overcoming her discomfort about employing her name and identity. In fact, despite fears of using her name, she began to consider marrying her boyfriend, as well as enrolling in a graduate-level university program, both of which she feared because they required her to present identification and use her identity. She also had begun to apply for employment in case management and grant writing. Termination occurred at the 30th session. Cassandra wept during portions of the session and told her therapist, "I'm really going to miss you." On her way out of the clinic after the session, she gave her therapist a warm hug, and seemed very comfortable doing so.

OUTCOME EVALUATION

Scores at admission and termination for all three clients on the DES, IES, and BDI are listed in Table 1, along with results of an additional administration to Cassandra at one-year follow-up. MMPI-2 profiles at admission and termi-

TABLE 1. Treatment Outcome of Three Cases of Dissociative Identity Disorder: Dissociative Experience Scale (DES), Impact of Events Scale (IES), and Beck Depression Inventory (BDI) Scores at Admission, Termination and One Year Follow-Up

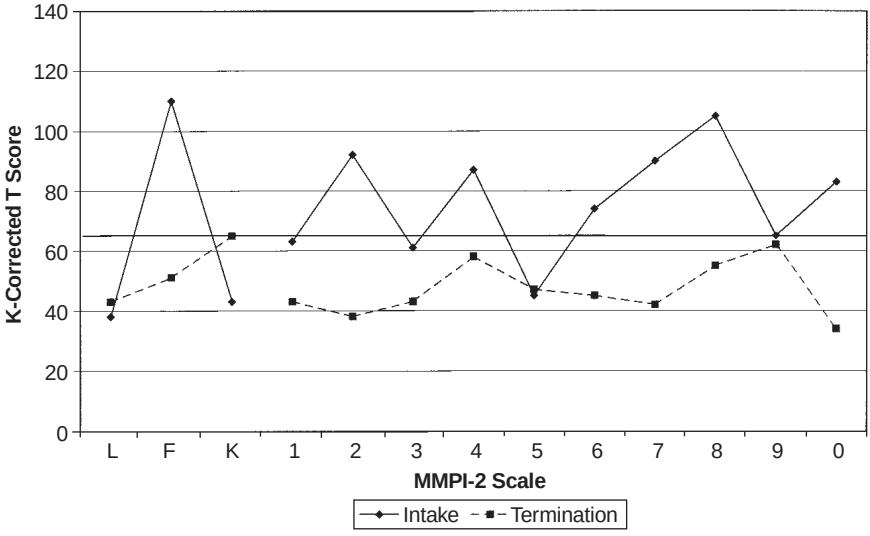
	Administration		
	Admission	Termination	One Year Follow-Up
Scale/Client			
Dissociative Experiences Scale (DES)–Whole Score (Clinical Cut-Off = 30; Carlson et al., 1993)			
Alison	36.79	3.57	N/A
Blanche	28.93	2.50	N/A
Cassandra	77.40	58.93	47.50
Impact of Events Scale (IES)–Whole Score (Clinical Cut-Off = 35; Neal et al., 1994)			
Alison	55	13	N/A
Blanche	57	19	N/A
Cassandra	71	45	43
Impact of Events Scale (IES)–Intrusion Score			
Alison	27	5	N/A
Blanche	23	13	N/A
Cassandra	35	21	23
Impact of Events Scale (IES)–Avoidance Score			
Alison	28	8	N/A
Blanche	34	6	N/A
Cassandra	36	24	20
Beck Depression Inventory (BDI) (Clinical Cut-Off = 10; Beck & Steer, 1987)			
Alison	33	2	N/A
Blanche	22	5	N/A
Cassandra	40	8	6

nation of Alison, Blanche, and Cassandra appear in Figures 1, 2, and 3 respectively. Figure 3 also includes Cassandra's MMPI-2 profile at six-month follow-up.

Alison

At the outset of treatment Alison was not gainfully employed due to the severity of her anxiety and dissociative symptoms. Due to emotional dependency and difficulty functioning self-sufficiently she had remained in a marriage to a man whom she claimed was alcoholic and verbally abusive. At termination, she was again employed, and had been promoted and offered a $15,000 salary increase. She was living independently for the first time in her life, and was making excellent progress in developing her social life, including engaging in healthy dating, mutually supportive friendships, and effective parenting. Her

FIGURE 1. Case 1: Alison



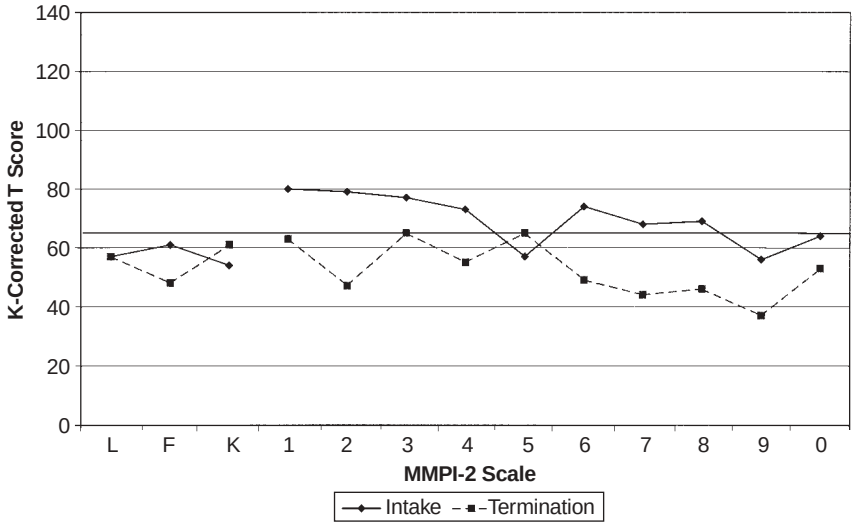
self-esteem had increased to a level where she was consistently able to be as considerate of her own needs as she had historically been of others' needs.

At termination Alison had shown no signs of dissociation in six months, despite exposure to stressors that previously would have triggered such reactions. She reported a sense of compete integration of identity fragments as well. Similarly, she denied any symptoms of depression for four months. After having undergone the TIR procedure, she reported that she no longer experienced any intrusive PTSD symptoms. Her scores on the DES, IES, and BDI all fell appreciably below their respective clinical cut-offs, substantiating that she no longer manifested significant dissociative, posttraumatic, or depressive symptoms. Similarly, her MMPI-2 profile was markedly less elevated than it had been at admission. While six of the ten basic MMPI-2 clinical scales were elevated at intake, all of them were below the clinical cut-off T score of 65 at the completion of therapy.

Blanche

Blanche entered therapy experiencing severe depression, suicidal ideation, PTSD, and dissociative symptoms. She was unemployed and had very few friendships. In the few relationships she did have she was markedly dependent and unassertive.

FIGURE 2. Case 2: Blanche



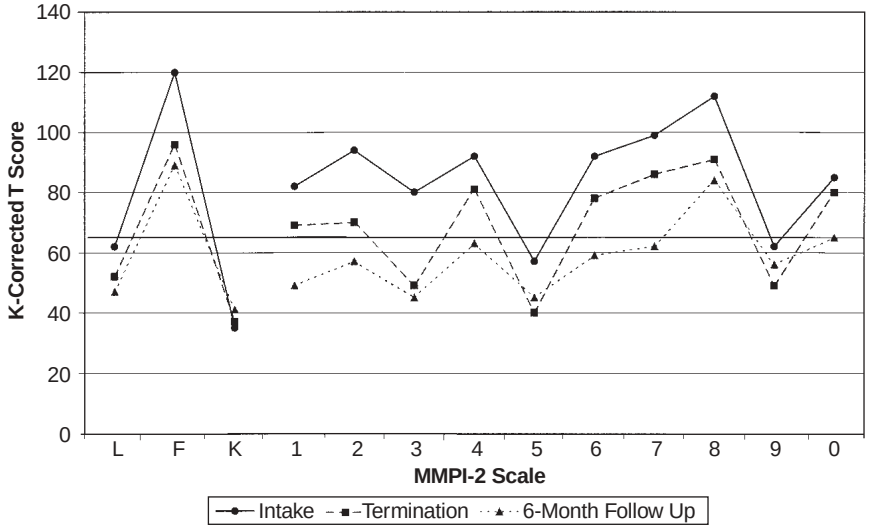
Upon completing her course of treatment at TRIP she no longer complained of depression, suicidal ideation, PTSD symptoms, or dissociation. Her scores on the BDI, IES, and DES were consistent with these observations: they were all below clinically significant levels. Although at admission seven of the clinical scale scores in her MMPI-2 profile were elevated, all of them were below a T score of 65 at the end of treatment.

By termination, Blanche had been working for a year, and she had grown assertive, self-confident, and autonomous enough that she was actively seeking a better job. She had greatly expanded her social circle, and had developed much more mutual and supportive relationships than she had previously. She had also made substantial progress in becoming more comfortable with her sexuality.

Cassandra

Cassandra's scores on the DES, IES, and BDI were appreciably higher at admission to TRIP than those obtained by Alison or Blanche. Although there were marked reductions in her scores on all three of these measures by termination, and further reductions at follow-up 12 months later, only her BDI score fell below the cut-off for clinical significance. Her IES scores approached the cut-off at termination, but her DES score was still elevated. This latter finding was consistent with post-treatment reports by Cassandra and her husband; al-

FIGURE 3. Case 3: Cassandra



though she experienced great improvement in other symptoms, there was evidence that considerable dissociative identity fragmentation remained. This pattern is reflected in Cassandra's 6-month follow-up MMPI-2 profile; all of her clinical scale elevations, which were extremely high at intake, were at sub-clinical levels at follow-up, with the notable exception of scale 8. MMPI-2 scale 8, which is a frequently elevated scale among survivors of childhood sexual abuse (Hunter, 1991; Langevin, Wright, & Handy, 1989; Scott & Flowers, 1988; Scott & Stone, 1986; Tsai, Feldman-Summers, & Edgar, 1979), is highly correlated with the DES (r = .70; Elhai, Gold, Mateus, & Astaphan, 2001) in this population.

However, the gains in daily functioning attained by Cassandra during her eight months of treatment were so dramatic that she strongly felt that termination was appropriate. At admission Cassandra had not been employed, driven, or left the house alone for several years; she was plagued daily by panic attacks and dissociative episodes. At termination she described a greatly enhanced ability to enjoy life, without the extreme panic and fear that had previously been such a constant for her. She was able to comfortably drive hundreds of miles alone. For the first time in her life she was able to undergo examination by a physician, sleep for six or more hours a night, and experience sex as pleasurable rather than aversive. She viewed these as "miraculous" achievements. At 12-month follow-up, she was not only working full time, but had also returned to school to obtain a doctoral degree. Her agoraphobia had fully remit-

ted; she was out of the house much of the time. Although still meeting criteria for DID, she no longer met criteria for PTSD or Panic Disorder. Also, she had not engaged in self-mutilation since her second therapy session.

It is extremely important to highlight that Cassandra's marked improvement in her ability to work, drive, and engage comfortably in a wide range of situations occurred despite the fact that considerable identity fragmentation remained. An important implication of this pattern of findings is that identity integration is *not* a pre-requisite for the attainment of meaningful and sizable gains in daily functioning. For many clients with DID, it may be more productive, therefore, to make increasing adaptive functioning a higher treatment priority than integration *per se*. The theoretical model underlying contextual therapy suggests that the treatment components that support general competency in living also gradually lead to a greater sense of continuity and cohesion of self.

Another noteworthy observation is that the 12-month follow-up assessment of Cassandra's functioning and symptomatology indicated considerable post-termination improvement. This is highly consistent with the conceptual foundation and intent of contextual therapy, which focuses on teaching clients adaptive capacities that they failed to learn growing up, rather than on resolving problems for them. Cassandra's continued progress at follow-up suggests that she did in fact learn adaptive coping skills that she was able to apply and build upon after treatment ended.

CONCLUSIONS

The current case studies provide provisional support for the effectiveness of contextual therapy for clients with DID. Both the clients' anecdotal reports and their standardized test scores reflect the attainment of substantial improvement in functioning and reduction in symptomatology. Moreover, these gains were achieved within time frames that are relatively brief in comparison to the three to five year course of treatment commonly projected for clients with DID (International Society for the Study of Dissociation, 1997).

Nevertheless, several factors that moderate the conclusions stated above need to be taken into account in evaluating the outcome. There are a number of aspects of our methodology that warrant caution in interpreting our findings and conclusions. A single case study design was used, and the three cases assessed were not randomly selected. The generalizability of the outcomes obtained in these three cases, therefore, is not possible to determine. Moreover, these were *post hoc* rather than *a priori* analyses. Rather than setting out at the beginning of treatment to conduct single case design studies, we decided, based on the availability of archival data collected for more formal research purposes, to more formally assess treatment outcome in response to our clini-

cal observations suggesting that these clients were making substantial progress. For these reasons, the results described here cannot be assumed to be representative of those that can be expected when contextual therapy is applied to clients with a DID diagnosis. Instead, our findings should be considered a preliminary indication of the types and extent of therapeutic gains that are attainable with contextual therapy in at least some instances. Controlled outcome studies need to be conducted for more definitive conclusions to be made about the effectiveness of contextual therapy.

There were also limitations created by the circumstances under which treatment was delivered that may well have attenuated or slowed down the pace of therapeutic progress. All of the clinicians treating these comparatively complex cases were relatively novice therapists. Most of them were in their second year of supervised practicum, with little previous clinical experience. In addition, practicum placements were limited to one year. It had therefore been necessary for the two of the three clients whose treatment extended beyond a year to adjust to the transfer to a second, and in one case to a third, clinician by the time therapy had been completed. This is obviously a less-than-ideal condition under which to conduct treatment. It is a particular hardship for PCA survivors, whose history of adverse interpersonal experiences frequently presents a formidable obstacle to establishing a sense of trust and safety in the therapeutic relationship (Gold, 2000). These considerations raise the possibility that it may well be that even more favorable outcomes may be reached more rapidly when the treating clinician is more experienced and is in a position to remain available throughout the course of therapy.

While one of our objectives in presenting detailed descriptions of these cases was to illustrate the application of contextual therapy, there are inherent limitations to accounts such as these. It is easiest to delineate the concrete interventions employed in contextual therapy, and therefore to leave the reader with the impression that these methods are what constitute the totality of this approach. This is not the case. The two other major components of contextual therapy are indispensable to the attainment of substantive treatment gains. One of these, the development of a collaborative therapeutic alliance, teaches the client via first-hand experience that interpersonal relationships, in stark contrast to those often encountered previously, can be cooperative, productive, and a source of security and empowerment. The other main component of contextual therapy, collaborative conceptualization, also arrived at via collaboration between client and therapist, serves as a powerful correction of perceptions that have fueled mistrust of others and denigration of self. We hope that our case descriptions have provided enough of a sense of the role of these two less concrete aspects of contextual treatment that they are not overlooked.

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