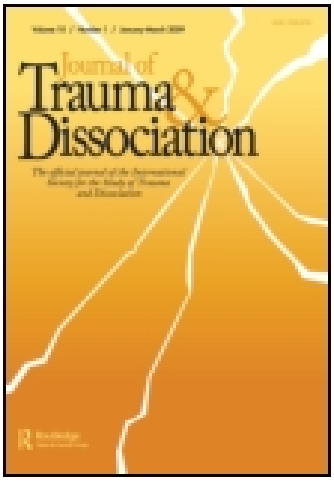

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# For Better or Worse: The Role of Revictimization and Stress in the Course of Treatment for Dissociative Disorders

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# ARTICLES

# For Better or Worse: The Role of Revictimization and Stress in the Course of Treatment for Dissociative Disorders

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*Revictimization and life stressors are common among dissociative disorder (DD) patients, yet no studies have examined the prevalence rates for these experiences or their relationships with treatment outcome. This study aimed to examine the rates of revictimization and victimization of others using therapist–DD patient pairs from the naturalistic Treatment of Patients with Dissociative Disorders (TOP DD) study while also considering the role of revictimization and life stressors among 49 patients who greatly improved or worsened during 30 months of treatment. Therapists reported that sexual and physical revictimization in the previous 6 months was high among the patients (3.5%–7.0% and 4.1%–7.1% in the overall TOP DD sample, respectively), and emotional revictimization was quite high (29%–36%). Revictimization showed a decreasing trend over the 30 months of the study.*

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*Therapists reported that more than a quarter of the patients who were revictimized were also occasionally emotionally or physically abusive to others. More patients showed sudden improvement versus sudden worsening in patient-reported symptoms at 1 or more time point(s). Patients who improved had significantly fewer revictimizations and stressors overall than patients who worsened, suggesting that revictimization and/or stressors may contribute to worsening in treatment. Further research is needed to learn more about the roles of revictimization, victimization of others, and stressors in DD treatment.*

*[Supplementary material is available for this article. Go to the publisher's online edition of Journal of Trauma & Dissociation for the following supplemental resource: Baseline Demographic Information of TOP DD Improving and Worsening Subgroups]*

*KEYWORDS dissociative, dissociation, revictimization, treatment, stress*



Although improvement in psychotherapy is expected, researchers and clinicians have recognized that patients may improve, not change, or worsen (e.g., Bergin, 1963). An estimated 5%–10% of adult patients demonstrate deterioration in clinical trials and routine mental health care (Lambert & Ogles, 2004), and as many as 10%–30% deteriorate in patient populations with complex symptom presentations (e.g., substance abuse; see Ilgen & Moos, 2006). An overreliance on inflexible treatment protocols and patient factors such as low motivation, complex symptomatology, comorbidity, and resistance have been cited among possible reasons for deterioration (Lambert, 2011).

Revictimization can serve as a significant impediment to treatment progress. Sexual and physical revictimization is high among survivors of childhood sexual and physical abuse (e.g., Arata, 2002; Desai, Arias, Thompson, & Basile, 2002; Trickett, Noll, & Putnam, 2011) and is associated with increased posttraumatic stress disorder (PTSD) symptoms and dissociation (Barnes, Noll, Putnam, & Trickett, 2009). However, even typical life stressors, such as problems at work or with family, can exacerbate symptoms for those in trauma-related treatment (Baars et al., 2011; Chu, 1992, 2011; Kluft, 1990, 1994; Koopman, Gore-Felton, & Spiegel, 1997). Traumatized individuals are vulnerable to increased psychological distress when stressors occur later in life, even if the stressor would not typically be considered traumatic (Bremner, Southwick, & Charney, 1995; Koopman, Gore-Felton, Classen, Kim, & Spiegel, 2001). Women diagnosed with PTSD related to childhood sexual abuse show marked sensitivity to later stressors (Koopman et al., 2001). Another study (Classen et al., 2002) found a relationship between mild to more distressing nontraumatic life stressors over

the previous 6 months (e.g., occupational success or difficulties, marital problems, housing changes) and worsened PTSD symptoms.

Nontraumatic stressful events may lead to poor prognosis in treatment. In a study of experienced trauma therapists' ratings of variables they thought most predictive of treatment failure for complex trauma patients, including dissociative disorders (DD) patients (Baars et al., 2011), therapists rated recent or ongoing revictimization, lack of social support, lack of resources (e.g., financial resources, housing), and difficulties maintaining an alliance with their therapists as likely to predict a poor outcome. In addition, Kluft (1994) described a number of features that characterize DD patients most likely able to respond more rapidly to treatment, including the ability to develop and sustain a strong therapeutic alliance, manage life stressors effectively, maintain positive interpersonal relationships, and perceive themselves as being in control of their lives.

Although the clinical literature describes high levels of revictimization among DD patients (International Society for the Study of Trauma and Dissociation [ISSTD], 2011; Kluft, 1990), data are lacking on the actual rate of sexual, physical, and emotionally abusive revictimization. Data are also lacking on the rate of stressors occurring among these patients. It is important to determine whether such experiences impact treatment outcomes for patients with DD. A longitudinal, naturalistic study of patients diagnosed with dissociative identity disorder and dissociative disorder not otherwise specified, the Treatment of Patients with Dissociative Disorders (TOP DD) study, found that DD patients improved with treatment (see Brand et al., 2009, 2012). Treatment was associated with decreased symptoms and increased adaptive functioning over 6, 18, and 30 months, according to both patient and therapist reports (Brand et al., 2012). The TOP DD data were utilized in the present study to (a) describe the number of participants who experienced physical, sexual, and emotionally abusive retraumatization as well as rates of physical and emotional abuse of others during the 30 months of treatment, (b) examine the rates of stressors and revictimization reported by participants who demonstrated large increases in symptoms compared to those who reported large decreases in symptoms during the study, and (c) discuss the possible relationships between stress and revictimization and treatment outcome in this sample. Because revictimization and life stressors have the capacity to challenge one's sense of safety, view of self and the future, and coping skills, we hypothesized that patients who showed worsening in treatment would have higher levels of stress and revictimization compared to those who showed improvement in treatment.

## METHOD

The present study relied on practice network methodology, in which community therapists and their patients are recruited as the participants

in research. TOP DD therapists were recruited using a variety of methods, including e-mail invitations sent to professional listservs and promotion of the study at the annual ISSTD conference. These therapists were asked to invite one DD patient from their caseloads to participate. The methodology of this study is explained in detail in Brand et al. (2009).

## Participants

Patients in the TOP DD study had already been diagnosed with dissociative identity disorder or dissociative disorder not otherwise specified at intake into the study and had been in treatment with their therapists for an average of 5 years. The study did not exclude patients based on comorbidity, suicidality, psychosis, hospitalization during the study, or high-risk behaviors. Patients were only excluded if they were younger than 18 or unable to read English.

Participants in the current study were a subsample of the TOP DD study's participants (Brand et al., 2009, 2012). Participants were included in the current study's analyses if both the therapist and patient completed baseline surveys as well as at least two of the three follow-up surveys completed at 6, 18, and 30 months; 49 therapist–patient pairs were included. Therapists completed password-protected Web-based surveys adapted from a naturalistic community study on borderline personality disorder (Zittel Conklin & Westen, 2005), and patients completed paper-and-pencil questionnaires given to them by their therapists to be completed and mailed in without the therapist seeing their answers. The study received institutional review board approval, and all participants provided informed consent prior to participation. Neither therapists nor patients were compensated for their participation.

From the subsample of 49 patient–therapist pairs, patients were selected to be in the worsening group if they demonstrated a 20% increase in symptoms ($n = 15$) as evidenced by a 20-point increase on the Dissociative Experiences Scale (DES), a 20-point increase on the PTSD Checklist—Civilian Version (PCL-C), and a 0.7-point increase on the Symptom Checklist 90–Revised (SCL-90-R). Patients included in the worsening group were 9.4% of the overall TOP DD patient samples at Time 2, 12.2% at Time 3, and 14.4% at Time 4. These worsening patients were compared with 34 improving patients who demonstrated a 20% decrease in symptoms between any two time points as evidenced by a 20-point decrease on the DES or PCL-C and a 0.7-point decrease on the SCL-90-R. This improving group comprised 19.9%, 26.0%, and 30.6% of the overall TOP DD patient samples at Times 2, 3, and 4, respectively. There were more married patients in the improving group than in the worsening group; no other significant differences between the two groups were found (see Online Table 1).

## Clinician Measures

*Revictimization.* Therapists answered questions regarding patients' sexual, emotional, and physical victimization as an adult. Follow-up surveys inquired about recent revictimization. For sexual assault, therapists answered the question "Has the patient been raped or been the victim of a sexual assault in the last 6 months?" Therapists answered *no, once, 2–5 times,* or *more than 5 times.* For physical revictimization, therapists answered the question "Has the patient been in a physically abusive relationship in the last 6 months?" by stating *no* or *yes.* Emotional revictimization was assessed by asking "Has the patient been in an emotionally abusive relationship in the last 6 months?" Therapists who answered that their patients were involved in physically or emotionally abusive relationships were asked whether the patient was the victim, the perpetrator, or both.

*Impact of life stressors.* Therapists rated the degree to which life stressors negatively impacted the patients' functioning over the previous 6 months on a scale from 0 to 5 at each follow-up survey, where 0 indicated *no negative impact,* 3 indicated *somewhat of a negative impact,* and 5 indicated *highly negative impact.* This study utilized life stressors that have been discussed in the clinical trauma literature as impacting progress in treatment (e.g., Baars et al., 2011; Kluft, 1990, 1994). The degree of negative impact of revictimization was assessed because individuals might respond with different degrees of distress following revictimization. Stressors included three *revictimization-related stressors* (i.e., experiencing physical abuse, sexual abuse, and/or verbal abuse), six *resource-related stressors* (i.e., health problems; housing difficulties; difficulties at work, school, or volunteer job; financial problems), three *family-related stressors* (i.e., problems involving the family of origin, marriage or relationship problems, difficulties involving biological or adopted children), two *patient resistance items* (i.e., resistance or retaliation among parts of self, demonstrating fear of change), and two *difficulties establishing trusting relationship with treatment team* (i.e., difficulty with mistrust toward the therapist, difficulty with mistrust toward others besides the therapist in the treatment team).

## Patient Measures

*DES.* The DES (Bernstein & Putnam, 1986) is a widely used 28-item self-report measure for the assessment of dissociative experiences. Cronbach's alpha coefficients for the DES calculated at each follow-up for the current study ranged from .95 to .96 (Brand et al., 2012).

*PCL-C.* The PCL-C (Weathers, Litz, Huska, & Keane, 1994) is a 17-item measure of PTSD symptomatology and severity. It assesses symptoms in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition,* PTSD criteria (American Psychiatric Association, 2000). Respondents rate

how much each symptom has bothered them in the past month using a 5-point scale (1 = *not at all* to 5 = *extremely*). Total scores are calculated by summing responses from all items. Total scores of 50 points or more are consistent with a PTSD diagnosis (e.g., Weathers & Ford, 1996). Cronbach's alpha coefficients for the PCL-C calculated at each follow-up for the current study ranged from .89 to .93 (Brand et al., 2012).

*SCL-90-R.* The 90 items of the SCL-90-R (Derogatis, 1994) measure a variety of psychiatric symptoms. Items are rated on a 5-point scale of symptom distress (0 = *not at all* to 4 = *extremely*). The Global Severity Index is the average score of all 90 items. Across the follow-ups, Cronbach's alpha coefficients in the current study ranged from .96 to .98 for the Global Severity Index (Brand et al., 2012).



## ANALYSES

Given the small sample, extensive statistical analyses were not conducted. Qualitative descriptions are used to convey findings within groups; chi-square analyses were used to compare findings between groups.

## RESULTS

### Changes in Symptoms

Of the 34 patients in the improving subsample, 20 patients' scores decreased on one measure, 13 patients' scores decreased on two measures, and 1 patient's scores decreased on all three measures. Several patients' symptoms decreased across more than one data point (see Table 1). Symptom scores improved an average of 1.01 points on the SCL-90-R (*SD* = 0.27; range = 0.7–2.08), 33.23 points on the DES (*SD* = 11.25; range = 20.36–61.78), and 26.73 points on the PCL-C (*SD* = 4.20; range = 21–34).

For the 15 patients in the worsening subsample, scores increased an average of 0.86 points on the SCL-90-R (*SD* = 0.62; range = 0.7–2.85), 36.80 points on the DES (*SD* = 17.34; range = 23.93–81.42), and 30.75 points on the PCL-C (*SD* = 11.63; range = 22.25–44.0). On both the SCL-90-R and DES, two patients demonstrated increased scores across more than one data collection point (see Table 1).

### Incidence of Revictimization and Victimization of Others

Across the entire TOP DD sample, the rate of total revictimization tended to decrease over time (Cochran's Q, $p = .097$; see Table 2). Among the worsening group, therapists reported four incidents of sexual revictimization

**TABLE 1** Changes in Symptomatology Among Patients Across Multiple Data Collection Points

| Group | Measure | Patients who demonstrated rapid change | Patients who demonstrated rapid change across more than one data point |
|---|---|---|---|
| Improving ($n = 34$) | SCL-90-R | 27 | 6 |
| | DES | 15 | 6 |
| | PCL-C | 9 | 2 |
| Worsening ($n = 15$) | SCL-90-R | 7 | 2 |
| | DES | 7 | 2 |
| | PCL-C | 3 | 0 |

*Notes:* Worsening = 20% increase in symptoms; improving = 20% decrease in symptoms. SCL-90-R = Symptom Checklist 90–Revised; DES = Dissociative Experiences Scale; PCL-C = Posttraumatic Checklist—Civilian Version.



(26.67%), one report of physical abuse revictimization (6.25%), and three reports of emotional abuse revictimization (18.75%) in the previous 6 months. The rate of sexual revictimization in the previous 6 months was higher than that found in the overall TOP DD sample at any data point (26.67% vs. 3.5%–7.0% across data points, respectively), whereas the rate of physical revictimization was comparable (6.25% vs. 4.1%–7.1%, respectively). The rate of emotional revictimization in the previous 6 months was lower in the worsening group than in the overall TOP DD sample (18.75% vs. 29.0%–36.0%, respectively). Across types of abuse, revictimization rates of the worsening subgroup were significantly higher than those reported by the improving subgroup. Only one incidence of any victimization occurred during the time period in which symptoms decreased among the improving group (i.e., one sexual revictimization), which represented a statistically significant difference between the groups, $\chi^2(1, N = 67) = 8.79$, $p < .01$. When victimization of others was assessed in the entire TOP DD sample, 26.3% of patients (5 out of 19) who were victims of physical abuse were also perpetrators of physical violence. In 60% of the cases (3 out of 5) the physical abuse was no longer occurring by the final data point, and in all of the cases patients who perpetrated violence did so only at one time point. Similarly, 26% of patients (25 out of 96) who experienced emotional abuse were perpetrators of emotional abuse. However, perpetration of emotional abuse was more enduring. Seven patients perpetrated emotional abuse over two data points, and only 10.4% of the emotionally abusive patients had stopped being emotionally abusive by the end of the study. None of the TOP DD participants who were not victimized were perpetrators of either physical violence or emotional abuse. None of the participants in the improving or worsening groups were victimizing others at the time their symptoms changed.

**TABLE 2** Incidence of Revictimization in the Previous 6 Months in Total TOP DD Sample Across 30 Months

| | 6-month follow-up: Time 2 ($n = 183$) | | | 18-month follow-up: Time 3 ($n = 172$) | | | 30-month follow-up: Time 4 ($n = 145$) | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Present | Absent | % of sample with revictimization | Present | Absent | % of sample with revictimization | Present | Absent | % of sample with revictimization |
| Sexual abuse | 11 | 172 | 6.0 | 12 | 160 | 7.0 | 5 | 140 | 3.5 |
| Physical abuse | 13 | 170 | 7.1 | 10 | 162 | 5.8 | 6 | 139 | 4.1 |
| Victim | 13 | | 7.1 | 10 | | 5.8 | 6 | | 4.1 |
| Perpetrator | 2 | | 1.1 | 1 | | 0.5 | 2 | | 1.4 |
| Both victim and perpetrator | 2 | | 1.1 | 1 | | 0.5 | 2 | | 1.4 |
| Emotional abuse | 61 | 122 | 33.3 | 62 | 110 | 36.0 | 42 | 103 | 29.0 |
| Victim | 61 | | | 62 | | | 42 | | 29.0 |
| Perpetrator | 11 | | | 17 | | | 8 | | 5.5 |
| Both victim and perpetrator | 11 | | | 17 | | | 8 | | 5.5 |
| Total incidents of revictimization | 85 | | | 84 | | | 53 | | |

### Impact of Stressors

For each stressor category, there were some therapists who did not report any increased stressors for their patients, whereas other therapists reported several types of stressors within each category. Increased stressors included any positive change of 2 or more points. The improving group demonstrated significantly fewer stressors overall compared to those in the worsening group, $\chi^2(10, N = 67) = 29.04$, $p < .01$ (see Table 3). During times when their scores decreased, the improving group experienced significantly fewer revictimization-related stressors and difficulties establishing trusting relationship with the treatment team than the worsening group: revictimization-related stressors, n = 6 in 40% of the worsening sample versus $n = 6$ in 19% of the improving sample, $\chi^2(3, N = 67) = 13.92$, $p < .01$; difficulties establishing trusting relationship, $n = 20$ in 53% of the worsening sample versus $n = 4$ in 11.8% of the improving sample, $\chi^2(2, N = 66) = 20.67$, $p < .001$. Patients in the improving group also had fewer resourcerelated stressors than those in the worsening group, $n = 20$ in 53% of the worsening sample versus $n = 17$ in 41.4% of the improving sample, $\chi^2(3, N = 67) = 8.14$, $p < .05$. Family-related stressors and patient resistance stressors were not significantly different between those in the improving versus worsening subgroups.

## DISCUSSION

The purpose of this study was to examine the incidence of revictimization and life stressors and to consider relationships of these variables to

**TABLE 3** Stressors Reported by Therapists of Patients with Rapid Worsening and Improving of Symptomatology

| Variable | Revictimization-related stressors | Family-related stressors | Resource-related stressors | Patient resistance | Difficulty developing trust in treatment team | Total stressors |
|---|---|---|---|---|---|---|
| Patients with worsened symptoms ($n = 15$) | 16 | 15 | 20 | 4 | 20 | 89 |
| Patients with improved symptoms ($n = 34$) | 6** | 14 | 17* | 7 | 4*** | 48** |
| Total stressors | 23 | 29 | 37 | 13 | 24 | 137 |

*Notes:* Worsening is defined by a 20% increase in symptoms, and improving is defined by a 20% decrease in symptoms. The number of revictimizations can be higher than the number of patients in a group because patients' multiple revictimizations were counted.

*$p < .05$.

**$p < .01$.

***$p < .001$.

treatment outcome in DD patients observed across 30 months of treatment. Retraumatization and life stressors were examined in a subset of DD patients who demonstrated 20% increases or decreases in symptoms. This study is a first step toward developing knowledge about the impact that stressors and recent traumas have on treatment progress for DD patients.

## Subgroups with Improved and Worsened Symptoms

In the TOP DD patient sample, 21%–30% of patients' symptoms improved by 20% at one or more data points during the overall 30 months of the TOP DD study. Between 9% and 14% showed worsening at one or more time points. It appears that revictimization and stressors were experienced during the same time that patients showed symptomatic worsening, suggesting that the revictimizations and stressors may have contributed to the patients' escalation in symptoms. Alternatively, patients who were less symptomatic may have been able to prevent revictimization or more effectively manage stressors.

This rate of worsening is similar to that in a large-scale study that examined a representative sample of patients in trials for anxiety and/or depressive disorders ($n = 496$; Hansen, Lambert, & Forman, 2002). These researchers found that 8.7% of patients deteriorated during treatment in studies that underrepresented patients demonstrating high-risk behaviors (e.g., active suicidality, substance abuse). The TOP DD study included patients with these difficult-to-stabilize behaviors, yet the rates of worsening were not heightened. Furthermore, the percentage of DD patients who worsened was lower than that found in some trauma treatment studies (e.g., 25% in Tarrier et al., 1999).

In the current study, participants whose symptoms improved by 20% or more tended to demonstrate a pattern of improvement across symptoms. For most of the patients, the improvement was steady across the study, even if the changes were less pronounced at some time points (i.e., less than 20%). Many patients' greatest improvements came at the last point of data collection (Time 4). Therefore, we do not have follow-up data that can clarify whether the improvements endured. Two patients worsened following a period of sudden improvement; both patients' therapists reported increased stress in resource-related issues (i.e., financial resources and housing) and an increase in stress from verbal abuse during the period of worsening. One of the patients also reported an increase in family-related stress. The patients who worsened demonstrated a less consistent pattern of symptoms over time. Two of the patients (13.3%) who showed worsening in either posttraumatic or general psychiatric symptoms simultaneously improved in dissociation, suggesting that symptom worsening does not always occur across all domains in these complex patients. Furthermore, there did not tend to be a linear pattern of overall worsening across symptom domains for most of the patients, indicating that it was not a widespread, long-term

decline. A total of 20% of patients ($n = 3$) from the worsening group reported increased symptoms across the three measures and across data points. One of these three had a considerable increase in symptoms between Time 2 and Time 3 that was associated with recently experienced revictimization and considerable family- and resource-related stressors. Unfortunately, this participant did not participate in the final data collection, so we do not know whether the stressors, ongoing revictimization, and high symptomatology continued. It is unknown how the patients who showed a period of worsening would have fared had they not been in treatment during the time in which they were struggling with heightened stress and/or revictimized, but it is plausible that they may have done substantially worse without treatment. Among those worsened patients whose therapists reported difficulty developing trust with the treatment team, none of the therapists indicated that their patients struggled with this as their only stressor. This study, along with other findings from the TOP DD study, indicates that a phasic, trauma-focused treatment is not harmful for the majority of DD patients, contrary to the opinions offered by some authors, who make these claims despite lacking any systematic data that substantiate their opinions (e.g., Lilienfeld, 2007; Lilienfeld & Lambert, 2007; Piper & Merskey, 2004).

*Revictimization.* Consistent with the clinical literature (e.g., Barnes et al., 2009; Chu, 1992; Classen et al., 2002; Kluft, 1990; Whitfield, Anda, Dube, & Felitti, 2003), TOP DD patients had a high rate of revictimization. Over 30 months, 3.5%–7% experienced sexual revictimization, 4.1%–7.1% experienced physical revictimization, and 29%–36% experienced emotional abuse. The number of revictimizations showed a trend of decreasing over the course of the study. Therapists reported that one quarter of the DD patients in physically or emotionally abusive relationships were also emotionally or physically abusive to others as well, although the majority of patients who were physically abusive were no longer so at the last data collection point. This is an important finding, as studies have not examined the rate of abuse perpetration among DD patients. A longitudinal study found that sexually abused females who perpetrated mild physical abuse against a partner were more likely to experience severe domestic violence by this partner (Trickett et al., 2011). These results highlight the importance of fostering healthy interpersonal relationships as well as affect and impulse regulation during treatment for DD patients.

Only one patient with rapidly improved symptoms experienced an incident of revictimization during the time period in which she improved, whereas those with worsening symptoms were reported by their therapists to have experienced significantly more recent revictimizations. It is not possible to determine causality with these data. Those with improved symptoms may have already established sufficient boundaries and assertiveness so that they were not entangled in abusive relationships, enabling them to focus more on participating in and benefiting from treatment.

*Stressors and resistance.* Recent verbal assaults were the most frequent revictimization-related stressor reported for patients with both worsened and improved symptoms. Our findings are consistent with causal research that has demonstrated that verbal abuse in adulthood predicts posttraumatic symptoms beyond sexual and physical abuse experienced in adulthood (Norwood & Murphy, 2012). One quarter of the therapists reported that patient resistance was associated with rapidly worsening symptoms. Significantly more therapists perceived their worsening patients as struggling with difficulty trusting their treatment teams compared to the improving patients. The Guidelines for Treating Dissociative Identity Disorder in Adults (ISSTD, 2011) discuss the difficulties of establishing and maintaining the therapeutic relationship with DD patients and the challenges inherent in establishing internal cooperation between dissociated parts of the self in dissociative identity disorder patients. In contrast, none of the therapists of patients whose symptoms rapidly improved perceived patients as having notable difficulty trusting their treatment teams.

It is surprising that family-related stress occurred at the same frequency among the improving and worsening groups. There was a trend for resource-related stress, such as difficulties with finances, housing, health, work and family, to be higher among the worsening as opposed to the improving group. For the improving group, work-related stress was the most frequently reported stressor. One possible explanation for this might be that as symptoms decreased, patients were more able to seek and maintain employment or volunteer positions, thus exposing themselves to work stress. This would be consistent with the finding that TOP DD study participants demonstrated increased volunteer and social activities over 30 months of treatment (Brand et al., 2012).

The decrease in life stress among patients whose symptoms rapidly improved also warrants consideration. In addition to two patients who demonstrated decreases in abusive situations, there were almost 60 instances of decreased life stress in the improving subsample. Of note is that 15 of these were in the area of patient resistance and difficulties establishing trust with the treatment team. The ability of patients to decrease resistance and fear of change and increase trust in treatment team members is an important finding that warrants further study. Investment in treatment and trust in the therapeutic alliance is particularly important for DD patients (e.g., ISSTD, 2011; Kluft, 1993; Steele, van der Hart, & Nijenhuis, 2001). Future research needs to further investigate the impact of the therapeutic alliance on treatment outcome for DD patients.

## Limitations and Future Directions

Limitations include attrition from the overall TOP DD sample, which limited the size of this subsample and the analyses that could be conducted; an

inability to determine a causal relationship between trauma revictimization or life stressors and symptom change; and the absence of patient reports of revictimization and stressors. In addition, there were no data on those patients whose life stressors may have resulted in their termination from treatment or from the study. Attrition data from the TOP DD study showed that both external reasons (e.g., patient or therapist relocation, financial stress) and psychological reasons (e.g., negative feelings about treatment, decompensation) contributed to terminating treatment.

This study provides preliminary information about rates of revictimization and stress among DD patients during the course of treatment and some hypotheses about how stressors and revictimization may contribute to sudden improvements or worsening in symptoms. Overall, more patients showed rapid improvement than worsening. Patients who showed sudden worsening experienced more revictimization and stressors than did patients who made sudden improvement. Sustained worsening occurred in a small minority (1.1%) of these DD patients. Future studies should further investigate the links between stressful life events, treatment improvement, and worsening for DD patients, such as the relationship between multiple types of victimization and stress and symptom change. Additional research that investigates methods for resolving mistrust of treatment providers, as well as reducing revictimization and victimization of others, would also be informative for treating this population.



## REFERENCES

Arata, C. M. (2002). Child sexual abuse and sexual revictimization. *Clinical Psychology: Science and Practice*, *9*, 135–164.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders (4th ed, Text Revision)*. Washington, DC: American Psychiatric Association.

Baars, E. W., van der Hart, O., Nijenhuis, E. R. S., Chu, J. A., Glas, G., & Drajer, N. (2011). Predicting stabilizing treatment outcomes for complex posttraumatic stress disorder and dissociative identity disorder: An expertise-based prognostic model. *Journal of Trauma & Dissociation*, *12*, 67–87.

Barnes, J. E., Noll, J. G., Putnam, F. W., & Trickett, P. K. (2009). Sexual and physical revictimization among victims of severe childhood sexual abuse. *Child Abuse & Neglect*, *33*, 412–420.

Bergin, A. E. (1963). The effects of psychotherapy: Negative results revisited. *Journal of Counseling Psychology*, *10*, 244–249.

Bernstein, E., & Putnam, F. W. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease*, *174*, 727–735.

Brand, B. L., Classen, C. C., Lanius, R., Loewenstein, R. J., McNary, S. W., Pain, C., & Putnam, F. W. (2009). A naturalistic study of dissociative identity disorder and dissociative disorder not otherwise specified patients treated by community

clinicians. *Psychological Trauma: Theory, Research, Practice, & Policy*, *1*(2), 153–171.

Brand, B. L., McNary, S. W., Myrick, A. C., Loewenstein, R. J., Classen, C. C., Lanius, R. A., . . . Putnam, F. W. (2012). A longitudinal, naturalistic study of dissociative disorder patients treated by community clinicians. *Psychological Trauma: Theory, Research, Practice, & Policy*. Advanced online publication.

Bremner, J., Southwick, S., & Charney, D. (1995). Etiology of posttraumatic stress disorder. In M. Mazure (Ed.), *Does stress cause mental illness?* (pp. 68–104). Philadelphia, PA: Saunders.

Chu, J. A. (1992). The revictimization of adult women with histories of childhood abuse. *Journal of Psychotherapy Practice & Research*, *1*(3), 259–269.

Chu, J. A. (2011). *Rebuilding shattered lives: Treating complex PTSD and dissociative disorders*. Hoboken, NJ: Wiley.

Classen, C. C., Nevo, R., Koopman, C., Nevill-Manning, K., Gore-Felton, C., Rose, D. S., & Spiegel, D. (2002). Recent stressful life events, sexual revictimization, and their relationship with traumatic stress symptoms among women sexually abused in childhood. *Journal of Interpersonal Violence*, *17*, 1274–1290.

Derogatis, L. R. (1994). *SCL-90-R: Administration, scoring and procedures manual*. Minneapolis, MN: National Computer Systems.

Desai, S., Arias, I., Thompson, M. P., & Basile, K. (2002). Childhood victimization and subsequent adult revictimization assessed in a nationally representative sample of women. *Violence and Victims*, *17*, 639–653.

Hansen, N. B., Lambert, M. J., & Forman, E. M. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice*, *9*(3), 329–343.

Ilgen, M. A., & Moos, R. H. (2006). Exacerbation of psychiatric symptoms during substance abuse disorder treatment. *Psychiatric Services*, *57*, 1758–1764.

International Society for the Study of Trauma and Dissociation. (2011). Guidelines for treating dissociative identity disorder in adults, third revision. *Journal of Trauma & Dissociation*, *12*, 115–187.

Kluft, R. P. (1990). Dissociation and subsequent victimization: A preliminary study. *Dissociation*, *3*(3), 167–173.

Kluft, R. P. (1993). Clinical approaches to the integration of personalities. In R. P. Kluft & C. G. Fine (Eds.), *Clinical perspectives on multiple personality disorder* (pp. 101–103). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1994). Treatment trajectories in multiple personality disorder. *Dissociation*, 7(1), 63–76.

Koopman, C., Gore-Felton, C., Classen, C., Kim, P., & Spiegel, D. (2001). Acute stress reactions to everyday stressful life events. *Journal of Child Sexual Abuse*, *10*(2), 83–99.

Koopman, C., Gore-Felton, C., & Spiegel, D. (1997). Acute stress disorder symptoms among female sexual abuse survivors seeking treatment. *Journal of Child Sexual Abuse*, *6*(3), 65–85.

Lambert, M. J. (2011). What have we learned about treatment failure in empirically supported treatments? Some suggestions for practice. *Cognitive and Behavioral Practice*, *18*, 413–420.

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 139–193). New York, NY: Wiley.

Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science*, *2*(1), 53–70. doi:10.1111/j.1745-6916.2007.00029.x

Lilienfeld, S. O., & Lambert, K. (2007). Brain stains, traumatic therapies can have long-lasting effects on mental health. *Scientific American Mind*, *18*, 46–53.

Norwood, A., & Murphy, C. (2012). What forms of abuse correlate with PTSD symptoms in partners of men being treated for intimate partner violence? *Psychological Trauma: Theory, Research, Practice, and Policy, 4*(6), 596–604.

Piper, A., & Merskey, H. (2004). The persistence of folly: A critical examination of dissociative identity disorder. Part I. The excesses of an improbable concept. *Canadian Journal of Psychiatry*, *49*, 592–600.

Steele, K., van der Hart, O., & Nijenhuis, E. R. S. (2001). Dependency in the treatment of complex posttraumatic stress disorder and dissociative disorders. *Journal of Trauma & Dissociation*, *2*(4), 79–116.

Tarrier, N., Pilgrim, H., Sommerfield, C., Fragher, B., Reynolds, M., Graham, E., & Barrowclough, C. (1999). A randomized trial of cognitive therapy and imaginal exposure in the treatment of chronic posttraumatic stress disorder. *Journal of Consulting & Clinical Psychology*, *67*(1), 13–18.

Trickett, P. K., Noll, J. G., & Putnam, F. W. (2011). The impact of sexual abuse on female development: Lessons from a multigenerational, longitudinal research study. *Development and Psychopathology*, *23*, 453–476.

Weathers, F. W., & Ford, J. (1996). Psychometric review of PTSD Checklist. In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 250–251). Lutherville, MD: Sidran Press.

Weathers, F. W., Litz, B. T., Huska, J. A., & Keane, T. M. (1994). *The PTSD Checklist—Civilian Version (PCL-C)*. Boston, MA: National Center for PTSD.

Whitfield, C. L., Anda, R. F., Dube, S. R., & Felitti, V. J. (2003). Violent childhood experiences and the risk of intimate partner violence in adults. *Journal of Interpersonal Violence*, *18*(2), 166–186.

Zittel Conklin, C., & Westen, D. (2005). Borderline personality disorder in clinical practice. *American Journal of Psychiatry*, *162*, 867–875.