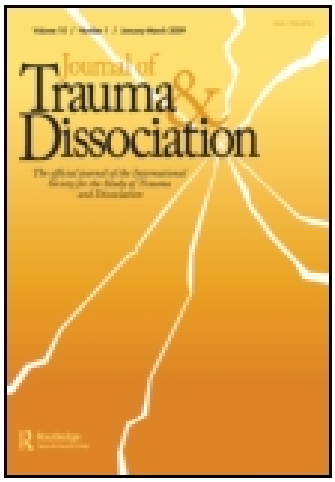

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The Treatment of Dissociative Identity Disorder with Cognitive Analytic Therapy: Experimental Evidence of Sudden Gains

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The Treatment of Dissociative Identity Disorder with Cognitive Analytic Therapy: Experimental Evidence of Sudden Gains

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ABSTRACT. The central aim of this study was to assess the effectiveness of cognitive analytic therapy (CAT) with a patient presenting with DID. The methodology employed an A/B single case experimental design with six-months continuous follow-up in seven experimental measures. A and B represent the assessment of seven dissociative experimental variables under two conditions: baseline (A) and treatment (B). Treatment consisted of 24 sessions of CAT with four follow-up sessions, which is standard within the CAT model for personality disorder patients. A battery of measures of general psychological functioning was also completed at assessment, termination, and follow-up. During treatment the intensity of a range of dissociative symptoms was observed to be reduced, with sudden gains evident due to specific CAT interventions in specific dissociative symptoms. The long-term effectiveness of the intervention was established by the illustration of either continued stability or continued improvement in experimental variables across the follow-up period. Analysis of the general measures illustrates clinically significant change across a variety of robust psychometric measures. The study illustrates the utility of single-case approaches with dissociative disorders and the potential for utilizing CAT generally with such presentations.

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Dissociation is typically recognized as presenting over a wide spectrum, varying from essentially normal cognitive processes to psychophysiological features of a wide range of mental health problems (Bernstein & Putnam, 1986; Fleiss, Gurland, & Goldberg, 1975). Dissociative Identity Disorder (DID; DSM-IV, American Psychiatric Association, 1994) is generally recognized as existing at the clinical extreme of the dissociative spectrum disorders, with multiple identities mirroring the polyfragmentation of personality structure (Braun, 1986, 1988; Fine, 1999; Kluft, 1991; Ross, 1996; Spiegel, 1993). The DSM-IV diagnostic criteria have been criticized for focusing on a narrow, and thus overly restrictive range, of dissociative symptoms, and in doing so ignoring the polysymptomatic presentations typical with DID patients (Coons & Chu, 2000). There appears a gender difference in terms of diagnosis that corresponds to the setting within which DID cases present, and an associated bias in the volume of research conducted. Females tend to outnumber males 10:1 in clinical settings, with these settings forming the context for the vast majority of the available literature (Putnam, Guroff, Silberman, Barban, & Post, 1986; Ross, Norton, & Wozney, 1987). Males outnumber females in forensic facilities (Bliss, 1986), with a lesser amount of corresponding research evidence available.

Despite its relatively lengthy tenure in the official diagnostic nosology, DID continues to be a diagnosis that can be greeted with varying degrees of skepticism and cynicism amongst mental health professionals (North, Ryall, Ricci, & Wetzel, 1993). There are essentially two contrasting clinical positions regarding DID. The first conceptualizes DID as an iatrogenic phenomenon that is shaped in vulnerable and suggestible patients by therapists (Mair, 1999; see Bliss 1988 for general discussion). The second formulates DID as the symptomatic expression of the effects of various childhood trauma(s), generally severe in type, imposed upon individuals who are often predisposed towards dissociative means of coping (Bliss, 1986; Braun, 1986; Goodwin, Cheeves, & Connell, 1988; Kluft, 1991; Loewenstein, 1994; Putnam, 1989, 1997; Ross, 1996; Spiegel, 1993; Steinberg, 1995). Within the trauma field, there is a broad consensus that recognizes DID as the adult symptomatic expression of a chronic and severe form of childhood onset post-traumatic disorder (Putnam & Loewenstein, 1993). The typical forms of childhood trauma reported in the histories of DID patients, such as

chronic sexual abuse (Kluft, 1985), may also occur in the context and setting of the conspicuous absence of benign early attachment relationships (Blizard, 1997, 2003; Liotti, 1992, 1999).

The most commonly cited treatment paradigm for DID is psychodynamically informed psychotherapy with the eclectic incorporation of other therapeutic techniques such as hypnotherapy (Putnam & Loewenstein 1993; Kluft & Fine, 1993). However, the DID treatment literature is impressively diverse in that it also contains examples of the usage of expressive therapies (Baum, 1991), group therapy (Coons & Bradley, 1985) behavior modification (Price & Hess, 1979), cognitive therapy (Fine, 1996), cognitive-behavior therapy (Caddy, 1985), art therapy (Engle, 1997) and family therapy with the contemporary family, not the family of origin (Sachs, Frischholtz, & Wood, 1988). There is a single published account of employing cognitive analytic therapy (CAT) with DID (Pollock, 2001), which falls into the traditional case study account of the therapy. Adjunctive pharmacotherapy, mainly for anxiety, affective, and post-traumatic stress disorder symptoms has also been advocated via antidepressants and benzodiazepines (Lowenstein, 1991; Torem, 1995). DID treatment guidelines are available which provide a synthesis position (International Society for the Study of Dissociation [ISSD], 1997).

In terms of the effectiveness of interventions provided for DID, there have been few systematic studies of treatment outcome. Randomized control trials are conspicuously absent from the DID outcome literature. Rather, the DID outcome literature consists largely of reviews of sizeable personal case series of patients (see Kluft, 1991 for an example), with attendant methodological limitations. The outcome literature can also be criticized methodologically for an overrepresentation of clinical case studies. Such "traditional" case studies have been criticized as being scientifically unsound and therefore prone to excessive levels of bias in reporting (Kazdin, 1981). Such reports could potentially add fuel to charges of iatrogenesis. Single case experimental design (SCED) blends the complexity of case description with scientifically focused methods of evaluation. Specifically, data is gathered serially across assessment baselines over specified treatment periods in conjunction with follow-up phases (Turpin, 2001). SCEDs provide therapists with objective means of demonstrating the symptomatic impact of phases of the intervention and the intervention as a whole (Bromley, 1986), through the minimization of threats to internal validity such as maturation, extraneous influences, and reactivity (Cook & Campbell, 1979). The flexibility inherent in the design of SCEDs in investigating complex clinical

phenomena such as chronic and gross dissociation is most appealing to clinicians wishing to enhance the accountability and transparency aspects of clinical practice (Morley, 1994).

This study presents the assessment, case description, treatment, and outcome of a patient presenting with DID. The methodology employed to examine effectiveness is that of a single case experimental design (SCED; Turpin, 2001). SCEDs are advocated as a scientifically based means of examining and describing case studies (Hilliard, 1993) and Turpin (2001) recommends the use of A/B designs in complex cases. The patient reported widespread and severe dissociative symptomatology, with such symptoms forming the experimental measures within the case (Morley, 1996). The methodology employed in the present case replicates the design employed by Kellett and Beail (1998), a methodology that has been identified as an example case that satisfies core design principles and hence represents good practice in SCED (Turpin, 2001). The general design criteria of SCED approaches are (1) stable extended baselines, (2) repeated measures, (3) single well-specified treatment, (4) reversibility, and (5) generalizability. The SCED used in this study met criterion 1 via a 35 day baseline (Barlow & Hersen, 1984; Huitema, 1985), criterion 2 via target measures being completed continuously across baseline, intervention and follow-up periods, and criterion 3 via a single well specified intervention (Ryle, 1991, 1997; Ryle & Kerr, 2002). Design criterion 4 (reversibility) was impossible to achieve due to ethical considerations (Long & Hollin, 1995; Hayes, 1981). Design criterion 5 (generalizability) was satisfied due to the case having population validity for DID cases and ecological validity due to the transparency of the methodology (Morley, 1989). However, the construct validity (Cook & Campbell, 1979) of the case is questionable due to a lack of similar interventions and methodologies for comparison.

The experimental hypotheses for the case were as follows:

1. CAT would reduce the intensity of the state dissociation experimental measures.
2. CAT would have beneficial effects on trait dissociation, personality structure, and general aspects of mental health.

METHOD

Measures of General Psychological Functioning

The patient completed a range of validated self-report measures of psychological functioning at initial assessment, termination of treat-

ment, and also at the final follow-up session. Measures were selected with three purposes in mind: firstly, assessment of general mental health, secondly, assessment of dissociative psychopathology, and thirdly, assessment of personality structure. Morley (1994) states that global measures of psychopathology are appropriate at such time points, as the measures aid in the assessment of the general impact of the intervention. As part of the general assessment of mental health the Brief Symptom Inventory (BSI; Derogatis, 1993; a screening tool for the presence of general psychiatric symptomatology), Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erlbaugh, 1961; a measure of the intensity of depressive symptoms), and the Inventory of Interpersonal Problems 32 (IIP-32; Barkham, Hardy, & Startup, 1994; an indicator of interpersonal dysfunction) were completed. Dissociative symptoms were assessed by completion of the Dissociative Experiences Scale (DES-II; Carlson, Putnam et al., 1993; a measure of the intensity of trait dissociation), and the State Scale of Dissociation (SSD; Kruger & Mace, 2002; a seven scale measure of state dissociation). The personality assessment was undertaken via the Personality Structure Questionnaire (PSQ; Pollock, Broadbent, Clarke, Dorrian, & Ryle, 2001; a measure of identity disturbance of personality).

In terms of the DES-II assessment score, a cut-off score of 30 and above is optimal for signaling patients experiencing severe levels of dissociation (Carlson & Putnam, 1993), although the DES-II is not considered to be a diagnostic instrument. The patient scored 51.78 on the DES-II, providing evidence of the presence of clinically relevant dissociative symptomatology. Analysis of the DES-T (that utilizes eight questions from the DES that are most closely identified with a taxon (class) of individuals who demonstrate pathological dissociation) (Waller, Putnam, & Carlson, 1996) revealed a score of 51.25, thus placing the score in the pathological dissociative class. The patient met the NIMH research criteria for DID (Loewenstein & Putnam, 1990).

Experimental Measures

Due to complexity of the case, it was decided to initiate a SCED. This comprised an A/B multiple baseline time series design with six-month continual follow-up. A and B represent the recording of a series of daily observations under two conditions: baseline assessment (A) and treatment (B). Experimental data were collected continuously throughout the baseline, treatment, and the six-month follow-up periods. Such continuous assessment across phases strengthens the internal validity of the

methodology (Kazdin, 1981). "Multiple baseline" refers to the measurement of different experimental variables within the single case (Bilsbury & Morley, 1979), in the current case referring to symptoms of state dissociation. The effectiveness of the intervention phase (B) is judged via the extent to which the experimental variables shift when the intervention is introduced, and by whether any positive changes in such variables remain sustained throughout the intervention. Due to CAT having distinct phases of treatment (see intervention section for description), it was possible to objectively assess the patient's responsiveness to treatment phase change. The outcome of phase changes during treatment has not been previously objectively examined in the DID literature. The design of the current study enabled assessment of the degree to which responsiveness to phase changes were also sustained across the six-month follow-up period. The collection of experimental variables throughout an extended follow-up period is unusual in SCED practice (Kazdin, 1981), but facilitated a more thorough analysis of potential relapse in the current case.

Kellett and Beail (1997) noted, "The close alignment of clinician and client on the design and rationale for single-case approaches, can in itself be an active and authentic aspect of therapeutic process" (p. 48). After the patient had completed the initial psychometrics, representative high-scoring individual items from the SSD (Kruger & Mace, 2002) were selected, which were reported to be a good reflection of typical and commonly experienced dissociative symptoms. Six representative items were selected from the SSD scales, with the hypermnesia scale not represented due to the patient stating that no particular item had sufficiently high face validity. The six target measures of state dissociation were as follows (1) derealization ("Right now things around me seem unreal or dreamlike"), (2) depersonalization ("Right now my body feels disconnected from my thoughts, my feelings, myself"), (3) identity confusion ("I do not feel like a whole person right now"), (4) identity alteration ("Right now we are more than one person looking at this statement"), (5) conversion ("I am feeling immobile like a statue, whilst being aware of what is going on around me"), and (6) amnesia ("I am forgetting what I want to do or say"). The patient also completed a frequency count of perceived identity shifts in executive control during each day.

Data were collected for a five-week (i.e., 35 day) period of the baseline assessment (A), for twenty-five weeks (i.e., 175 days) during intervention (B), and for twenty-four weeks (i.e., 168 days) for the follow-up period. Data was therefore collected for 378 continuous days. The num-

ber of observations in the baseline satisfied requirements for adequate baseline duration (Barlow & Hersen, 1984; Huitema, 1985). Four sessions were completed during the follow-up period, initially three sessions one month apart and a final follow-up session three months after the third follow-up session. This form of structured and extended follow-up is consistent with CAT practice for personality disorder presentations (Ryle, 1997).

Rationale and Ethics for CAT Intervention

The ISSD (1997) treatment guidelines state that integration is the primary and over-arching goal of any psychotherapeutic intervention with DID, and suggest that the typical treatment length for psychotherapeutic interventions with complex cases is three to six years of bi-weekly appointments. The fact that CAT is explicitly a short-term focal psychotherapy, it therefore needed to be ethically considered as an appropriate form of intervention in this case. The case supporting the use of CAT in this case were as follows (a) the patient had already received long-term psychoanalytic psychotherapy, with little reported progress with dissociative difficulties, (b) the patient was offered CAT and provided informed consent to participate regarding the treatment contract, and (c) CAT theory regarding trauma, dissociation, and personality organization is available (Ryle, 1997; Pollock, 2001; Ryle & Kerr, 2002) and was directly transferable to the current case.

Intervention: Theory and Practice

The Multiple Self States Model (MSSM) in CAT was specifically developed in order to aid case conceptualization of patients in chronic and enduring psychological distress where dissociation is evident. The MSSM is particularly useful in formulating DID presentations, as the model rests on the assumption that distress is created by the operation of dissociated self-states and associated state-switching containing a limited range of contrasting role patterns (Ryle, 1997). The patient at assessment is encouraged to name and characterize key self-states such as those that are abandoning, abusing, or contemptuous, with assessment prompts available to elicit such information (Ryle, 1995). All self-states are considered equally important aspects of self. Clinically, the whole is championed, as to respond to and chart single self-states with a DID patient would reinforce separateness and dissociation. The MSSM contains descriptions of three levels of identity disturbance (Pollock et al.,

2001). Level one contains reciprocal role procedures (RRPs), which are the basic unit of analysis in CAT. An RRP is essentially a relational element that contains the internalization and expression of self-other interactions learnt during the developmental years. Each role (e.g., neglecting) has a reciprocal (e.g., neglected) with the patient expressing such roles in adult life in relation to self-management and/or social interactions in a stereotyped and over-restrictive manner. At level two, metaprocedures organize the deployment and mobilization of task and/or socially appropriate RRPs. Should the patient fail to develop appropriate metaprocedures, the self is experienced as fragmented, discontinuous and, at times, contradictory thus creating the proliferation of discrete and distinct self-states. The explicit psychological function of metaprocedures is that of connection. The patient lacking in metaprocedures remains prone to shifting rapidly between self-states according to context and specific stressors, with an associated sense of incoherence. These dissociative shifts between self-states represent discontinuities between memory, affect and behavior between separate self-states. Repetitive experiences of abuse make individuals more vulnerable to dissociation, thus heightening fragmentation. Retraumatization evoked by memories or situations reminiscent of the abuse can produce major dissociative amnesic episodes. At level three, the patient's abilities to reflect on and observe the self is limited, with an associated lack of comprehension and ability to learn to prevent stereotyped negative outcomes. There is a discontinuity of experience and memory. For example, in certain self-states, the patient may be acutely aware of their own suffering or that of others, but this capacity is lost when either circumstance or intrapsychic events provoke state-switching. A specific objective of a CAT intervention with patients with identity disturbance is to facilitate integration of previously fragmented self-states, by reducing the influence of dissociative processes and symptomatology.

CAT is a structured time-limited focused psychotherapy. Patients with personality disturbance receive twenty-four weekly sessions and four sessions of follow-up, with the follow-up sessions spread over a six-month period (Ryle, 1991). CAT has a number of specific tools that demarcate it from other psychotherapies and represent the "active" components of treatment. After a period of three assessment sessions, the patient receives a narrative reformulation of their difficulties. This is in the form of a letter that is read to the patient, reformulating the origins of their distress and stating target problems and associated processes and symptoms. The clear statement of problems, processes, and symptoms signals to the patient that CAT is concerned with the recurrent dys-

functional functioning that maintain poor mental health for the patient. In the current case the reformulation letter focused on the early and repeated traumas in the patient's attachment record, and the associated fragmentation of personality structure maintained in the present day via dissociative processes and symptoms. The letter was presented to the patient at week 5. The next stage of a CAT intervention is the construction of a sequential diagrammatic reformulation (SDR); in the current case, the SDR was explicitly based on the MSSM (Ryle, 1997). The SDR is constructed over a series of sessions, but completed with the patient at session 10 (week 12 of contact with the patient). The SDR has a variety of purposes including creating greater reflective capacity in the patient, managing transference in the sessions and labeling exits for the self-states more productive to mental health. At the termination of CAT, both patient and therapist write a "goodbye letter." The function of the letter from the therapist is to summarize achievements made in the therapy, key insights, and to signal challenges that appear to lie ahead for the patient. The goodbye letter also forms a means of acknowledging and managing strong abandonment reactions that can be aroused at the termination of therapy, which are predictable in patients with complex psychological needs, particularly those with borderline personality disorder (Ryle, 1997).

Assessment Details

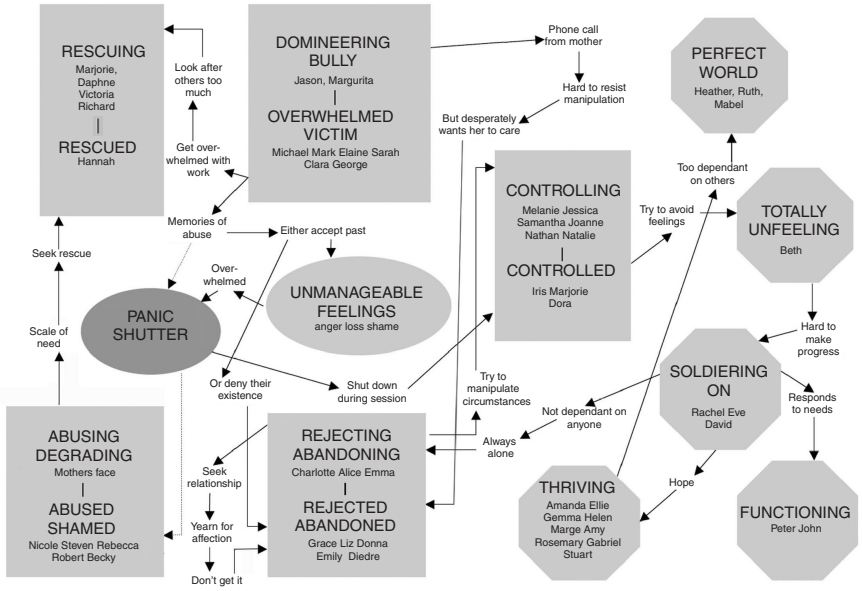
The aim of the following section is to describe the assessment details in terms of self-states identified, and to link such details to the SDR produced in this case (see Diagram 1). Molly (pseudonym) stated that she came from a nuclear family and that she was the youngest child of four children (one elder brother and two elder sisters). She described the presence of gross and persistent early attachment difficulties in that the parenting style of both parents was generally cold, rejecting, and uncaring. This was reflected in the SDR as evidence of a rejecting/abandoning to rejected/abandoned self-state. Parents were described to be either in verbally aggressive conflict or locked in a cold interpersonally distancing stance, with the home psychological climate being defined by variations between cold, ambivalent apathy or awareness of frightening, aggressive conflict. Molly stated that her father "hated" all women and was a closet bisexual whom eventually died of neurosyphilis and hepatitis. Molly described a belief that her mother had systematically physically abused her throughout her childhood by means of methods such as secretly poisoning her food, drugging her, and practicing some

form of "voodoo." Molly could not describe or recall any physical gestures of affection being shown towards her from either parent. Her mother was described as contrarily showering physical and emotional affection on two of the children, whist consistently rejecting Molly and another sister. The family was described as typically suppressing any affective responses to non-conflict situations, with interactions and transactions being typically intellectual in content. Molly stated that she effectively became, in her words, a "wallpaper child," whom adaptively learnt early in her life to blend into the family background suppressing any impulses/affect/needs, whilst remaining hypervigilance for any interpersonal or physical threats. The tendency to suppress all feeling type reactions and impulses was summarized by an unfeeling state on the SDR. Should Molly not be totally cut-off from feelings then she tended to be overwhelmed by intense and unmanageable feelings. She had developed a coping response (see SDR) of a "panic shutter" that tended to snap shut at the hint of distressing emotions or interpersonal threat. Molly stated that she had used the panic shutter to negotiate previous therapeutic relationships and had employed it in a means of keeping all interactions strictly cognitive in origin and therefore "safe."

Molly reported that from the age of five she was subjected to sexual abuse that she claimed contained a ritual component. She stated that she was sexually abused by both grandparents on her mother's side, and grandfather and father on the other side of her family. She reported being abused in the context by a highly organized pedophile ring via ritualized forms of abuse. She provided memories of seeing animals being killed after sexual acts had been committed against them and also forced human abortions. This recorded on the SDR in the form of an abusing/degrading to abused/shamed self-state, which was also used to reflect the behavior of her mother towards her.

Molly began to experience psychological problems early in her life. She began obsessional counting and other rituals from the age of five after a vomiting incident, and reported a three-month period muteness following a visit to the maternal grandparents around the age of thirteen. Molly was diagnosed with gastric problems at age ten, which her mother consistently attempted to disprove by frequently secreting trigger foods into her diet, producing a variety of unpleasant physical reactions. Due to the presence of extensive agoraphobia as a teenager, Molly frequently failed to attend school. Across her lifecycle, she complained of long standing phobias and obsessive-compulsive symptoms in relation to food, vomiting, dirt, and contamination issues in general. She described feeling dirty all of her life. General OCD issues were summa-

DIAGRAM 1. Multiple Self-States Sequential Diagrammatic Reformulation (SDR)



rized on the SDR via a controlling to controlled self-state. Molly had a history of deliberate self-harm in her twenties, but denied any aspects of deliberate self-harm from that point. She stated, however, that she had rarely been free from suicidal ideation.

In terms of relationships, Molly described having three prior relationships with male partners. She described that all the relationships contained the consistent theme of abusive controlling aspects to partners' behaviors. Molly reported yearning for a fulfilling non-abusive relationship, but acknowledged that she had little idea how to maintain such a relationship due to deep fears regarding dependence, commitment, and sexual activity. In past relationships she acknowledged that she had tolerated sexual activities via dissociation and shifts in executive control. Such difficulties were summarized as a domineering bully to overwhelmed victim self-state on the SDR. Molly tended to grimly proceed through life without apparent respite from emotional suffering represented in the SDR as "soldiering on." Her only relief from soldiering on was in fantasy as she assumed that all was well in her world and that she was living a full and satisfied life, represented in the SDR as the "perfect world" state.

In terms of previous contact with mental health providers, Molly had been a service-user since her teens. She had seen a child guidance counselor at age 13 and attended an outpatient eating disorder unit at age 17. At age 19 she sought treatment with a medical hypnotist, but reported being sexually abused during treatment. She was treated as an inpatient at a behavioral unit for five months due to vomit phobia at age 21. Molly had completed two lengthy individual treatment contracts with clinical psychologists and had attended two groups for survivors of sexual abuse. Prior to the present referral due to relocating, Molly had been receiving weekly psychoanalytic psychotherapy for a period of four years, during which the psychoanalyst had identified DID processes. Her attitude towards seeking help and also her inability not to offer help to others was summarized by a rescuing to rescued self-state. Molly acknowledged when she had coped well with a difficult situation, or needed to display some form of skill or competence, then such "tasks" would be frequently undertaken by dissociated identities. These processes were summarized as thriving and functioning states on the SDR, emphasized as separate and therefore not contributing to her sense of wholeness.

Clinical Evidence to Support the Diagnosis

The aim of the following section is to provide additional evidence as to the chronicity and prevalence of dissociative symptoms, which in turn supports the validity of the DID diagnosis. The clinical information is organized according to Dell's (2001) suggested criteria for assessment of dissociative disorders.

Evidence of Pervasive Dissociative Functioning

Molly's description of events and occurrences across childhood, adolescence, and distal and/or proximal adult life displayed a consistent inability to recall episodic and autobiographical memories. Attempts at clarification of episodic details in sessions often resulted in failure, due to her inability to recall. In terms of depersonalization, Molly reported recurrent and persistent disruptions in her sense of the relationship between her mind and body. She stated that her mind could not operate in executive control at all times. Her experience of herself was one of housing a variety of separate selves, rather than being a single, unitary and integrated self. In the home, she reported often feeling confused as to why she was in certain rooms in the house with little knowledge of

how she had actually got there, with her environment subsequently seeming unfamiliar, strange, and threatening (derealization). Dissociative flashbacks were typically reported to contain vivid, visceral re-experiencing of the childhood sexual abuse. Molly reported that should she spend time on her own (which was common due to avoidance of social situations), then she often lost track of the passage of time. She reported tending to sit for hours on end, without being able to register the passage of time and feeling surprised and dysphoric when she recognized that a significant time lapse had actually occurred. Trance states of up to three hours were reported. Protracted silences in sessions were closely monitored to assess for the presence of unhelpful trance states.

Evidence of the Partial Dissociated Influence of Self-States

Molly was well aware of the presence of long-standing and extensive internal dialogues both between dissociated identities and between such identities and herself. She stated being aware of hearing child voices at times. During sessions, she was able to describe the content of such dialogue and opinions/reactions to therapeutic endeavors such as the narrative reformulation. In sessions, Molly would often report a sense of distance from her own voice and would often be anxious as to whether her voice sounded distorted. She reported rarely feeling in executive control of her own cognition. Molly was able to report on therapeutic endeavors being sabotaged by identities who had the role of "controlling protector," due to her thoughts being interrupted by alters with alternative advice. Molly reported a chronic sense of low self-efficacy in terms of abilities to control her own behavior. She described a sense of her behavior being prone to varied and separate internal influence and control. She described chronic fragility to her mood structure, whereby she experienced incredulity about many of her perceptions, reactions, and feelings. Molly, throughout the early and middle stages of the therapy, described a complete sense of incomprehension regarding her identity and associated core values, beliefs, and schemas.

Evidence of Fully Dissociated Self-States

Molly reported a reoccurring sense of surprise, and associated subsequent confusion, when she "discovered" evidence or was told by others that she completed or had engaged in certain tasks for which she had no recall. Molly was able to provide the names, functions, roles, and pref-

erences for 53 dissociated identities (40 female alters and 13 male alters). She stated that such identities had been assuming executive control since her early childhood. Phenomenological research has illustrated that the median number of identities in cases of DID varies between eight (Ross, 1996) and nine (Putnam et al., 1986). Molly would therefore be considered a poly-fragmented case of DID.

Intervention: Theoretical Innovations and Comparison to Similar DID Treatment Models

As previously stated, the provision of CAT with personality disordered patients rests on the theoretical keystone of early trauma(s) creating the conditions, via dissociation, for the creation of separate self-states. Behavior, affects, and interactions will be determined by the operation of one of the self-states, with amnesia evident between the self-states creating tendencies for disjointed rapid shifts in moods and presentations and a poor associated sense of identity. The procedures generated by these discrete self-states are clearly mapped on the SDR in Diagram 1. In the Pollock (2001) DID case, it was recognized that amnesia can occur not only between the self-states, but also, crucially, between the reciprocal roles of a self-state. The current case extends this theoretical insight to state that the dissociated identities observed in DID are conceptualized as an expression of one pole of the reciprocal role being dissociated within the reciprocal role from the other pole. For example, in the current case, the identity "Jason," reflecting a bullying role, was dissociated from the identity "Mark," reflecting a passive over-whelmed victim role (see Diagram 1). The naming and specifying of dissociated identities with specific roles dissociated from reciprocally specific identities and roles created an SDR that reflected the patient's multiplicity, but served to anchor the previously dissociated fragmentation within a coherent theoretical whole.

The DID treatment model most akin to the CAT approach appears that of Fine's (1993, 1996, 1999) tactical-integration model (TIM) and, in particular, the technique of "mapping" the dissociated identities. Mapping in TIM entails placing the patient's name in the center of a page with dissociated identities placed on the page in relation to similarities and differences to each other, in order to produce distinct groupings. Mapping is stated to be the first unifying step of the treatment (Fine, 1999). Although the TIM and CAT models share some similarities in terms of diagrammatic representation, it is apparent that the SDR method differs critically in terms of the inclusion on the map of recipro-

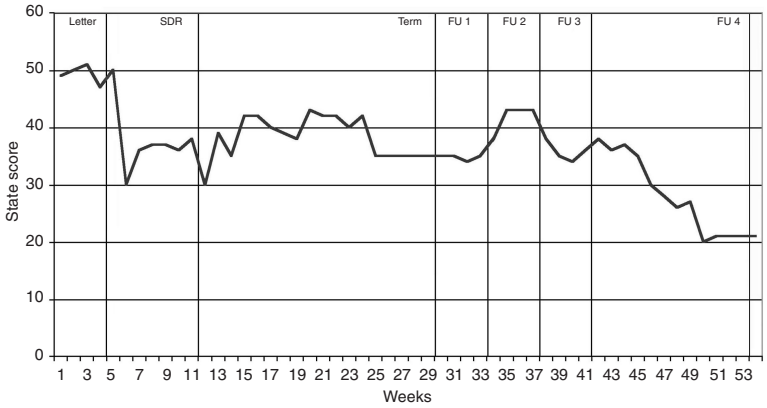
cal roles, self-states, and procedures that provide linkages between self-states, (see Diagram 1). The SDR is also used reflexively during subsequent treatment sessions as a means of anticipating and managing transferential material (Ryle, 1997) in a manner not evident in the TIM.

RESULTS

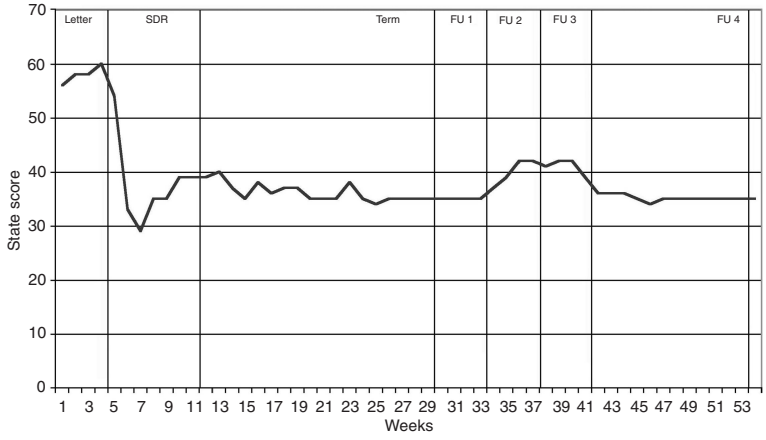
The study hypotheses were addressed in three ways: (1) the effect of the intervention on state dissociation via examination of the experimental measures, (2) the effect of the intervention on the identity shift frequency experimental variable, and (3) the effectiveness of the intervention on general mental health, state/trait dissociation, and personality structure via psychometric evaluation. In terms of the first objective, the intervention appears to result in a reduction in the intensity of state dissociation across the intervention as measured by the experimental variables. The experimental measures are reported in Graphs 1, 2, and 3. For ease of interpretation, each experimental measure has been summarized into a total weekly score. Due to considerations of space only the depersonalization, identity confusion, and identity alteration graphs are included as examples.

The data indicates a general pattern of reductions in state dissociation over the duration of the intervention. All state dissociation scores indicate that reductions accrued during the intervention were maintained, and in some cases augmented (e.g., depersonalization) across the fol-

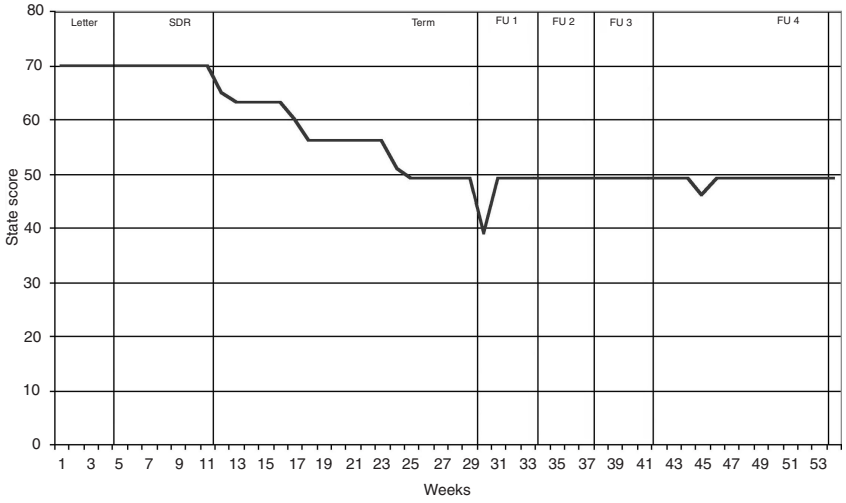
GRAPH 1. State Depersonalization Scores



GRAPH 2. State Identity Confusion Scores



GRAPH 3. Identity Alteration Scores



low-up period. There is evidence of "sudden gains" in terms of reductions in depersonalization and identity confusion due to the effect of the reformulation letter. The identity alteration experimental measure appeared immune to the effect of the reformulation letter, yet illustrated sudden gains due to the SDR (see Graph 3). It is important to note that the deterioration in state dissociation observed in the middle of the fol-

low-up phase (weeks 36 to 39 on Graphs 1 and 2) were due to the death of the patient's mother.

Graph 4 describes the effect of the intervention on the frequency of identity shifts experimental variable, measured throughout the three phases. Again, data is summarized into a total weekly score for ease of interpretation. There is strong evidence that the number of identity shifts perceived by the patient increased across both the intervention and follow-up periods, illustrating that the patient was less dissociated for, and correspondingly more aware of, switches in executive control.

General measures of psychological functioning were employed to illustrate the impact of the intervention phase upon state/trait dissociation, global distress, and personality integration. The scores on the measures are summarized in Table 1. As a number of the measures have been psychometrically validated, it was possible to assess clinical significance using Jacobson's Reliable Change Index (RCI; Jacobson & Truax, 1991). The RCI determines whether recorded change in a measure as a result of intervention is greater than the change that would be expected due to measurement error. Scores greater than 1.96 on the RCI indicate that clinically meaningful and significant change has occurred during the course of the intervention (Jacobson & Truax, 1991). In Table 1, the individual psychometric scale scores are presented under the columns titled assessment, termination, and follow-up, with RCI 1 representing the assessment of clinical change between assessment and termination and RCI 2 a mirror analysis of change analysis between termination and final follow-up. It was impossible to apply the RCI to

GRAPH 4. Frequency Count of Identity Awareness

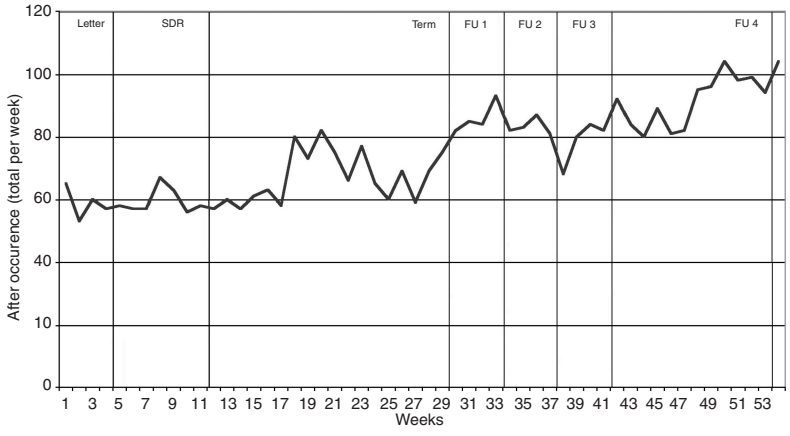


TABLE 1. Psychometric Evaluation of General Measures

	Assessment mean	Termination	RCI 1	Follow-up	RCI 2
Personality Structure Questionnaire	37	23	2.60*	19	0.74
Dissociative Experiences Scale	51.78	28.57	1.94	22.50	0.53
State Dissociation Scale	4.51	2.12	N/A	1.32	N/A
Derealization (SDS)	7.25	2.87	N/A	2.37	N/A
Depersonalization (SDS)	7.00	3.00	N/A	1.75	N/A
Identity Confusion (SDS)	7.00	4.00	N/A	1.87	N/A
Identity Alteration (SDS)	4.12	2.37	N/A	1.37	N/A
Conversion (SDS)	3.50	1.12	N/A	0.62	N/A
Amnesia (SDS)	1.33	0.66	N/A	0.16	N/A
Hypermnesia (SDS)	1.40	0.80	N/A	0.40	N/A
BDI	48	6	12.13*	6	0.00
Somatization (BSI)	2.57	1.14	3.66*	0.86	0.71
Obsessive Compulsive (BSI)	2.50	1.14	2.77*	0.86	0.57
Interpersonal Sensitivity (BSI)	3.00	0.50	5.00*	1.33	−1.66
Depression (BSI)	2.83	0.83	3.63*	0.83	0.00
Anxiety (BSI)	3.33	1.33	3.63*	1.17	0.29
Hostility (BSI)	2.20	0.20	3.33*	0.20	0.00
Phobic Anxiety (BSI)	3.20	1.40	5.14*	1.40	0.00
Paranoid Ideation (BSI)	2.40	0.60	3.75*	0.60	0.00
Psychoticism (BSI)	2.80	1.00	4.61*	0.80	0.51
Global Severity Index	2.81	0.94	N/A	0.94	N/A
Positive Symptom Distress Index	2.81	1.35	N/A	1.28	N/A
Positive Symptom Total	53	37	N/A	39	N/A
IIP-32 Scales	1.75	0.72	N/A	0.71	N/A
HTB Assertive	1.25	0.50	0.69	0.75	−0.23
HTB Sociable	3.00	1.25	1.68	1.25	0.00
HTB Supportive	1.75	0.25	1.87	0.50	−0.31
HTB Involved	1.75	0.50	1.64	0.25	0.32
Too Caring	1.50	0.75	0.91	0.60	0.18
Too Aggressive	1.00	0.75	0.37	0.75	0.00
Too Open	0.25	1.00	−0.93	0.50	0.62
Too Dependant	1.50	0.75	0.97	0.75	0.00

*RCI > 1.96; clinically significant change

the State Scale of Dissociation Scores (SDS; Kruger & Mace, 2002) due to the measure being a state rather than trait index and therefore the required test-retest reliability information was not available to calculate the RCI. Similarly, the GSI, PSDI, and PST of the BSI (Derogatis, 1993), full IIP-32 (Barkham et al., 1996), and the DES-T (Waller, Putnam, & Carlson, 1996) test-retest reliability analyses aren't reported in test manuals, therefore ruling out RCI calculations in the current case.

Due to the nature of the case, the PSQ score is of particular interest. The results indicate a marked and clinically significant reduction in sense of fragmentation between assessment and termination of treatment, indicating some degree of perception of integration of personality structure. Further, but not clinically significant, reductions in the PSQ were observed between termination and follow-up. The SDS and DES-II scores would suggest a general reduction in state and trait dissociative tendencies due to treatment. Despite the RCI for the DES-II between assessment and termination being only close to clinical significance, both the termination and follow-up scores were below the cut-off point for identifying severe levels of dissociation on the DES-II, illustrating the presence of a category shift on the measure. The DES-T items (Waller et al., 1996) fell from 51.25 at assessment to 28.75 and 22.50 at termination and follow-up, respectively, indicating reductions in core trait dissociative symptoms. The BDI results indicate that the depression total score was reduced by 42 points over the course of the intervention. This represents clinically significant change. The absence of depressive symptomatology was maintained at follow-up. All nine primary symptom scales of the BSI were significantly reduced over the course of the intervention, but no further clinically significant change was recorded between termination and follow-up. No clinically significant change was observed in the IIP-32. The IIP-32 measure indicated the least amount of change in comparison to the other psychometrics employed. The psychometric picture is one of clinically significant reductions in dissociation and associated degree of personality integration due to treatment, with neither further improvement nor deterioration in such variables at follow-up.

DISCUSSION

The data provide support for the original hypotheses. The first hypothesis stated that the CAT intervention would reduce the intensity of state dissociation. Graphs 1, 2, and 3 illustrate marked reductions in experimental measures of state dissociation over the course of treatment.

Sudden gains are evident due to the reformulation and SDR, with such marked changes being unlikely to result from repeat testing or changes in the instrument (Kazdin, 1981). Due to the stability of baselines, the immediacy and magnitude of phase change illustrated in experimental variables appears valid and attributable to treatment effects (Hayes, 1981). It is interesting to note that such reductions in state dissociation were maintained over the follow-up period, and in the depersonalization measure were further enhanced across the follow-up period. This would indicate that the patient was continuing to use the tools of the CAT intervention following completion of the intervention phase, resulting in further reductions in state dissociation. Indeed, the patient reported frequently using the SDR as a means of self-reflection and symptom management. In terms of the frequency count of the number of shifts to identity awareness (Graph 4), following a stable baseline period, a consistent pattern appears of a gradual increase in the number of identity shifts perceived across intervention and follow-up. This result would suggest that the patient was more aware of identity shifts due to the intervention, due to associated reductions to the previous amnesic barriers existing between and within self-states.

The second hypothesis stated that the intervention would have a positive effect on co-morbid mental health issues via analyses of the general measures of psychological functioning. The PSQ results indicate that the intervention had some degree of success in terms of integration of the previously highly fragmented personality. Follow-up data on the PSQ would indicate that integration efforts were active and on-going during the follow-up period, but not of sufficient pace to merit clinically significant change. This would suggest that effective efforts to integrate can occur and continue post-therapy for some DID patients. Choe and Kluft (1995) have illustrated that the DES is suitable as an indicator of therapeutic outcome in DID. The general levels of trait dissociation measured via the DES-II were shown to be reduced due to treatment, with the patient being below the cut-off point for identifying severe levels of dissociation following treatment, and with no relapse at follow-up (nor further reduction). Clinically, it is important to note that the patient retained the diagnosis of DID despite the effects of the intervention. CAT, however, does not market itself as a "cure" for mental distress, but rather an effective means of increasing patients' abilities to employ more effective models of self-care, via the development of more positive RRPs. The patient, in her "goodbye" letter, described the experience of treatment as enabling the first steps towards integration to take place. The SDS scores would indicate general reductions in state disso-

ciation due to the intervention across the scales. Levels of depression and general psychiatric symptomatology were all illustrated to improve with no relapse at follow-up (nor further improvement). The IIP-32 results did not illustrate clinically significant change due to the intervention although scores were reduced. The original test-retest results for the IIP-32 are worryingly low, which may account for the lack of significant RCIs in the current analysis.

An issue of concern in relation to the outcome data relates to whether the positive effects of the intervention illustrated were produced by the CAT tools or whether symptom reduction was alternatively produced by non-specific therapeutic factors. Warmth, empathy, and respect have been previously stressed as the core ingredients of conducting psychotherapy with DID (Kluft, 1993). Examination of the graphs indicates key turning points in the data: the narrative reformulation and the introduction of the SDR. Evidence of such sudden gains at the introduction of an intervention in previously stable data would indicate that effects were produced by the introduction of the change–in the current context, the CAT tools (Bromley, 1986). However, clinically it appears that such tools can only be effective in the context of a "good enough" therapeutic relationship; the therapeutic relationship in CAT has been hypothesized to "activate" the tools of the therapy (Kellett, 2004). It is impossible to disentangle and specify precisely the factors that caused the sudden gains, but they seem likely to be the CAT tools in the context of a secure therapeutic base.

A methodological issue in the current study is the reliability of the experimental measures. In terms of the six measures of state dissociation employed, the fact that the measures were taken directly from the SDS, which has proven reliability, would suggest that the experimental measures have sufficient reliability. The measure of identity shift frequency is difficult to assess in terms of reliability, due to the degree of amnesia that is evident in DID cases. Graph 4 would suggest that the patient was less amnesic for identity shifts due to the intervention, which is indicative of progress. The fact that all data was self-reported represents another methodological limitation, with the possibility that the patient provided data that kowtowed to "experimental demand" (Hersen, 1978). However, if this were the case, the patient would have provided experimental data that represented a blanket positive response both to the narrative reformulation and the SDR. The fact that different dissociative symptoms were observed to respond differentially to the various phases of the intervention lessens the likelihood that the patient was merely attempting to please/placate. The caution regarding the over-interpreta-

tion of the experimental measures also applies to the general measures of psychological functioning. Choe and Kluft (1995) counsel caution in interpreting changes in DES scores, with the recognition that self-reported reductions on such scores may not actually be an accurate reflection of treatment effects, but rather attempts to gratify therapists.

Future experimental designs would benefit from triangulated multiple baseline data that draw on self-report, reports from significant others, and also clinician ratings in order to increase the validity of any self-reported therapeutic improvements. The current methodology, while an improvement to the traditional case study approach in DID, has not achieved "gold standard" levels of possible objectivity. Although the current case benefited from the collection of data across a lengthy follow-up period, with such an approach highly unusual in SCED, a methodological issue is the timing of the final follow-up session. Although it would have been beneficial to have another follow-up session, for example, eighteen months after the actual final follow-up conducted, such an approach would not be consistent with the CAT model. Such work with personality disordered patients places great emphasis on termination issues as an active component of the therapy, due to its short-term nature within a strict 24 plus 4 session framework (Ryle, 1997).

Jacobson and Traux (1991) state that that clinical, rather than statistical significance, should be the criterion for meaningful change during SCEDs. Clinically significant change represents the experience of major benefit by the patient, not the slight (but possible significant) shifting of data points on graphs. It is obvious in the current study that the patient did not achieve integration, the ultimate goal of psychotherapeutic endeavors with DID patients. Nevertheless, the patient reported benefiting greatly from the intervention in terms of insight, decreased sense of fragmentation, and increased abilities to self manage. This resulted in an increased capacity to work, less self-sacrificing, a wider general behavioral repertoire, and reduced obsessive-compulsive symptomatology. Molly stated that to see the SDR and to observe the constituent previously fragmented parts of her personality contained on one page had in itself an authentic, active, and integrative effect. This observation is born out in the data described in Graph 3, with a sudden gain in terms of the self-state alteration score due to the completion of the SDR. It was interesting to observe that the goodbye letters written by both patient and therapist for the final treatment session contained highly similar themes, content, and structure, enhancing the already strong perception the patient felt understood and accepted. Molly noted in her goodbye letter that being able to describe her sense of characterological

shame with another person had helped to reduce feelings of self-loathing, and as a result she had developed a more compassionate mind. The apparent usefulness of the CAT conducted did appear somewhat reliant on previous extensive treatment in other modalities and broad self-recognition of fragmentation, possibly enabling the patient to make maximal usage of the short-term CAT approach (Kellett, 2004).

This SCED, in conclusion, has illustrated the effectiveness of CAT with a case of apparently poly-fragmented DID. The experimental design has highlighted that differing CAT tools appear to have differing effects on various dissociative symptoms. The general quality of the evidence in terms of treatment outcome in DID could be improved by the increased application of such small n or $n = 1$ experimentally based evaluation methodologies. SCEDs may provide a valuable avenue of evaluation for DID treatment outcomes due to the complexities of designing methodologically adequately controlled, sufficiently statistically powered, group-based experimental designs. SCED approaches can be effectively dovetailed with "everyday" clinical endeavors, thus encouraging and facilitating wide-ranging data collection regarding DID treatments across clinical and forensic settings.

REFERENCES

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders, fourth edition.* Washington, DC: Author.

Barkham, M., Hardy, G.E., & Startup, M. (1994). The IIP-32: A short version of the inventory of interpersonal problems. *British Journal of Clinical Psychology*, *35*, 21-35.

Barlow, D.H., & Hersen, M. (1984). *Single case experimental design* (2nd ed.). New York: Pergamon Press.

Baum, E.Z. (1991). Movement therapy with multiple personality patients. *Dissociation*, *4*, 99-104.

Beck, A.T., Ward, C.H., Mendelson, M., Mock, J., & Erlbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, *4*, 561-571.

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

Bilsbury, C.D., & Morley, S. (1979). Obsessional slowness; a meticulous replication. *Behaviour Research and Therapy*, *17*, 405-408.

Bliss, E.L. (1986). *Multiple personalities, allied disorders and hypnosis*. New York: Oxford University Press.

Bliss, E.L. (1988). Professional skepticism about multiple personality. *Journal of Nervous and Mental Disease*, *176*, 533-534.

Blizard, R.A. (1997). The origins of dissociative identity disorder from an object relations and attachment theory perspective. *Dissociation*, *10*, 223-229.
Blizard, R.A. (2003). Disorganized attachment, development of dissociated self-states and a relational approach to treatment. *Journal of Trauma & Dissociation*, *4*, 27-50.
Braun, B.G. (1986). *Treatment of multiple personality disorder*. Washington DC: American Psychiatric Press.
Braun, B.G. (1988). The BASK (behavior, affect, sensation, knowledge) model of dissociation. *Dissociation*, *1*, 4.
Bromley, D.R. (1986). *The case study method in psychology and related disciplines*. Chichester, UK: Wiley.
Caddy, G.R. (1985). Cognitive behavior therapy in the treatment of multiple personality. *Behavior Modification*, *9*, 267-292.
Carlson, E., Putnam, F., Ross, C., Torem, M., Coons, P., Dill, D., Loewenstein, R., & Braun, B. (1993). Validity of the DES in screening for multiple personality disorder: A multi-center study. *American Journal of Psychiatry*, *150*, 1030-1036.
Carlson, E., & Putnam, F.W. (1993). An update on the dissociative experiences scale. *Dissociation*, *6*, 16-27.
Choe, B.M., & Kluft, R.P. (1995). The use of the DES in studying treatment outcome with DID: A pilot study. *Dissociation*, *8*, 160-164.
Cook, T.D., & Campbell, D.T. (1979). *Quasi-experimentation: Design and analytical issues in field settings*. Chicago: Rand-McNally.
Coons, P.M., & Bradley, K. (1985). Group psychotherapy with multiple personality patients. *Journal of Nervous and Mental Disease*, *173*, 515-521.
Coons, P.M., & Chu, J. (2000). Psychiatrists' attitudes toward dissociative disorder diagnoses. *American Journal of Psychiatry*, *157*, 1179-1180.
Dell, P. (2001). Why the diagnostic criteria for dissociative identity disorder should be changed. *Journal of Trauma & Dissociation*, *2*, 7-36.
Derogatis, L.R. (1993). *Brief Symptom Inventory: Administration scoring and procedures manual* (3rd ed.). Minneapolis, MN: National Computer Systems.
Engle, P. (1997). Art therapy and the dissociative disorders. *Art Therapy*, *14*, 246-254.
Fine, C.G. (1993). A tactical-integrationalist perspective on multiple personality disorder. In R.P. Kluft & C.G. Fine (Eds.) *Clinical perspectives on multiple personality disorder* (pp. 135-153). Washington DC: American Psychiatric Press.
Fine, C.G. (1996). A cognitively based treatment model for DSM-IV DID. In L.K. Michelson & W.J. Ray (Eds.), *Handbook of dissociation* (pp. 401-413). New York: Plenum Press.
Fine, C.G. (1999). The tactical-integration model for the treatment of DID and allied dissociative disorders. *American Journal of Psychotherapy*, *53*, 361-376.
Fleiss, J.L., Gurland, B.J., & Goldberg, K. (1975). Independence of depersonalization and derealization. *Journal of Consulting and Clinical Psychology*, *43*, 110-111.
Goodwin, J., Cheeves, K., & Connell, V. (1988). Defining a syndrome of severe symptoms in patients with severe incestuous abuse. *Dissociation*, *1*, 11-16.
Hayes, S.C. (1981). Single case experimental design and empirical clinical practice. *Journal of Consulting and Clinical Psychology*, *49*, 193-211.
Hersen, M. (1978). Do behavior therapists use self-report as a major criteria? *Behavioral Analysis and Modification*, *2*, 328-334.

Hilliard, R.B. (1993). Single case methodology in psychotherapy process and outcome research. *Journal of Consulting and Child Psychology*, *61*, 373-380.
Huitema, B.E. (1985). Autocorrelation in applied behavioural analysis: A myth. *Behavioural Assessment*, *7*, 107-118.
International Society for the Study of Dissociation. (1997). *Guidelines for the treatment of dissociative identity disorder in adults*. ISSD, Northbrook: IL.
Jacobson, N.S., & Traux, P. (1991). Clinical significance; a statistical approach to defining change in psychotherapy research. *Journal of Abnormal Psychology*, *59*, 12-19.
Kazdin, A.E. (1981). Drawing valid inferences from case studies. *Journal of Consulting and Clinical Psychology*, *49*, 183-192.
Kellett, S. (2004). Process issues in conducting cognitive analytic therapy (CAT) with dissociative identity disorder. *Reformulation: Theory & Practice in Cognitive Analytic Therapy*, *23*, 11-16.
Kellett, S., & Beail, N. (1997). The treatment of chronic post-traumatic nightmares using psychdynamic-interpersonal psychotherapy: A single-case study. *British Journal of Medical Psychology*, *70*, 35-49.
Kluft, R.P. (1985). Using hypnotic inquiry protocols to monitor treatment progress and stability in multiple personality disorder. *American Journal of Clinical Hypnosis*, *28*, 63-75.
Kluft, R.P. (1991). Clinical presentations of multiple personality disorder. *Psychiatric Clinics of North America*, *14*, 695-719.
Kluft, R.P. (1991). Hospital treatment of multiple personality disorder. *Psychiatric Clinics of North America*, *14*, 695-719.
Kluft, R.P., & Fine, C.G. (1993). *Clinical perspectives on multiple personality disorder*. Washington, DC: American Psychiatric Press.
Kluft, R.P. (1993). Basic principles in conducting psychotherapy of multiple personality disorder. In R.P. Kluft & C.G. Fine (Eds.), *Clinical perspectives on multiple personality disorder* (pp. 19-50). Washington, DC: American Psychiatric Press.
Kruger, C., & Mace, C.J. (2002). Psychometric validation of the State Scale of Dissociation (SSD). *Psychology and Psychotherapy: Theory, Research and Practice*, *75*, 33-51.
Liotti, G. (1992). Disorganized/disoriented attachment in the etiology of the dissociative disorders. *Dissociation*, *5*, 196-204.
Liotti, G. (1999). Disorganization of attachment as a model for understanding dissociative pathology. In J. Soloman & C. George (Eds.), *Attachment disorganization* (pp. 291-317). New York: Guilford Press.
Loewenstein, R.J., & Putnam, F.W. (1990). The clinical phenomenology of males with multiple personality disorder: A report of 21 cases. *Dissociation*, *3*, 135-143.
Loewenstein, R.J. (1991). Rational psychopharmacology for multiple personality disorder. *Psychiatric Clinics of North America*, *14*, 721-740.
Loewenstein, R.J. (1994). Diagnosis, epidemiology, clinical course, treatment and cost effectiveness of treatment for dissociative disorders. *Dissociation*, *7*, 3-11.
Long, C.G., & Hollin, C.R. (1995). Single case design: A critique of methodology and analysis of recent trends. *Clinical Psychology and Psychotherapy*, *2*, 177-191.

Mair, K. (1999). Development of a dogma; multiple personality and child abuse. *The Psychologist*, *12*, 76-80.

Morley, S. (1994). Single-case methodology in psychological therapy. In S.J.E. Lindsay & G.E. Powell (Eds.), *The handbook of adult clinical psychology* (pp. 722-746). London: Routledge.

Morley, S. (1996). Single-case research. In Parry, G. & Watts, F.N. (Eds.), *Behavioural and mental health research: A handbook of skills and methods* (2nd ed., pp. 233-264). Hove, UK: Psychology Press.

North, C., Ryall, J., Ricci, D., & Wetzel, R. (1993). *Multiple personalities, multiple disorders*. New York: Oxford University Press.

Pollock, P.H. (2001). A case of dissociative identity disorder. In P. Pollock (Ed.), *Cognitive-analytic therapy for survivors of sexual abuse* (pp. 144-164). Chichester, UK: Wiley.

Pollock, P.H., Broadbent, M., Clarke, S., Dorrian, A., & Ryle, A. (2001). The Personality Structure Questionnaire (PSQ): A measure of the multiple self-states model of identity confusion in cognitive analytic therapy. *Clinical Psychology and Psychotherapy*, *8*, 59-72.

Putnam, F.W., Guroff, J.J., Silberman, E.K., Barban, E.K., & Post, R.M. (1986). The clinical phenomenology of multiple personality disorder: Review of 100 recent cases. *Journal of Clinical Psychiatry*, *47*, 285-293.

Putnam, F.W. (1989). *Diagnosis and treatment of multiple personality disorder*. New York: Guilford Press.

Putnam, F.W., & Lowenstein, R.J. (1993). Treatment of multiple personality: A survey of current practices. *American Journal of Psychiatry*, *150*, 1048-1052.

Putnam, F.W. (1997). *Dissociation in children and adolescents: A developmental perspective*. New York: Guilford Press.

Price, J., & Heiss, N. (1979). Behaviour therapy as precipient and treatment in case of dual personality. *Australian and New Zealand Journal of Psychiatry*, *13*, 63-66.

Ross, C.A. (1996). *DID: diagnosis, clinical features and treatment of multiple personality* (2nd ed.). New York: John Wiley & Sons.

Ross, C.A., Norton, C., & Wozney, K. (1996). Multiple personality disorder: An analysis of 236 cases. *Canadian Journal of Psychiatry*, *34*, 413-418.

Ryle, A. (1991). *Cognitive analytic therapy: Active participation in change*. Chichester, UK: Wiley.

Ryle, A. (1995). *Cognitive analytic therapy: Development in theory and practice*. Chichester, UK: Wiley.

Ryle, A. (1997). *Cognitive analytic therapy and borderline personality disorder: The model and the method*. Chichester, UK: Wiley.

Ryle, A., & Kerr, I. (2002). *Introducing cognitive analytic therapy: Principles and practice*. Chichester, UK: Wiley.

Sachs, R.G., Frischholtz, E., & Wood, J. (1988). Marital and family therapy in the treatment of multiple personality disorder. *Journal of Marital and Family Therapy*, *14*, 249-259.

Spiegel, D. (1993). *Dissociative disorders: A clinical review*. Lutherville, MD: Sidran Press.

Steinberg, M. (1995). *Handbook for the assessment of dissociation: A clinical guide*. Washington, DC: American Psychiatric Press.

Torem, M.S. (1995). Medications in the treatment of dissociative identity disorder. In J.L. Spira & I.D. Yalom (Eds.), *Treating dissociative identity disorder* (pp. 99-132). San Francisco: Jossey-Bass.

Turpin, G. (2001). Single case methodology and psychotherapy evaluation: From research to practice. In C. Mace, S. Moorey & B. Roberts (Eds.), *Evidence in the psychological therapies* (pp. 91-113). London: Brunner-Routledge.

Waller, N., Putnam, F., & Carlson, E. (1996). Types of dissociation and dissociative types: A taxometric analysis of dissociative experiences. *Psychological Methods*, *1*, 300-321.

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