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Evaluating the Unified Protocol in the Treatment of Dissociative Identify Disorder

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Abstract

The Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders (UP; Barlow, Allen, & Choate, 2004) is a transdiagnostic cognitive behavior therapy for emotional disorders that addresses mood, anxiety, somatoform, and borderline personality disorders. Patients diagnosed with dissociative identity disorder (DID) form a nontrivial subset of patients. Extant treatment guidelines (ISSTD, 2011) emphasize the need to strive for fusion of identities (i.e., the creation of a unified sense of self). In contrast, the UP strives to inculcate an array of adaptive emotion skills, including cognitive reappraisal, emotional awareness, and affect tolerance, prior to planned exposure to traumatic memories. In this study, we provide the first assessment of the effectiveness of the UP with 5 individuals diagnosed with DID and co-occurring disorders and symptoms tracked at multiple time points. After 18–22 sessions, 4 patients exhibited significant reductions in anxiety, depression, and dissociative symptoms, and increases in emotional regulation, with significant improvements in symptomatology maintained after follow-ups of 1, 3, and 6 months. A fifth participant with prominent suicidal ideation was treated for 42 sessions and achieved comparable reductions in symptoms. None of the patients met criteria for DID or any other disorder at 6-month follow-up.

Keywords: unified protocol; dissociative identity disorder; dissociative disorder; dissociation; emotional dysregulation

Dissociation is marked by a lack of or disruption in normal integration of psychological functions, which includes thoughts, feelings, memories, perceptions, and awareness of the environment (American Psychiatric Association, 2013, DSM-5). Dissociative symptoms are comorbid with an array of psychological disorders, including posttraumatic stress disorder (PTSD), psychotic spectrum disorders, eating disorders, obsessive-compulsive disorder (OCD), substance use disorders, panic disorder, bipolar disorder, and especially borderline personality disorder (BPD) and major depressive disorder (MDD) (see Lynn et al., in press).

The most debilitating dissociative disorder is dissociative identity disorder (DID; formerly called multiple personality disorder), which combines symptoms of depersonalization/derealization disorder (DDD) and dissociative amnesia, along with a disintegration of the sense of self and discontinuity in the usual sense of agency. The diagnostic criteria for DID in DSM-5 (American Psychiatric Association, 2013) include at least two distinct “personality states” (Criterion A) with alternations in sense of self, behavior, emotional regulation, perception, and consciousness. DID is an infrequent yet not rare diagnosis, at least compared with schizophrenia, with prevalence estimated to range from 1% to 3% in the general population and from 4% to 14% among inpatients and outpatients (International Society for the Study of Trauma and Dissociation, 2011; Johnson, Cohen, Kasen, & Brook, 2006; Sar, 2011).

Two perspectives on dissociation, the posttraumatic model (PTM) and the sociocognitive model (SCM), have vied for empirical support. According to the PTM, dissociation arises as a defensive posttraumatic response: Personality states emerge to contain or ward off negative emotions and/or to detach/dissociate from painful memories and emotionally overwhelming

experiences, especially when they occur in early life (e.g., childhood sexual and physical abuse; e.g., Dalenberg et al., 2012; see Lynn et al., 2012, for a contrary view). In contrast, the sociocognitive model (Lilienfeld et al., 1999; SCM; Lynn et al., 2012; Spanos, 1994; see Dalenberg et al., 2012, for a contrary view) questions the causal relation between traumatic events and dissociation and the data that support the link. Instead, the SCM argues that socio-cultural narratives shape the belief in distinct indwelling “selves” or “alter personalities,” which can also arise as a function of suggestive and iatrogenic influences in psychotherapy (e.g., calling forth personality states with hypnosis) against a background of high levels of fantasy proneness, suggestibility, cognitive failures (e.g., lapses in memory), media influences that disseminate stereotypical and dramatic depictions of DID (e.g., Sybil, *The Three Faces of Eve*), and potentially psychopathology and negative affect. Importantly, there is a recent trend toward convergence between the PTM and the SCM that DID reflects an emotional disorder that features a distorted representation of the self (see Chiu et al., 2016; Lynn et al., 2012). Despite the subjective sense of “separate selves” or personalities, individuals with DID do not consistently display inter-identity amnesia when tested with implicit and/or behavioral measures of amnesia (Huntjens, Verschuere, & McNally, 2012; Lynn et al., 2012, for a review).

We suggest that for treatment purposes, it is helpful to view dissociative disorders through the lens of variables (i.e., emotion-regulation, avoidance, meta-consciousness) associated with a transtheoretical and transdiagnostic perspective. Although controversy and conflict have revolved around the PTM and the SCM, they both view difficulties in emotional regulation (i.e., the process “through which individuals modulate their emotions consciously and non-consciously to appropriately respond to environmental demands”; Aldao, Nolen-Hoeksema, & Schweizer, 2010, p. 218) as pertinent to dissociation (see Lynn et al., in press). Researchers

(Cicchetti & Tucker, 1994) have conceptualized DID as the product of dysfunctional self-organization and adaptive emotion-regulation mechanisms, manifested especially in the ability to cope with stressful situations (Powers, Cross, Fani, & Bradley, 2015). The SCM, in turn, contends that dramatic, often puzzling shifts in affect, cognition, and behavior in DID signify emotion dysregulation and come to be (mistakenly) understood as manifestations of so-called alter personalities (see Lynn et al., 2015). Accordingly, strategies geared to enhance regulation would appear to be instrumental in treating DID. Importantly, many of the disorders that covary substantially with dissociative disorders, including borderline personality, substance abuse disorders, eating disorders, mood disorders, and psychotic spectrum disorders, are likewise marked by deficits in emotion regulation (see Lynn et al., in press).

A second convergence, emphasized by the PTM and not inconsistent with the SCM, is that dissociative presentations are associated with avoidance of anxiety-eliciting behaviors and dysphoric thoughts, emotions, and memories (Lynn, Condon, & Colletti, 2013). Disruptions in emotional regulation and dissociative symptoms theoretically arise when avoidance of negative affect, for example, promotes instability across emotional states, precludes habituation to anxiety-provoking cues and processing of negative affect and becomes rewarding via negative reinforcement and increasingly automatized and compartmentalized (see Lynn et al., 2019).

The transdiagnostic nature of dissociative symptoms is further evident in findings that avoidance figures prominently in many psychological disorders highly comorbid with dissociative disorders that span borderline personality disorder, PTSD, depression, panic and other anxiety disorders, substance use disorders, and eating disorders. (e.g., Berman, Wheaton, McGrath, & Abramowitz, 2010; Cribb, Moulds, & Carter, 2006; Forsyth, Parker, & Finlay, 2003; Hayes, Wilson, Gifford, Follette, & Stroschal, 1996). Training in adaptive cognitive-behavioral strategies

that promote safe exposure to highly negative emotions could promote emotion-regulation and continuity of experiences across affective states and thereby mitigate dissociative symptoms.

A third transdiagnostic variable, congenial with the PTM and SCM, is deficits in meta-consciousness, which we define as a capacity to be aware of and comprehend one's mental states, emotions, and action tendencies; infer inner states of others; and articulate cognitive, affective, and situational antecedents and potential consequents of thoughts, feelings, and behaviors (see Lynn et al., 2019). Dissociative symptoms are associated with a lack of awareness of feelings and cognitions, and mindfulness is negatively correlated with dissociation (see Lynn et al., 2019). Deficits in meta-consciousness also are present in disorders with accompanying dissociative symptoms, including borderline personality disorder, schizophrenic spectrum disorders, OCD, depression, and eating disorders (see Lynn et al., 2019).

Unfortunately, none of the extant DID treatments have systematically addressed all three (i.e., emotional-dysregulation, experiential avoidance, deficits in meta-consciousness) transdiagnostic and transtheoretical markers of dissociation. Of all the major psychological disorders, DID has garnered among the least attention in terms of empirically supported treatments. Maxwell, Merckelbach, Lilienfeld, and Lynn (2018) review intervention studies of dissociation that include hypnosis, psychodynamic therapy, Janet's stage-oriented treatment model, eye-movement desensitization and reprocessing, cognitive-behavioral therapy, cognitive analytic therapy, expressive therapies, group therapy, behavior modification, cognitive therapy, art therapy, and family therapy. Unfortunately, much of the extant literature is based on anecdotal and case reports: There are no randomized controlled trials (RCTs) of DID and few systematic single-case studies. However, a large (nonrandomized) observational 30-month naturalistic outcome study of DID treatments conducted by community clinicians, which did not

follow a uniform or systematic protocol, yielded promising findings (Brand et al., 2013). The most well-developed CBT protocol (Hunter, Baker, Phillips, Sierra, & David, 2005) evaluated 21 individuals diagnosed with DDD and was delivered in an outpatient setting over 4 and 20 sessions. The treatment secured improvements in functioning posttreatment and after 6 months but targeted primarily only one of the proposed transdiagnostic symptoms we discussed (i.e., avoidance) and did not use mediational analyses to evaluate treatment mechanisms. Foote and Van Orden (2016) observed reductions in self-harm and suicidal behaviors in a case study of a DID patient treated with dialectical behavior therapy for 2 years (DBT; Linehan, 1993). Unfortunately, the researchers did not report psychological testing to document gains and whether gains were associated with increased emotion regulation and self-management skills that were the focus of treatment.

In this article, we present the first study of adults diagnosed with DID treated with a well-established empirically based transdiagnostic cognitive-behavioral intervention, the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders (UP; Barlow, Allen, & Choate, 2004) that addressed variables integral to DID. We describe the UP in terms of eight treatment modules (presented below) that are designed to enhance (a) motivation, emotion regulation, meta-consciousness, tolerance of emotions and physical sensations, and cognitive flexibility; and (b) to decrease emotion avoidance and emotion-driven behaviors (i.e., behaviors driven by an emotion itself) via exposure, cognitive reappraisal, and mindfulness/present-moment focus. The treatment typically includes 9–18 sessions of approximately 50–60 minutes weekly but can be extended in number and duration based on patient needs (see Barlow et al., 2011). In our study, sessions were 60–90 minutes in length and ranged from 18–42 sessions.

The UP is particularly well suited to treat the emotional disorder DID in that it is a

relatively brief cost-effective intervention that, among extant cognitive-behavioral approaches, arguably addresses most explicitly key variables implicated in DID (i.e., emotion regulation, meta-consciousness, experiential avoidance).

We evaluated an 18–22 session UP intervention of four individuals with DID followed at multiple time points with well-validated psychometric measures. We hypothesized that participants would exhibit stable scores on measures of dissociation, emotional dysregulation, and comorbid disorders at baseline, exhibit improvements at the end of the treatment, and maintain gains at a 6-month follow-up. We also report a case study of a fifth patient, with prominent suicidal features, treated in an extended program of 42 sessions. Finally, we identify challenges in the treatment of DID and present suggestions for future research.

Method

Participants

Our research was part of a larger study that recruited participants (i.e., patients who met diagnostic criteria for DID, major depression, all anxiety disorders, and somatoform disorder) with a brochure circulated to private psychologists' and psychiatrists' offices, counseling centers and a general hospital, and also posted on Instagram and Facebook. We recruited all participants referred. We treated five native born Iranian adults (four females and one male, three recruited from doctoral-level clinical psychologists/Anna, Pari, Mona, and two from psychiatrists, Amin, Leila) who were included if: (a) they were over 18 years old; (b) their primary diagnosis was DID; and (c) their medication, dosage, or type of medication remained stable within 3 months prior to treatment. We excluded participants if they met criteria for a current substance use disorder, current psychotic disorder, current bipolar disorder, organic brain disorder (or disease),

or imminent suicidal ideation. See Table 1 for descriptive and diagnostic information.

Prescribed medications were stable for all participants over treatment.

Measures

Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I; First et al., 1996)

The SCID-I is a semistructured interview based on DSM-IV (American Psychiatric Association, 1994) criteria of Axis I disorders. Psychometric properties (Drill, Nakash, DeFife, & Westen, 2015; Zanarini et al., 2000) are well-established in many studies (kappa scores range .61–.83; Lobbestael, Leurgans, & Arntz, 2011). The Persian version of SCID-I specificity values exceeded 85% for most psychiatric disorders (Sharifi et al, 2009).

Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II; First et al., 1997)

The SCID-II is a semistructured interview based on DSM-IV (American Psychiatric Association, 2000) criteria for personality disorders. Psychometric properties are well-established (Ekselius, Lindstrom, von Knorring, Bodlund, & Kullgren, 1994), with kappa statistics ranging from .65 to .98 (Ekselius, et al., 1994; Lobbestael et al., 2011). The Persian SCID-II has adequate, but not impressive, kappa (overall weighted κ 0.52 lifetime diagnoses; 0.50 for current diagnoses; Mobasher, Mohammadkhani, Mazinani, & Fadaei, 2009).

Structured Clinical Interview for DSM-IV Dissociative Disorder (SCID-D, Steinberg, 1994)

The SCID-D is a semistructured interview based on DSM–IV-TR (American Psychiatric Association, 2000) criteria for dissociative disorders and evaluates amnesia, depersonalization, derealization, identity confusion and identity alternation, each assessed on four-point scales ranging from 0 (*none*) to 4 (*severe*). The measure possesses good-to-excellent reliability and validity (Steinberg, 1994). The Persian version yielded 100% agreement regarding diagnosing dissociative disorders (Thamasebi Zadeh & Dadkhah, 2014).

Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988)

The 21-item BAI assesses cognitive and somatic anxiety symptoms. The BAI possesses good psychometric properties (Osman, Barrios, Aukes, Osman & Markway, 1993) with Cronbach's $\alpha = .92$ (Beck et al., 1988). The internal consistency of the Persian version of the BAI appears good ($\alpha = .92$) (Kaviani, & Mousavi, 2008), and internal consistency in our sample was adequate ($\alpha = .77$).

The Beck Depression Inventory–II (BDI-II; Beck, Steer, & Brown, 1996)

The 21-item BDI assesses depression symptoms and possesses excellent psychometric properties (Beck, Steer, Ball, & Ranieri, 1996). We used the Persian version, which is a widely used valid and reliable instrument with Cronbach's alpha .91 (Ghassemzadeh, Mojtabai, Karamghadiri, & Ebrahimkhani, 2005). In our study, internal consistency was adequate ($\alpha = .79$).

Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004)

The 36-item self-report questionnaire contains six subscales with higher scores indicating difficulties with emotional regulation. Responses range from 1 (*almost never*) to 5 (*almost*

always). The measure possesses excellent psychometric properties with excellent internal consistency ($\alpha = 0.93$), test-retest reliability, construct, and predictive validity (Gratz et al, 2004). The Persian version (Mazaheri, 2015) possesses good to excellent internal consistency in current study ($\alpha = .89$)

Dissociative Experience Scale (DES; Carlson & Putnam, 1993)

Participants indicate how often they experience dissociation 0 (*not at all*) to 100 (*always*) on the 28-item scale. The measure possesses excellent psychometric properties (excellent internal consistency and test-retest reliability; range .84–.96 [Carlson et al., 1993]). The Persian version (Nejad, & Farahati, 2007) possesses excellent internal consistency in the current study ($\alpha = 0.90$).

Procedure

The university Ethics Committee approved the study, and participants consented to treatment. None were in concurrent psychotherapy, and prior to the study participated in only one assessment session with the referring professional. Three SCID diagnostic interviews (see below; SCID-I, SCID-II, and SCDID-D) were administered once each week for 3 weeks prior to treatment to ensure a reliable diagnostic baseline. Three doctoral-level clinical psychologists (one was the second author, who reviewed responses) and a psychiatrist interviewed each participant independently with the same instruments. Assessments confirmed the diagnosis of DID. During three weekly baseline sessions after the interviews and a 30-minute rest period, self-report measures were administered by paid assessors not involved in treatment and blind to the aims of the study. Participants were not, however, provided with an opportunity to talk about complaints and concerns, so as not to confound assessment and treatment. The sessions were

conducted in a private psychological clinic, and sessions were conducted in the same well-appointed room for all individuals.

Participants completed all measures (BDI-II, BAI, DERS, DES) in the treatment phase, 20–30 minutes prior to each 60–90-minute treatment session over 18–22 weeks, and at a 1-month, 3-month, and 6-month follow-up. However, we treated one of the five patients for 42 weeks. The SCID, SCID-II and SCID-D were administered at baseline, the end of therapy, and at 1, 3, and 6 months after the UP intervention. The same doctoral-level assessor worked with each patient across all assessment phases.

None of the participants terminated therapy prematurely. Interventions were delivered by the first author, a doctoral-level clinical psychologist trained in the UP in a 7-day workshop and supervised in the treatment for 2 years prior to the current study by the second author. Each assessment was audio recorded and treatment sessions were video recorded, with the exception of one participant who preferred to be audio recorded. For the voice/video record of therapy sessions, the individual's name was changed.

A doctoral-level clinical psychologist, trained and experienced in implementing the UP for 7 years (second author), listened to recordings of the therapy sessions to monitor treatment adherence. Although a formal fidelity checklist was not implemented, at weekly supervision sessions the sequence, content, and objectives of each module were judged to adhere to the UP. The supervisor provided detailed feedback to the therapist for each participant.

General Description of the Use of the Unified Protocol

Sixty- to 90-minute individual treatment sessions, which were free of charge, were conducted over a 6-month period. The therapy sessions corresponded to the core UP modules

(e.g., Barlow et al., 2011 treatment workbook) with relatively few modifications noted below, albeit with flexibility to meet challenges of working with DID patients. Prior to initiating the modules, the nature, length of treatment, and general goals were negotiated, and a crisis plan developed, given the often-volatile nature of symptom presentation. The following UP modules were administered, with latitude regarding number of sessions devoted to each module and with carry-over of interventions across modules to promote continuity and ingrain learning.

Psychoeducation and treatment rationale (Sessions 1–2). Early sessions provide a rationale and overview of the UP, including discussion of the nature and function of emotion and the importance of (a) identifying different aspects of emotional experience (i.e., thoughts, physical sensations/feelings, and behaviors); (b) accepting and tolerating negative emotions nonjudgmentally; (c) recognizing the role of negative emotions and avoidance in triggering personality states; and (d) understanding associations among reminders of traumatic events, dissociative symptoms, and avoidance of emotions and negative reinforcing effects of doing so.

2. Motivational enhancement (Session 3). This session was essential to (a) clarify the pros/benefits and cons/costs of changing (and not changing/decisional balance) to refine manageable goals; (b) reduce missed sessions or dropouts; and (c) facilitate treatment engagement during exposure and when personality states manifested resistance to confronting disturbing emotions.

3. Emotional awareness (Sessions 4–5). Emotional awareness was prerequisite to emotion regulation and fostering meta-consciousness across personality states. The therapist facilitated a present-focus nonjudgmental attitude toward dysregulated emotions, instructed

participants in identifying the antecedents or triggers of emotions, such as "switching" to different personality states, as well as responses to triggers, and consequences of such responses (e.g., failure to process emotions).

4. *Cognitive reappraisal (Sessions 6–7)*. Cognitive reappraisal challenged and defused maladaptive beliefs including catastrophizing ("thinking the worst") and jumping to conclusions (e.g., "I am bad, worthless, a whore"), and promoted adaptive beliefs and appraisals (e.g., painful emotions are transitory, nonjudgment, the past need not determine the present, personality states can be accommodated within a single "personality").

5. *Decreasing emotional avoidance (Session 8)*. This session included psychoeducation to underscore the role of avoidance strategies in maintaining dissociative symptoms and producing detrimental effects on treatment progress, including compartmentalizing disturbing emotions via the belief in separate personality states and fugue states as behavioral avoidance that promoted dissociation via negative reinforcement.

6. *Awareness of physical sensations (Sessions 9–10)*. This was implemented to increase meta-consciousness and a sensation vocabulary to facilitate communication and recognition of sensations, thoughts, and triggers of emotion dysregulation and experiential avoidance prior to exposure in sessions 11–17; Session 33 in the treatment of Leila, see below).

7. *Imaginal and situational emotional exposures*. The goal of imaginal and situational exposures to fear-evoking memories and triggers of emotion dysregulation was to promote

tolerance and, ideally, acceptance and integration of avoided emotions that were expressed as different personality states and to enhance emotion regulation, particularly unpredictable shifts in emotions. Sessions were extended up to 80 to 90 minutes, and scenes started with the lowest item on the hierarchy. Subjective Units of Distress (SUDS) were assessed, at minimum, pre and post exposure on a 1–10 scale in terms of intensity (ranging from 1= *none or almost no distress* to 10= *maximum ever or most intense*).

8. *Integration/Review/Recommendations (Session 18–22, 42)*. In the final session, the therapist provided posttreatment recommendations and focused on (a) progress in relation to earlier articulated goals pertinent to daily living and relationship quality, (b) the importance of monitoring progress at least weekly, and (c) the value of implementing adaptive strategies to reduce the probability of relapse as a consequence of experiential avoidance and emotional dysregulation. The therapist encouraged participants to increasingly internalize an “inner therapist” and also underscored the probability of experiencing natural fluctuations in symptoms after treatment. Scheduling daily activities (behavioral activation) was recommended to foster planning and goal-orientation, self-efficacy, emotion regulation, and mindfulness. Finally, the therapist explained that a lapse in progress need not signify relapse, but rather an indication to apply the full range of cognitive-behavioral strategies learned in the program.

Some Unique Challenges

Working with DID patients poses unique challenges—particularly the treatment-interfering effects of emerging personality states; we therefore emphasize the need to administer the UP flexibly. For example, as participants embarked on the therapy with a personal narrative

of possessing “multiple selves” with associated names, a challenge was to not invalidate their presentation to risk compromising the therapeutic alliance while, nevertheless (a) avoiding suggestive questions that reify or reinforce the existence of separate “parts” and (b) conveying the idea that perceived parts could be accommodated within a broader narrative of a single, more unified sense of self. The therapy dynamics at times required that the therapist engage with named personality states, particularly early in therapy prior to the establishment of rapport and later when participants clearly expressed a preference for such names and/or expressed anger, frustration, or other negative emotions when names were not used. To the extent feasible, the therapist referred to the function described by the participant (e.g., express anger, protect feelings) rather than to a named “part” and emphasized that (a) perceived parts were often ways of experiencing or expressing distressing thoughts, feelings, or actions that he/she felt uncomfortable with or avoided confronting directly and (b) that the therapy was geared to increase continuity across personality states and awareness of the totality of experiences. To convey the phenomenology of participants and for clarity of communication, we herein refer to names used by participants.

No special efforts were initiated to recover memories of trauma or to identify additional personality states beyond those reported. Additionally, no attempts were made to corroborate memories. Exposures were premised on the belief that whether or not memories were accurate, their intrusive and emotionally dysregulating nature warranted their being addressed.

Design and Data Analysis

In our single-case series, we applied an A-B design with a baseline that included a 3-week waiting period. At the end of the 18–22 session intervention, or at the end of the 42-session

intervention in one case, 1-month, 3-month, and 6-month follow-ups were employed. We summarized the data in terms of change in diagnostic status, visual graph, percentage change, reliable change index (RCI; Jacobson & Truax, 1991), and effect size (ES). For ES, we used Hedges's g (Hedges, 1981), because it is less restrictive regarding standard deviations at different time points. We also used the BDI-II and BAI to evaluate therapy gains with comorbid conditions.

Results

Table 1 presents the background information of all five participants, including their sex, education level, vocation, prescribed psychotropic medications, initial principal (DID) diagnoses and comorbid diagnoses, diagnosis at the end of treatment, and final diagnosis after the 6-month follow-up assessments. After treatment, none of the participants met full criteria for any diagnosis. Nevertheless, all of the participants still fulfilled DSM-5 criterion A for DID (i.e., two or more distinct personality states present), although by the end of treatment they acknowledged that what they initially perceived as different identities were actually aspects of themselves. Importantly, their diagnostic status persisted through the 6-month follow up. Table 2 provides descriptive statistics, effect sizes, and percentage of change for participants across self-report measures, averaging across baseline scores, the mean of the intervention phase, and the mean of the follow-up period. Moreover, we report the RCI for self-report measures at posttreatment and follow-up assessments. RCIs were calculated as follows:

$$S_E = S_1 \sqrt{1 - r_{xy}} \quad \longrightarrow \quad S_{(diff)} = \sqrt{2(S_E)^2}$$

$$RC = \frac{X_2 - X_1}{S_{diff}}$$

In this formula, S_1 is standard deviation of pretreatment, r_{xy} is test-retest reliability, X_1 is pretreatment score and X_2 is posttreatment score; RCI greater than 1.96 indicates a significant reliable change. Figures 1 to 5 present a more granular representation of scores on these latter measures covering all three baselines, the beginning, middle, and end of treatment, and the one, three, and six-month follow-up period. What follows is a description of the treatment for each patient. Pseudonyms were used in all cases.

Single-Case Analysis

Participant 1

At the outset of treatment, Anna met diagnostic criteria for DID, MDD, GAD, excoriation, and BPD. She was 28 years old, single, a master's student, and complained her amnesia was so extensive that she recalled few and hazy memories prior to age 7 and experienced difficulty recognizing old friends. Anna's goals were to remember her childhood and to eliminate skin picking (excoriation disorder, DSM-5). She reported many conflicts and serious arguments with her mother, shame in her presence, and fear of her controlling influence. She reported a 6-year-old personality state she called "Elsa," who was physically and sexually abused (raped) for 5 years, between the ages of 4 to 8, by Nima, a 20-year-old man who lived upstairs. She said the abuse engendered a personality state she called "Baby," whom she believed served as a protector. She recalled arguments with her mother about Nima and stated that she punished her, blamed her, and admonished her to "not talk about these things."

Treatment Course

We present the case of Anna in greater detail than cases that follow to illustrate key

aspects of the UP. In Sessions 1–2, the therapist introduced the modules, provided a tentative case formulation, and discussed record-keeping and homework. The therapist suggested that memory gaps could be interpreted as motivated avoidance/suppression of disturbing experiences associated with adverse events that generalized to many situations and experiences. She hypothesized that excoriation, dysregulated emotions, and emotion suppression were unconsciously initiated and automatized to cope with memories and painful emotions of anxiety, sadness, shame, and anger in response to traumatic events and humiliation, blame, and self-hatred her mother evoked. Accordingly, Anna did not learn to confront, regulate, accept, and integrate thoughts, memories, and emotions across changing circumstances and represented “unacceptable” emotions or “protective” functions of the personality as “personality states” with different names.

For DID patients, completing homework can be frustrating and problematic. Homework can be reviewed in different emotional states to facilitate cross-state continuity of experiences. Participants can be instructed to post homework assignments on refrigerators, doors, or more private yet accessible and often frequented places and to complete homework at set times and specific settings. In Session 3, the therapist shared more information about emotions, their function, different aspect of emotion (physical sensations, thoughts, behaviors), and introduced the concept of emotion-driven behaviors (EDBs; also discussed in Session 7) related to skin picking and to “switching” personality states in response to negative emotions as ways to mitigate anxiety. Anna was encouraged to label and track emotions, thoughts, and feelings, in terms of antecedents, responses to emotion triggers, and the consequences of her responses (a processes called ARC, using forms in Barlow et al., 2011; completed in Sessions 3–5). As is

common with DID patients, Anna tended to not observe feelings and experienced difficulties differentiating positive and negative emotions and nuances among them:

T: We know that you have used dysfunctional strategies to cope with your uncomfortable emotions.

Anna: Yes, you said my forgetting is a consequence of avoiding my bad feeling.

T: Yes, and moreover, it seems you judge your emotion in either or terms such as "bad feeling or good feeling." Yet all emotions such as anger, shame, anxiety, sadness or happiness play an important role in your life and have essential functions.

Anna: But some of them are painful. For example, last night my mom called, asked about my dinner, her voice was blameful (she didn't eat regularly, which created some health problems), I don't remember what happened next but in the morning I found my cellphone was broken and again I picked my skin, my clothes and bed linens were bloody.

T: What physical sensations did you associate with your feeling during your conversation with your mom?

Anna: I don't know. I just remembered I was scratching my arm with my fingernail.

T: Like when you are anxious?

Anna: Hum. You know I just know I have a bad feeling. There are different from those emotions I experience with my exams.

T: Ok, there are thoughts that link with or trigger emotion. Did you notice any thoughts that accompany or come before your feeling?

Anna: I just remember I told myself, "she starts again."

T: So, you react to your feeling and thought by breaking your cellphone and skin picking. It sounds like you were angry about something and it led to skin picking?

Anna: Maybe, I never pay attention to my feeling.

Tracking thoughts and feelings, and a later focus on sensations in Sessions 9 and 10, fostered observation skills and consolidated and highlighted more general discussions of feelings. Anna

began to appreciate that dissociation was a dysfunctional coping mechanism with negative consequences, and she became more collaborative in treatment. An important aspect of treating DID patients is to identify ways to achieve a calm, stabilizing present-moment equilibrium during dysregulated experiences. To do so, in Sessions 4 and 5 (and subsequent sessions) the therapist invited Anna to name things in the room in the “here and now”; to count and/or focus on breaths (which all personality states share) or alternate breath counting with describing objects, and practice mindful nonjudgmental attention to whatever thoughts and emotions arise. An important goal is to let “feelings just be feelings” and “thoughts be just thoughts,” creating a distance from disturbing experiences and obviating the need for personality state “switches.” She was informed that mindfulness can enhance sound decision-making regarding how and when to respond to transitory experiences, if at all, and mindfulness practice was encouraged in extra-therapy situations. With DID patients, it may be necessary reiterate the rudiments of mindfulness practice and other instructions across different personality states if claimed amnesia exists. In later sessions, Anna brought a doll she played with in childhood to comfort her. Anna calmed Elsa by placing traumatic events in an imagined closet with two keys (one for the therapist and one for Elsa), and Anna was calmed with the sound of keys jangling, as they represented to her the sound of her mother manipulating her keys when she returned from work, which Anna associated with the termination of abuse. These tactics might be criticized for encouraging experiential avoidance. Nevertheless, they appeared helpful in titrating negative emotions, enhancing feelings of safety and control, and in facilitating engagement in treatment. Still, it was important for Anna to learn that she could cope with a complete range of feelings without these sources of temporary anxiety relief, so she practiced mindfulness and present-moment focus without these objects present.

In Sessions 6–7 which focused on cognitive reappraisal, the therapist (a) consistently reinforced the idea that Anna was no longer a powerless child—thereby providing reassurance she associated with needs reflected in Elisa and Baby and (b) interpreted Anna’s feelings of shame in her mother’s presence as overlearned automatic appraisals (see Barlow et al., 2011) that no longer possessed current validity, as Anna was not, in fact, at any time responsible for her abuse. Moreover, the therapist challenged Anna to “catch herself” when she jumped to conclusions and catastrophized that others would perceive her as she feared (e.g., “bad,” “a slut,” or notice if she did not recognize them immediately). To convey that how Anna interpreted her actions and situations exerted a strong effect on her feelings and self-perceptions, the therapist used an ambiguous picture with different possible interpretations (it is presented in Barlow et al., 2011).

T: Let’s look at the picture. What is your automatic interpretation about it? What do you think happened?

Anna: It seems the woman on the bed is dying and her husband and her friend are sad for her. Maybe they are crying for her. Poor young girl; by the way, I am not sure.

T: Don’t worry; there is not any right or wrong answer. Anna, do you know which factors contributed to your interpretation?

Anna: One of my friends was recently diagnosed with cancer. We are all sad for her.

T: I’m sorry for her, but do think this picture could tell an alternative story?

Anna: What do you mean? Think about it in different way?

T: Yes, maybe it has another meaning.

Elsa [her child part was dominant]: Her mother beating her [the girl in the bed] so bad and the father [the man in the picture] and her sister worried about her. They know her mother hates her.

This exercise stimulated a discussion of how her belief that her mother hates her contributes to Anna's belief that she deserves punishment and engenders feelings represented in

Elsa and reflected in skin picking, which could be conceptualized as a mild form of self-punishment and as a form of emotion-driven behavior. Cognitive reappraisal continued in the fifth module (Session 8) in challenging the belief that it is better to suppress or avoid emotions than to contact or confront them.

DID patients often lack awareness of physical sensations, which precludes optimum exposure and awareness of antecedents of avoidance strategies expressed in “switching” personality states. Therapists can foster awareness of sensations via questions and providing observational feedback (Sessions 9–10; sixth module, but also implemented earlier). The therapist, for example, occasionally made comments such as, “It seems your legs are trembling,” or asked, “What do you feel in your body? What sensation do you feel in your hands? Where in your body do you experience tension at this moment?” Anna learned to (a) track sensations, (b) differentiate cognitions and sensations, and (c) become mindful by tracking sensations (e.g., breathing rate, muscle tension) in concert with the therapist who provided feedback on breathing, posture, movements, and mannerisms. Enhanced somatic awareness helped Anna develop a more nuanced sensation vocabulary, which expanded communication of physical feelings, awareness of emotions, and antecedents of switches to Elsa (i.e., feeling fatigued, sleepy) and Baby (i.e., feeling nauseous). Sensation awareness enhanced Anna’s perceived ability to control Baby and cued her to initiate present focus. Cognitive reappraisal and affective tolerance thus promoted an understanding that negative emotions were temporary, and “switches” in response to negative emotions represented maladaptive avoidance that maintained symptoms. It is useful to identify a zone of optimal somatic arousal that facilitates the ability to tolerate and confront traumatic memories in exposure sessions. In subsequent sessions, as she became more adept in tracking sensations and anchoring herself in the present moment, she was better able to regulate intense

emotions and to re-associate negative experiences previously allied with different “parts.”

Exposure sessions (10–17) increased tolerance for strong affect and enhanced emotion recognition and the belief that “the past is past.” An initial exposure (pre-exposure SUDS 6, post-exposure SUDS 4) involved an argument in which her mother insisted Anna eat all of her food she prepared with tomatoes, for which Anna was allergic. Mother-directed anger typically triggered presentation of Baby, so the goal was for her to tolerate anger toward her mother and to assert her feelings regarding her mother post session. Another exposure session focused on fears that at an upcoming party with old friends she would not remember them or follow conversations. Exposure involved not remembering a friend’s name (SUDS 7; post exposure SUDS 4). Situational exposure followed with her later attending the party, staying for an hour, and speaking with several friends (pre-party SUDS 6; post party at home SUDS 3). A third exposure (SUDS 6; post exposure SUDS 4) involved Anna losing her notebook that her mother moved while dusting in the house. This memory was associated with fears regarding her mother controlling her life. One of Anna’s great fears was encountering tall, young men with brown beards and moustaches who reminded her of Nima. An exposure session (pre-exposure SUDS 9, post-exposure SUDS 5) centered around her lab assistant with these physical features who she feared would abuse her. Intercession of personality states proved challenging. It was necessary to use the sound of keys jangling and present awareness (e.g., refocused on breathing) and mindfulness to limit personality “switches” and to use cognitive reappraisal to affirm that she was no longer young and helpless and that most men with those physical features would not be like Nima or intend to hurt her. Encouragement and disputing catastrophic thinking such as realistically appraising “what’s the worst that can happen” was required for Anna to initiate multiple situational exposures with her saying “hi” to the assistant in the presence of a classmate

and engaging in conversations and, at the end of therapy, having lunch with him while another person was present (SUDS 3).

Anna's most terrifying memory (pre-exposure SUDS 10, post exposure SUDS 5) centered on her cousin's birthday party in Anna's house. This memory started with Anna (disclosed by Elsa) screaming. Anna's childhood house was a three-floor building with Nima's residence on the floor above. Anna recalled that Nima forced her to engage in oral sex there. After the incident, she stated she could not walk; she screamed and called for her mother who yelled and blamed her, brought her to her room, and beat her. Her mother threatened Anna that if she spoke about the incident, she would ask her to leave home, and she would not see her any more. Elsa said her mother kept her 1 week in her room, did not permit her siblings to talk or play with her, and told her siblings she is a "bad girl." As exposures progressed, Anna came to understand why she hated her childhood building where abuse was perpetrated; why she became anxious in the presence of houses with red doors, like her childhood home; and why she experienced anger in the presence of her mother who blamed her for the abuse.

Post-exposures Anna practiced mindful awareness (some associated with different "parts"), refocusing on breathing to enter her zone of optimal arousal, and exercising choices regarding how to react to strong emotions. As Anna achieved greater emotion regulation, her symptoms stabilized, and she was able to better tolerate exposure and confront traumatic memories. She also experienced enhanced recall of positive and negative childhood events.

In sessions 18–20, the therapist and Anna reviewed progress, highlighted the importance of continued monitoring, set weekly routines to promote behavioral activation, and discussed ways she could continue to expose herself to thoughts and emotions previously avoided. By the end of her 20-session therapy, Anna's anxiety decreased regarding Nima. Anna recognized there

was no need for her personality state Elsa to exist, as her neighbor died 10 years prior to treatment. This realization appeared key to enhanced emotional regulation and to a better relationship with her mother. Her depression and anxiety also gradually decreased over sessions, excoriation behaviors were eliminated, and her dissociative symptoms decreased significantly. She achieved reliable changes on the BAI (RCI=-33.11), BDI-II (RCI=-47.85), DES (RCI=-57.46), DES-T (RCI =-21.49) and the DERS (RCI=-134.42) at the posttreatment assessments. At follow-up, changes on the BAI (RCI=-25.72), BDI-II (-37.97), DES (RCI=-41.65), DES-T (RCI=-15.11), and the DERS (RCI=-88.08) were, likewise, reliable. After the final 6-month follow-up, her psychiatrist expressed no need to continue to prescribe psychotropic medicine.

Participant 2

At the start of therapy, Pari met criteria for DID, MDD, BPD, and DPD. She was 32 years old, single, and lived with her mother. She sought therapy for impoverished memory, which, like Anna, engendered worry and anxiety. Neurological consultation revealed no organic problems. Her first childhood memory reported was at age 7, and her first detailed memory was at age 9. She stated that she could not identify people in photos of “old days,” and “When my mother talks about past memories I can’t remember them; it makes me worry. When I said I didn’t remember them, she repeatedly said, ‘because you are stupid,’ so I pretend I remember them, but to tell you truth I don’t really have a vivid memory of my childhood... Last week one of my close friends complained about my cold behavior. She was sad because she said hello to me, but I behaved as if I didn’t know her, I even asked her name and asked her about our relationship. There are very shameful and terrifying experiences.”

Sometimes Pari found herself in places or engaged in actions without awareness of their antecedents. After her last break-up, she found herself in a different city, and she could not remember how or when she arrived there, or she found herself applying unusual makeup and apparel. She described her appearance as like a “whore” and noted that she found some dresses in her closet, but she could not remember when she bought them. She also discovered bruises on her leg and arms with no awareness of how or when they developed. At times she could not determine whether she was asleep or awake and complained about terrifying nightmares. She described a personality state she called Shadi, which reportedly appeared when she was 15 years old when she was sexually abused. She stated that when Shadi was dominant, she would seduce men she encountered on the streets. During foreplay, when a man would touch her genital area, she would suddenly become angry and attack him. She reported that another personality state she called “Par Par” was 4 years old and emerged when she was repeatedly sexually abused by her 30-year-old uncle, which lasted for 3 years. Therapy would be interrupted when Par Par would cry, hide her face with her hands, and yell, “I am bad girl I don’t want to play.” When Pari was 7 years old, she stated she witnessed her brother and uncle die in a car accident.

In summary, Pari experienced anger toward her mother for not protecting her; rage, hatred, and anxiety in relation to her uncle; and self-hatred and shame. She believed Shadi helped her to control her original perpetrator, protect Par Par from overwhelming shame and guilt, and enabled her to feel dominant, powerful and in control of men, rather than a victim.

Treatment Course

Pari’s initial goals included remembering more of her childhood and becoming aware of applying makeup and what occurred during fugue states. Early in treatment, Pari accepted the

interpretation that repeated fugues and amnesias could be conceptualized as maladaptive attempts to avert intense, painful emotions. The therapist explained that emotions could be viewed as neither good nor bad, nor “dangerous”—“just emotions” that could be used as cues to predict which personality states would appear to be dominant and to integrate painful and conflicting feelings under the aegis of a single “personality.” Pari recorded antecedents and consequences of shame and anger to distinguish between these primary emotions and her secondary reactions such as avoidance and passivity in social situations, a process abetted by regular mindfulness practice. As was the case with Anna, the therapist used an ambiguous picture to illustrate how automatic appraisals influence feelings (see Appendix A). With increasing acceptance of the idea that fugues, dissociation, and amnesia served as automatized avoidance-based “strategies,” she expressed a readiness to engage in exposure sessions.

Pari's exposure hierarchy started with her recent argument with her partner. During exposures Par Par described repeated physical abuse her mother perpetrated after her father died and how her grandmother beat her when she cried after her father's death or when her mother was not present. Another memory centered on her brother's accident, and the most distressing memory concerned sexual abuse in which her uncle forced her to perform oral sex. Her grandmother was shocked when she opened the door, after which her uncle left and her grandmother beat her and repeatedly screamed, “You are a whore, you are bad, you are guilty.” That day, her grandmother asked her mother to leave her house, and when Pari returned her mother beat her, broke her leg, and told her, “If you were dead, I would have a better life.”

Although she expressed love for her mother, and she believed she generally was a good parent, Pari at times felt inexplicable hatred toward her and avoided contact. During exposures, Pari recognized that these feelings stemmed from her belief her mother neglected her and was

partly to blame for her abuse. With emotional awareness, mindfulness training, and recognition that the past need not dominate her present, Pari adopted a more forgiving attitude toward her mother and was comforted knowing that her uncle who abused her was no longer alive and a threat. The mindfulness and somatic awareness modules also helped Pari achieve more integrated functioning as an “adult” in charge of her emotions and responses. Nevertheless, a significant challenge was the interference of the personality state, Shadi, when she became angry and ashamed of her sexual behavior. Rather than try to placate her or rebut her thoughts at these times, the therapist discovered that Shadi could be calmed and Pari oriented to the present by playing music she enjoyed, describing the therapy room, and smelling her father’s cologne she brought to sessions. Finally, as Pari gained awareness that her uncle threatened Par Par that her mother would “disappear” if she disclosed her abuse, Pari was able to empathize and interact with her mother and forgive her, which was one of the critical points in her 18-session therapy.

Pari’s depression, anxiety, and dysfunctional emotion regulation strategies decreased gradually. At the end of therapy, she did not experience fugues but still complained about anxiety, although she elected not to take medicine for anxiety. Her dissociative symptoms waned as she became aware of the roles of Shadi and Par Par, but integration was incomplete, and she did not remember full details of past traumatic memories. However, she remembered what occurred prior to fugue episodes and aggressive episodes, sexual partners, and some memories about her abusive uncle, although she was not able to recall how she traveled from Tehran to other cities during fugues. She did not experience fugues by the end of treatment. At the conclusion of treatment reliable changes were evident in her BAI score (RCI= -69.43), BDI-II (RCI=-71.16), DERS (RCI=-149.76), DES (RCI=-59.28), and the DES-T (RCI = -28.12) at post-

treatment assessments. Changes at follow-up on BAI score (RCI=-54.16), BDI-II (RCI=-62.5), DERS, (RCI=-110.66), DES (RCI=-22.33) and DES-T (RCI=-21.68) were, likewise, reliable.

Participant 3

At the start of therapy, Amin met criteria for DID, MDD, BPD, and NPD. He was 30 years old, an electronic engineer, and single. He entered therapy because of problems with colleagues. A week prior to treatment, he attacked a colleague and beat him severely. Aggressive behaviors occurred repeatedly since he was 20 years old, which led to termination from work and employer complaints. Although he did not remember fights, he nevertheless believed they occurred, as after the last fight his colleague proceeded to sue him, and Amin observed the fight recorded on closed circuit television at his workplace.

Although Amin was generally quiet, calm, and warm in relating to others, he was at times attention-seeking and his presentation changed suddenly: “There seemed to be a devil inside him,” his colleagues reportedly said, which under his influence, Amin reported, “everything would be destroyed, and no one could control him.” Amin did not remember much from childhood and after significant arguments with others, including his mother, found himself in different places or even cities with no recollection of how he got there. Initially, he described two personality states, “A,” a 4-year-old who reportedly was sexually abused by his stepfather, and later during treatment, another personality state emerged, Amir, age 45, whom he described as very aggressive. Amir evidenced no recall problems and was motivated to protect Amin. Amin experienced negative emotions that included anxiety, rage, and hatred toward his stepfather, who

was very old and lived in a nursing home in another city. The angry state reportedly emerged to respond to feeling powerless when, from the ages of 4 to 9, his stepfather abused him.

Treatment Course

Amin requested therapy to identify the roots of his aggression and determine why he did not remember angry episodes. As treatment progressed, he became aware of the roles and functions of personality states and described his goals as developing more satisfactory interpersonal relationships and emotion-regulation abilities. Amin benefited greatly from enhanced meta-consciousness via nonjudgmental awareness of emotions. An ambiguous picture (see Appendix A) helped Amin to appreciate the reciprocal nature of emotions and behaviors. Amin achieved insight that his aggressive behaviors could be conceptualized as maladaptive strategies to exit or escape anxiety-eliciting situations and feel less emotionally vulnerable and even powerful. A challenge that emerged with Amin and other patients was contending with intrusive images and emotions that required re-orientation to the present, as revealed in the following therapy excerpt with Amin: His child part, A, a vulnerable and frightened boy, placed a pillow on his face and implored the therapist to call his mother:

A: I need my mom, please call her.

T: There isn't anything to worry about.

A: I broke a glass, and "Shahin" [his stepfather] will punish me.

T: Look at me Amin, I am not in your past. All these things are in your past.

A: Please hide me.

To orient A to the present, the therapist occasionally used a mirror in which Amin observed his reflection as a young adult, no longer a vulnerable child. He was also invited to describe the room to further ground him in the moment. Somatic awareness exercises permitted Amin to identify tension and painful sensations in his hands when he was angry and upset about A's increasing dependency on the therapist. Amir texted the therapist, "*leave us alone, you are worthless, no one needs you.*" Imagining his father in a chair usually comforted him. As Amin acquired mindfulness skills, A reported less anxiety, and Amir became increasingly able to regulate emotions and feel less threatened by dependency on the therapist.

During exposure, Amin transitioned from a memory in which he recalled that Shahin severely beat his neighbor to the most terrifying memory in the hierarchy in which Shahin reportedly chained Amin to wall, beat him with a chain for 3 days, deprived him of water and food, and forced him to have oral sex and perpetrated other sexual acts on him when he escaped from the chains. Prior to the exposure, the therapist and Amin developed verbal cues which included the tone of his voice and the term "COMING" to terminate confrontation when stress levels (based on SUDS) became intolerable. To modulate negative emotion after some exposures, the therapist employed the split screen technique used in the treatment of DID (e.g., Kluft, 2013), in which Amin alternated attention from visualizing traumatic material on one side of the screen to a calming, "safe," and pleasant scene on the other side. Amin remembered some fugue experiences associated with "A" and when his stepfather injured his foot in a car accident. Because he was disabled, his stepfather was no longer able to hurt Amin.

The therapeutic relationship facilitated the 22-session therapy, particularly in Amin's recognizing and accepting emotions associated with personality states. One of the most challenging aspects of treatment was developing a therapeutic relationship with the anger state,

although anger abated when Amin came to believe his therapist did not judge him for aggressive behavior. Although he left his mother's house after treatment, he still could not forgive her, even though his stepfather also reportedly physically abused her. Amin experienced an impressive reduction in dissociative symptoms (e.g., fugues, depersonalization, forgetfulness of aggressive behavior were eliminated), as well as a reliable change on the BDI-II (RCI=-65.79), BAI (RCI=-69.64), DERS (RCI=-60.73), DES (RCI= -53.02), and the DES-T (RCI = -15.11) at posttreatment. At follow-up, changes in the BDI-II (RCI=-53.97), BAI (RCI=-55.54), DERS (RCI=-49.8), DES (RCI=-45.5) and DES-T (RCI=-11.74) were, likewise, reliable.

Participant 4

At the start of therapy, Mona met criteria for DID, MDE, GAD, BPD, and HPD. She was 28 years old and had been married for 1 month. Her husband said that whenever they had even small arguments, she whimpered and trembled; she begged and pleaded with him not to beat her, although he was not violent and never abused her. Sometimes, in the same situation, she became aggressive and attacked her husband, then suddenly became quiet. Afterwards, she was reportedly amnesic. Mona said she routinely found herself in a place with no awareness of how she arrived. Mona identified two personality states: "Mary" reportedly was 5 years old and sexually abused by her stepfather from ages 9 to 14, when she left home permanently. "Crone" was reportedly a cruel middle-aged woman that arose in response to her original perpetrator to protect Mary and Mona in interacting with her stepfather and, more generally, to cope with shame, loneliness, and feeling powerless during childhood. Mona experienced hate, rage, anger,

and fear in relation to her stepfather and shame, helplessness, and a mixture of tenderness, anger, and rage related to her mother.

Treatment Course

During the first of 21 sessions, the therapist shared Mona's diagnosis, which she, in turn, shared with her husband. This information helped him to understand why she avoided sex. Motivated to help, he learned techniques to help her "stay in the present" and function in a more adult manner. Developing a therapeutic relationship with Crone was challenging. When she was dominant, she attacked the therapist with recriminations to not engage with Mary and Mona, as she deprecated Mary as a weak, nagging, and clinging child. During the somatic awareness module, it became evident that when Mona felt suddenly sleepy, Crone became dominant, an insight that helped Mona anticipate and control Crone. Mona soothed Mary, who felt worthless and ashamed, as she believed "*Mary...wants to have sex with her stepfather, and she deserved bad punishment.*" Cognitive reappraisal helped her to understand that she was not to blame for abuse, as she was a child who could not protect herself and needed her mother. With this realization depression abated, although she still experienced shame regarding sexual memories, anger toward her mother, and hatred of her stepfather. At this point, her husband's support was instrumental, and Mona resolved to take care of Mary and protect her from her stepfather, and Crone expressed willingness to interact with Mona without yelling and swearing.

Exposures began with scenes of an argument with her husband and of sexual abuse at work perpetrated by a colleague prior to her marriage. Scenes progressed to sexual abuse by a stranger at a park, followed by exposure to a memory when her stepfather abused her when he touched her breast, genital area, engaged in intercourse with her and called her a whore and a

hooker. The most anxiety-eliciting memory was divided into five segments and focused on when her stepfather had intercourse with her and her mother tried to open the door and help her, but her stepfather pushed her to the wall and then attacked her mother and beat her with his belt. She saw her mother fall and stop breathing, at which time Mary stated, “I was scared, mom was dead, he will kill me, I killed my mom, I shouldn’t have made any noise, I killed my mom.”

Although Mona exhibited significant reductions in anxiety and depression at the start of therapy, after exposure interventions, her anxiety and depression increased suddenly. However, these symptoms and dissociative symptoms decreased gradually to the point that she achieved reliable change on the BDI-II (RCI=-35.86), BAI (RCI=-53.5), DERS (RCI=-87.71), DES (RCI=-77.9), and the DES-T (RCI = -30.37) at posttreatment assessments. At follow-up, changes on the BDI-II (RCI=-25.91), BAI (RCI=-39.34), DERS (RCI=-65.35), DES (RCI=-65.17) and DES-T(RCI=-20.39) were reliable as well. She remembered some memories of her childhood, and her relationship with her husband improved significantly. She reconnected with her mother, who had Alzheimer’s disease, and she learned that her stepfather was diagnosed with bipolar disorder and died 5 years prior to treatment.

Participant 5

At the outset of treatment, Leila met criteria for DID, MDD, GAD, anorexia nervosa, and BPD. She was a 24-year-old master’s-level student who sought therapy for relationship problems with her boyfriend and repeated suicide attempts. Leila had undergone different psychotherapies from the age of 12, but she had since terminated all treatments, and she could not remember what transpired. She reported a history of suicide and that she suffered from anorexia nervosa since

adolescence. When she entered the study, she weighed 88 pounds, she was 4 feet 11 inches tall, and her Body Mass Index (BMI) was 18. She worried her memory was impaired and that she could not remember childhood: She stated, "...when I view pictures from childhood, I can't recognize people. My mother told me she played with me when I was six years old, but I remember nothing." She stated she could not remember arguments with her boyfriend or suicide attempts: "I suddenly found myself while I cut my vessels or while I had an empty box of medicine in my hand; I didn't remember what had happened or I awakened in bed with a strange man." Sometimes, she could not determine if she was asleep or awake. Her boyfriend complained "too many people that lived inside her"; someone who acted like a child, crying, clinging to him, yet she at times became cruel, beat him, yelled, and asked him to leave her.

Leila identified three personality states: "Lili," 4 years old, who reported she was sexually abused, physically beaten, and left in a dark room; emotionally abused by her babysitter; and sexually abused by her 11-year-old cousin. Lili was afraid of the dark, needy, and felt unable to protect herself. "Lian," 16 years old, was perpetually angry and protected Lili from other personality states, especially her internal perpetrator, "Lulu," who was 37 years old, cruel, aggressive, believed to be responsible for suicide attempts, and sadistic in relation to Lili and Lian yet protected her from the original perpetrator. Leila remembered her mother cried most of the time and told Leila that if she were not born, she and her father would still be together and happy. Leila blamed her father and grandmother for not shielding her from abuse and engaged in sexual activities to ward off feeling lonely and feel protected, although she felt guilty afterward. Leila experienced anger, rage, hatred toward her babysitter, cousin, father and grandmother, and feelings of powerlessness, anger, shame, and sadness. Lili, her childlike personality state, was aware of traumatic memories and sought relationships with "safe people."

Treatment Course

As Leila became unstable in early sessions, meetings were held twice a week for 2 months. The therapist presented psychoeducation regarding her diagnosis and strived to encourage and motivate Leila. Emotional and somatic awareness fostered recognition that shame and thoughts of worthlessness triggered the emergence of Lili. Leila tracked emotions and personality states and used cognitive reappraisal to understand that she was not to blame for abuse and could decide how to respond to shame and guilt. Mindfulness fostered emotion regulation, decreased suicidal ideation, and Leila's ability to cooperate with a suicide safety plan.

Emotional avoidance and anxiety regarding change was manifested in distrust of the therapist and fears of confronting her feelings, as expressed by Lulu:

Lulu: What do you want of her [Leila], you want her to know all of the stories. [Yelling]

Therapist: Knowing all of the stories helps her to protect herself.

L: She couldn't tolerate them. If you try more, I will force her to kill herself.

T: You all have same body. You want to kill yourself, too?

L: You will leave her alone, like Mahtab (Leila's mother), like her grandma, like all other people. I know this, as I know how painful it would be for her. Leave us alone.

T: So, it seems you like her, it seems you try to protect her from confronting painful emotions, from developing relationships with others and getting rejected, and in the end experiencing disappointment. I know you try to prevent her from feeling humiliated. Why shouldn't she learn a better way to cope with her fears? I know you are worried that these changes might make her life worse; it is a chance, but I am absolutely committed to help her and to teach her more functional strategies to cope with her fears.

Even though the therapist related to different personality states, statements such as "one body one person" reflect the idea that DID symptoms rest on a fundamental error of belief—an error of misattributing thoughts, feelings, and behaviors to different personality states rather than to a single self (see Lynn et al., 2019).

Psychoeducation and mindfulness encouraged Leila to normalize what she called her “dark side” across personality states and gain confidence that she could make constructive choices in relationships. Leila recalled her parents’ divorce at age 4, sexual and emotional abuse perpetrated by her older sister, being criticized by her father for being sexually abused, and memories regarding her cousin. Exposures focused on scenes in which she (a) first imagined staying in a dark room prior to situational exposure (actually staying in a dark room); (b) her mother blaming her for divorce and her father remarrying (she did not have contact with her mother for 6 years thereafter); (c) physically meeting her cousin after more than 20 years in a situation where her uncle was also present; (d) awakened with a "strange man" who had rough sex with her (the subject of repeated nightmares); (e) engaged in a discussion with her grandmother about abuse by a man when she was lost in a park when her mother left her to buy ice cream, followed by situational exposure in which she spoke with her grandmother about the incident and asked why she threatened her if she informed her father; and (f) recounted physical, emotional, and sexual abuse by her babysitter (four sessions).

Treatment was extended to 42 sessions, as she lived with her father, who was responsible for many disruptive financial crises and arguments with girlfriends, some of which required police intervention and created a volatile, unstable environment. Leila’s BMI increased from 18 at the initial interview to 20 at the end of the treatment. Self-harm behaviors decreased, and she reported no suicide attempts or serious ideation during 6-month follow-up. Significant reductions

in anxiety and depression symptoms and increases in emotion regulation were achieved at the end of treatment. She achieved reliable changes at posttreatment assessments on the BDI-II (RCI=-11.02), BAI (RCI=-14.39), DERS (RCI=-22.84), DES (RCI= -13.67), and the DES-T (RCI = -26.4). At follow-up, changes on the BDI-II (RCI=-12.51), BAI(RCI=-8.25), DERS(RCI=-15.49), DES(RCI=-12.18), and DES-T (RCI=-16.6) were, likewise, reliable.

Discussion

Our research is the first to examine the effectiveness of the UP, a transdiagnostic cognitive-behavioral therapy, for the treatment of DID. The UP provides a relatively brief and viable alternative to treatment guidelines promulgated by the International Society for the Study of Trauma and Dissociation (ISSTD, 2011) that emphasize the interaction and fusion of identities. We secured provisional but highly promising findings that imply that the UP is effective in treating individuals diagnosed with both DID and comorbid conditions (e.g., anxiety, depression). In this case series with five adults, three blinded independent assessors used the SCID-I, SCID-II, and SCID-D to confirm the diagnosis of DID and thereby ensure the reliability among different practitioners of the diagnosis prior to treatment. During the intervention, participants completed all measures weekly. After the intervention, anxiety and depression decreased reliably, as did dissociation symptoms, including scores on the DES-T, a measure of severe dissociative psychopathology. Moreover, participants reported more functional emotional regulation strategies, and treatment gains were maintained after a 6-month follow-up. Although all participants met criteria for at least one comorbid anxiety or mood disorder at baseline, at the end of therapy and at follow-up, they no longer met full diagnostic criteria for DID or for a comorbid disorder.

Although participants reported that their different personality states were “trying to control them” at times, they eventually identified personality states as different aspects of themselves, rather than truly separate personalities. Additionally, the dominance of personality states was typically (although not completely) controlled with mindfulness/present-focus techniques.

Recovery and remembering of past memories were not a treatment goal but recall improved for some memories but not for others. Although teaching coping skills prior to traumatic memory exposure (Barlow et al., 2004) is probably essential to facilitate symptom alleviation, exposure to traumatic memories with inadequate preparation under conditions of emotional instability could produce deleterious effects (Brand et al, 2014; ISSTD, 2011).

A number of limitations warrant mention. First, we did not incorporate a randomized controlled trial or comparison conditions for natural fluctuations in symptoms, regression to the mean, the nonspecific effects of attention, demand characteristics, and rapport with the therapist. Second, the sample size was small. Third, all participants were referred by mental health professionals and volunteered for treatment, and they are not representative of DID in inpatient groups, for example. Fourth, all interventions were delivered by a single therapist, and her personal characteristics or distinctive style might have affected outcome. Fifth, subsequent research should use a formal therapist adherence protocol to document fidelity to the treatment, although we recommend flexibility be built into the protocol in treating this challenging population. Sixth, follow-up was restricted to 6 months. Although participants did not meet criteria for psychological disorders at the end of treatment, there was an uptick in self-reported symptoms at 6-month follow-up, and a decrease in reliable change scores (all changes were nevertheless still reliable), implying that symptom stability was not fully achieved in the longer term. Our findings, while encouraging, underscore the need for lengthier follow-up and perhaps more

protracted treatment or booster sessions. In future studies, it would be worthwhile to evaluate whether symptoms over follow-up are related to treatment skills. Seventh, our study permits no conclusions regarding what components of the UP alone, and in combination with others (e.g., education vs. exposure), played a role in positive outcomes. Moreover, we are not positioned to evaluate the contribution of adaptations to the UP, such as the split-screen technique, individualized methods to enhance present focus, and establishing a crisis plan. Additionally, the UP does not address how to work with people who believe they possess “separate selves,” so we accommodated this belief in the protocol. How best to intervene in this regard is still an open question. Eighth, and finally, the fact that we did not achieve integration of personality states implies that more intensive interventions are worthy of evaluation.

Future studies could compare the UP with empirically supported treatments, such as dialectical behavior therapy (DBT), which are geared to enhance emotional regulation, increase affect tolerance and meta-consciousness via mindfulness, and diminish experiential avoidance across affective states (Linehan, 1993). All participants were initially diagnosed with BPD, which is highly comorbid with DID, and for which DBT has demonstrated effectiveness. Accordingly, DBT may be a promising intervention for DID, although it has not been formally evaluated, apart from a single-case study that adapted DBT and did not administer psychometric instruments (Foote & van Orden, 2016).

The UP is agnostic with respect to the posttraumatic versus the sociocognitive model.

Nevertheless, DID treatment poses significant challenges, as implied by the SCM. As there is a link between dissociation and both fantasy-proneness and suggestibility (see Lynn et al., 2012), the SCM cautions that when new memories and personality states arise during treatment, one possibility is that suggestive elements in the therapy might be the cause. Alternately, the

widespread belief that trauma is associated with dissociation and that identifying personality states that contain traumatic memories is integral to successful therapy could spur accurate or inaccurate memory recovery and the belief in “multiple selves” (see Lilienfeld & Lynn, Ruscio, & Beyerstein, 2010). Accordingly, we recommend that DID treatments not neglect to evaluate (a) exposure to media portrayals of DID; (b) other sources of information regarding DID, including previous therapy experiences; and (c) exposure to suggestive methods (e.g., hypnosis for memory recovery; identifying dramatic shifts in behavior and affect as “personalities”) in current or prior therapy. Therapists would do well to eschew suggestive interventions and carefully monitor potential negative effects during therapy (e.g., Negative Effects Questionnaire, NES; Rozental et al., 2016), which are, notably, an underresearched area (Parry, Crawford, & Duggan, 2016). We did not corroborate participants’ initial reports and recovered memories of highly adverse events, some of horrific abuse. Yet even in cases in which historical events cannot be verified, exposure therapy may reduce subjective distress and increase emotional stability and self-regulation in response to putative memory triggers. As no evidence exists that special efforts to recover memories or uncover personality states are essential to successful outcomes, patients could be so informed at the start of treatment.

The UP in the treatment of DID could be refined or supplemented. For example, we strongly recommend that education in sleep hygiene be added to the UP for treating DID and perhaps in treating other emotional disorders that are potentially amenable to treatment with the UP in which sleep is disrupted or nonoptimal (e.g., borderline personality disorder, depression, PTSD, OCD). Research has consistently revealed an association between sleep disruptions, unusual sleep experiences (e.g., sleep paralysis), and dissociation (van der Kloet, Merckelbach, Giesbrecht, & Lynn, 2012). Moreover, sleep hygiene programs decrease dissociative symptoms

(van der Kloet, Giesbrecht, Lynn, Merckelbach, & de Zutter, 2012). Note that Participants 2 and 5 experienced a disturbed sleep-wake cycle and/or nightmares that appeared to play a role in their symptomatology. We recommend that sleep habits and problems be routinely evaluated, as should neurological problems in extensive amnesias, including fugue states, as dissociative amnesia has proven highly controversial (McNally, 2003, 2009).

DID is increasingly recognized as an emotional disorder reflected in a disturbance of the belief regarding the self and that therapy should, ideally, repair the division among perceived “parts.” Indeed, at the end of the current treatment, participants did not report they were “fully integrated” (met DSM Criterion A). The fact that the therapist used names for personality states quite possibly reified and reinforced their existence, although not doing so posed resistance from patients, raising concerns about invalidating their self-presentations, particularly prior to establishing a strong therapeutic alliance. Although a goal of the UP is not to promote personality synthesis, if this were a goal, it would probably be necessary, in certain cases, to implement a longer, more intensive intervention, with greater scaffolding to support the belief in a unified self. We recommend more concerted focus on narrative themes and emotions common among participants, including shame, guilt, self-blame, anger, powerlessness and need for “safety” to mitigate their expression in different personality states. Gentle challenges that express empathic understanding of the development and function of the narrative of a divided self and that eschew or greatly limit reference to personality states by name would be important to implement in interventions and examine in future studies. We attempted to convey the idea that different “parts” could be accommodated within a single self, and we recommend that future researchers do likewise from the inception of treatment.

In conclusion, we provided preliminary evidence for a protocol-based, relatively brief,

transdiagnostic, emotion-focused cognitive-behavioral therapy approach in treating DID. We were encouraged that (a) all participants completed therapy; (b) at the end of treatment they no longer met criteria for diagnoses; (c) their anxiety, depression, and dissociative symptoms decreased reliably; and (d) impressive gains were mostly maintained after 6 months. We hope our research will pave the way for larger randomized controlled trials with longer follow-ups. The time has come to systematically address the complex needs and psychopathology of persons with DID. Developing, evaluating, and refining extant and novel treatment alternatives for this serious and vexing condition should be a high priority for researchers and clinicians alike.

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Table 1. Initial and Final Diagnosis

Participants	Age	Medicine	Principal diagnosis	Comorbid Disorders Pre-treatment Assessment	Post-treatment Assessment	Six Month Follow-Up Assessment
Anna	28	Prozac	DID (5 symptoms)	GAD (5 symptoms) BPD (5 symptoms) MDD (7 symptoms) Excoriation	Subclinical Diagnoses DID (1 symptom) BPD (4 symptoms)	Subclinical Diagnoses DID (1 symptom) BPD (2 symptoms)
Pari	32	Prozac	DID (5 symptoms)	MDD (7 symptoms) BPD (6 symptoms) DPD (6 symptoms)	Subclinical DID (1 symptom) DPD (4 symptoms)	Subclinical DID (1 symptom) DPD (3 symptoms)
Amin	30	Prozac	DID (5 symptoms)	MDD (5 symptoms) BPD (5 symptoms) NPD (7 symptoms)	Subclinical DID (1 symptom)	Subclinical DID (1 symptom)
Mona	28	Paxil	DID (5 symptoms)	MDD (7 symptoms) BPD (7 symptoms) GAD (7 symptoms) HPD (6 symptoms)	Subclinical DID (1 symptom) BPD (4 symptoms) HPD (4 symptoms)	Subclinical DID (1 symptom) BPD (2 symptoms) HPD (2 symptoms)
Leila	24	Paxil	DID (5 symptoms)	MDD (7 symptoms) BPD (8 symptoms) GAD (8 symptoms) anorexia nervosa	Subclinical DID (1 symptom) BPD (4 symptoms)	Subclinical DID (1 symptom) BPD (4 symptoms)

Table 2. Descriptive Statistics, Effect Size and Percentage of Change

Anna					Pari					Amin					Mona					Leila		
B	I	F	ES	PC	B	I	F	ES	PC	B	I	F	ES	PC	B	I	F	ES	PC	B	I	F
9	15. 70	13	1.82	46 %	40. 33	21. 55	15. 33	1.98	46 %	39	20. 59	15. 66	1.98	46 %	30. 66	19. 42	19	1.92	36 %	41	26. 82	16. 33
8	27. 00	15	1.91	44 %	40 40	23. 05	14	2.06	42 %	40. 66	24. 54	14	1.87	40 %	40. 33	24. 57	18	2.19	39 %	45	28. 05	16. 33
5	89. 45	76	2.0	29 %	12 7.6 6	66. 88	72. 33	2.74	48 %	130 .66	95. 45	86. 33	2.24	27 %	13 8.6 6	99. 66	72	1.79	28 %	131. 33	98. 94	74
5	37. 00	33	2.54	32 %	58. 33	40. 77	36	1.82	30 %	55. 33	40. 54	35. 33	2.22	27 %	64. 66	44. 28	35. 33	1.69	31 %	66.6 6	45. 02	36. 33
6	48	33	1.79	37 %	83. 25	55. 79	32. 5	1.58	33 %	77. 5	48. 94	32. 5	1.87	37 %	84. 58	50. 15	30. 75	1.9	41 %	84.1 6	57. 07	31. 62

Notes: B= Mean of Baseline score; I= Mean of intervention phase; F=Mean of follow-up phase; BDI-II=Beck Depression Inventory, Inventory; DERS= Difficulties in Emotion Regulation Scale; DES= Dissociative Experience Scale; ES= Effect Size, PC= Percentage of c

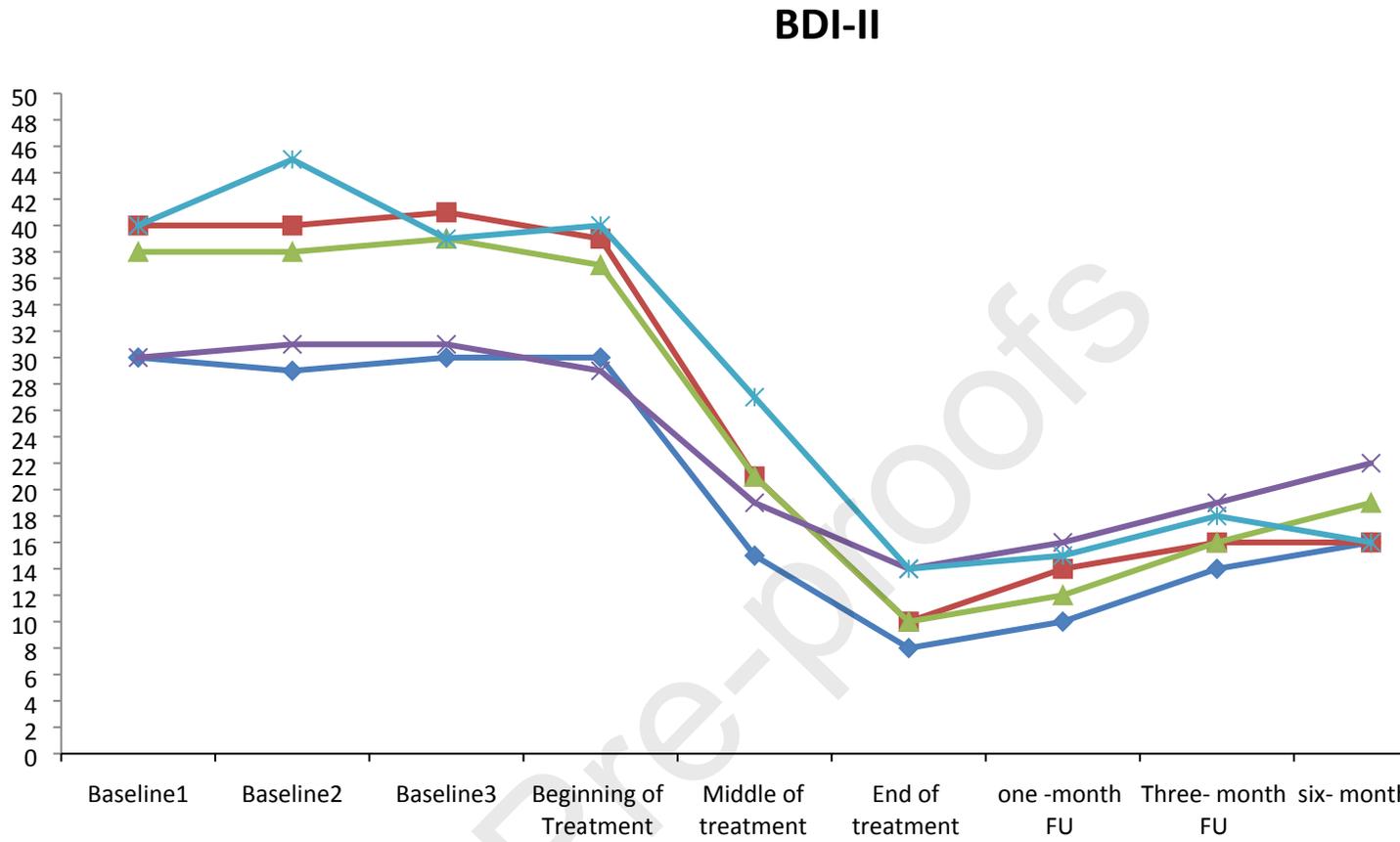


Figure 1. Scores over time BDI-II (one-month FU=assessments after one-month treatment interval, three-month FU= assessments after three-month treatment interval, Six-month FU= assessments after six-month treatment interval)

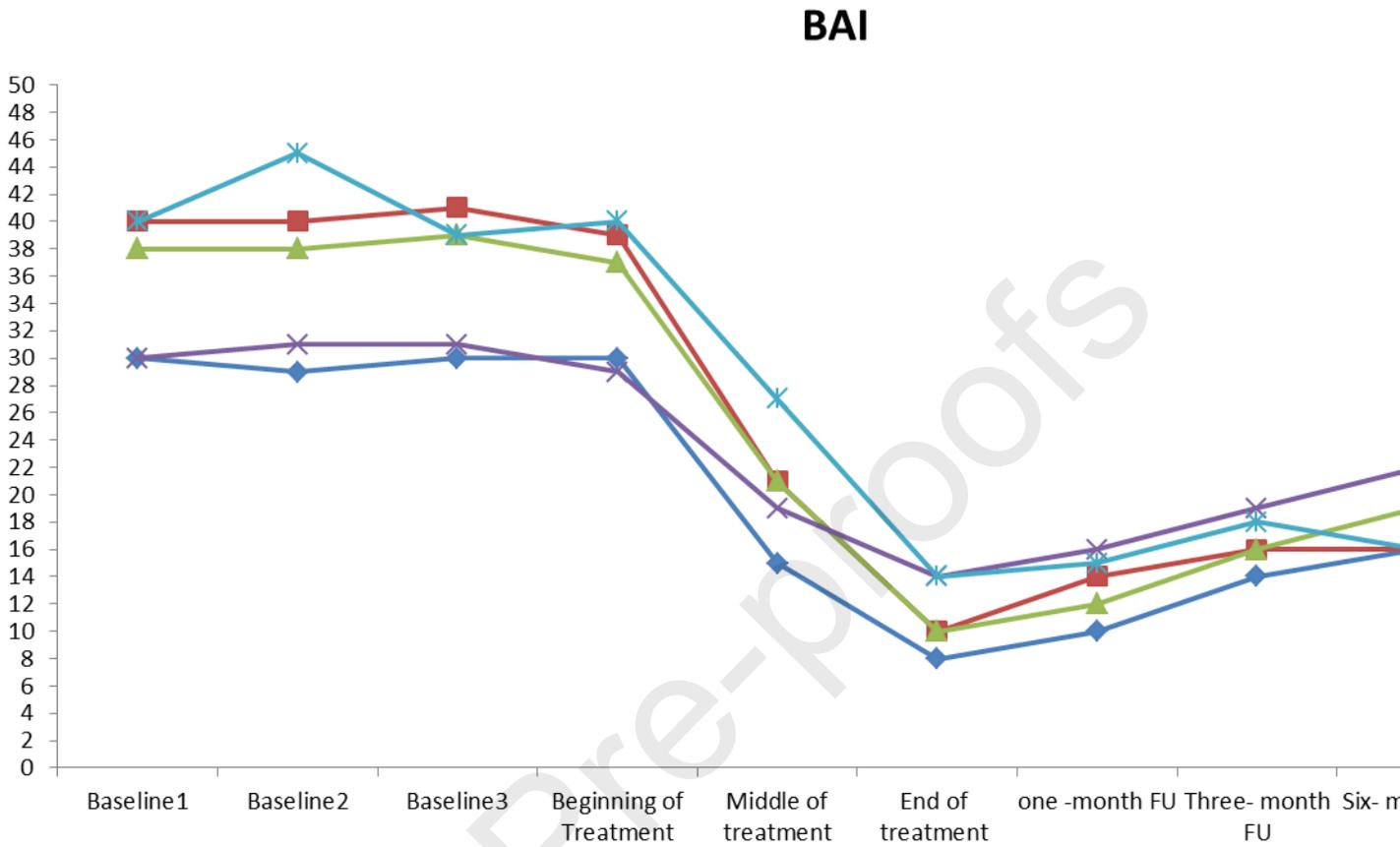


Figure 2. Scores over time of BAI (one-month FU=assessments after one- month treatment interval, three-month FU= assessments after three- month treatment interval, Six-month FU= assessments after six- month treatment interval).

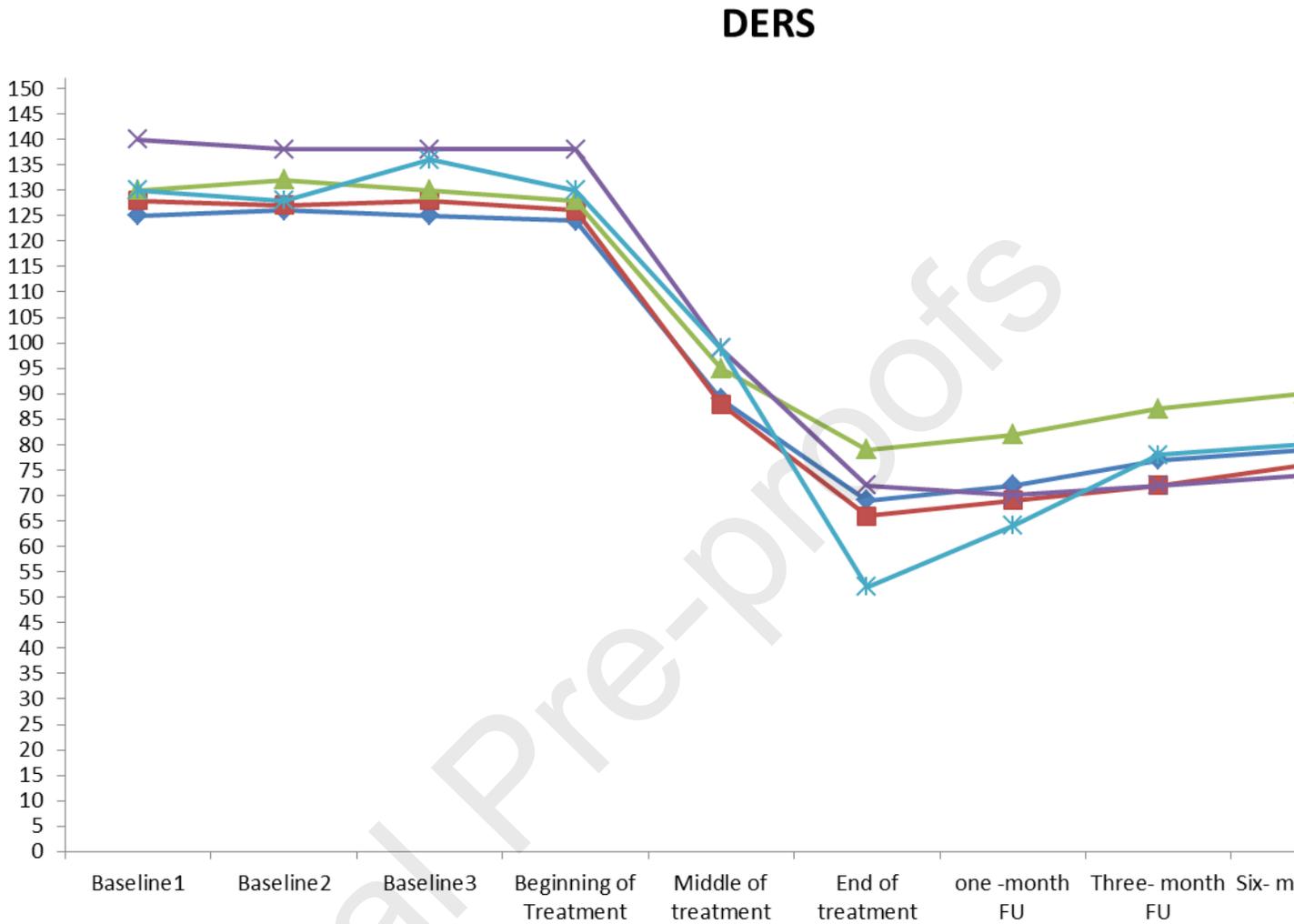


Figure 3. Scores over time of DERS (one-month FU=assessments after one-month treatment interval, three-month FU: three- month treatment interval, Six-month FU= assessments after six-month treatment interval).

DES

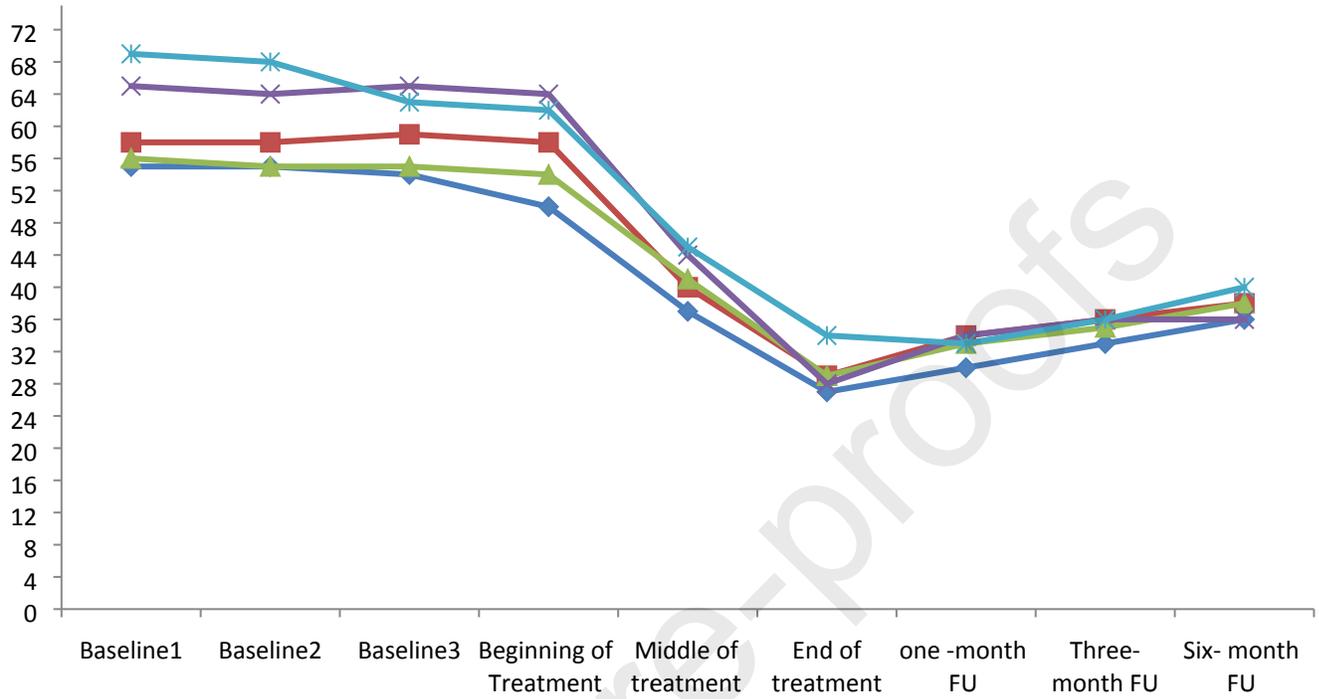


Figure 4. Scores over time of DES (one-month FU=assessments after one-month treatment interval, three-month FU: assessments after three-month treatment interval, Six-month FU= assessments after six-month treatment interval)



Figure 5. Scores over time of DES-T (one-month FU=assessments after one-month treatment interval, three-month FU: assessments after three-month treatment interval, Six-month FU= assessments after six-month treatment interval).

Five dissociative identity disorder (DID) patients treated with Unified Protocol

Four patients treated 18-22 sessions, one patient treated 42 sessions

None of patients met criteria for DID, comorbid conditions at six-month follow-up

Significant changes in anxiety, depression, dissociation, emotion regulation

Journal Pre-proofs