

CLINICIANS' ADHERENCE TO DD INTERVENTIONS

TOWSON UNIVERSITY
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DISSOCIATIVE DISORDER TREATMENT IN PRACTICE: AN EXPLORATION OF
COMMUNITY CLINICIANS' ADHERENCE TO EXPERT RECOMMENDED
FREQUENCY OF INTERVENTIONS

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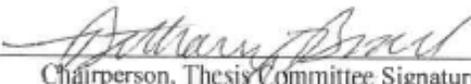
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Abstract

DISSOCIATIVE DISORDER TREATMENT IN PRACTICE: AN EXPLORATION OF
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FREQUENCY OF INTERVENTIONS

Sarah T. Sanchez

Few clinicians have been trained to treat patients with dissociative disorders (DD), despite their prevalence. An online educational program for DD patients and their clinicians was developed to make training for DD treatment readily available to clinicians, while assisting DD patients in stabilizing their symptoms and improving their functioning. The current study assessed the extent to which participating clinicians reported using DD treatment activities at the frequency recommended by DD experts in the context of clinician factors and patient outcomes. Participants were an international sample of predominantly white, female DD patients and their treating clinicians ($N = 89$). Adherence to experts' recommendations did not change over the course of the study, but clinicians' initial adherence may predict patient outcomes after two years. The findings suggest further research is necessary to determine whether a meaningful relationship exists between patient outcomes and clinicians' adherence to DD expert recommended frequency of treatment activities.

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CLINICIANS' ADHERENCE TO DD INTERVENTIONS

Introduction

Dissociative disorders (DD) are frequently found in the aftermath of trauma and feature a disruption of and/or discontinuity in the normal integration of consciousness, identity, perception, emotion, behavior, and more, which causes symptoms that have the potential to disrupt all areas of psychological functioning (American Psychiatric Association [APA], 2013). DD symptoms are characterized by positive dissociation (i.e. loss of continuity in subjective experience with associated unwanted, involuntary intrusions into awareness and behavior) and/or negative dissociation (i.e., inability to access information or control mental information) (APA, 2013; Dalenberg et al., 2012). Dissociative Identity Disorder (DID) is characterized by presence of two or more distinct self-states in addition to recurrent episodes of amnesia (APA, 2013). Dissociative disorder not otherwise specified (DDNOS), which was renamed Other Specified Dissociative Disorder (OSDD) in DSM-5, features mixed, chronic or recurrent dissociative symptoms that approach but fall short of diagnostic criteria for DID (APA, 2013). DID and DDNOS/OSDD were the focus of this study and are referred to collectively as DD. Due to the complexity of DD presentations and the variety of needs at each phase of treatment, it is critical for clinicians to have familiarity and expertise with the interventions that are appropriate for DD treatment. This is especially important because, contrary to common perception, DD are not rare disorders.

DD are as prevalent as many other disorders for which clinicians routinely screen (International Society for the Study of Trauma and Dissociation [ISSTD], 2011), such as major depressive disorder (7% 12-month prevalence; APA, 2013) and posttraumatic stress disorder (U.S. 12-month prevalence 3.5% with international prevalence estimates

clustering around 0.5-1.0%; APA, 2013). The prevalence of DD ranges from 0.4-14.0% depending on the source of information; the variation is likely due in part to differences in methodology and settings across studies (Dorahy et al., 2014; Friedl et al., 2000) in addition to the many factors that contribute to the complexity of DD.

Issues that complicate the diagnosis, research, and treatment of DD include, but are not limited to, poly-symptomatic profiles, extremely high comorbidity with non-dissociative psychopathology, and lack of clinician training and familiarity with dissociation (APA, 2013; ISSTD, 2011). As of 2014, no studies had found DID without multiple comorbid non-dissociative disorders (see Dorahy et al., 2014, for a review). DD comorbidity often includes posttraumatic stress (PTSD), mood, anxiety, substance use, and somatoform disorders (reviewed in Dorahy et al., 2014). Individuals with DD typically struggle with chronic self-injurious behavior and frequent suicidal thoughts and attempts (Foote, Smolin, Neft, & Lipschitz, 2008). Patients with DD are commonly excluded from research due to these comorbidities, thus treatment studies rarely include DD patients (see Brand et al., 2009, for a review). Despite their exclusion from studies, the prevalence rates of DD suggest it is not uncommon for clinicians to encounter and treat DD, although they may be unaware of, and fail to address, the patient's DD. Thus, research on the treatment of DD patients, and increased training of therapists about DD research and treatment, is urgently needed.

Conceptualization of DD as Trauma Disorders

The conceptualization of DD as disorders resulting from trauma, the trauma model, is the most widely accepted and studied model of the disorders (Dalenberg et al., 2012). There is substantial evidence to suggest that DID and the other complex DD are

“chronic complex posttraumatic developmental disorder” (Sar, Dorahy, & Kruger, 2017, p. 138). Despite research supporting the trauma model of dissociation, the etiology, validity, and conceptualization of DID and related complex DD such as DDNOS/OSDD have been highly debated (Brand et al., 2016; Dalenberg et al., 2012; Lilienfeld et al., 1999). The trauma model of DD posits a causative role for trauma in DD development while a competing model, called the fantasy model of DD or the sociocultural model, denies a strong or causative relationship between trauma and dissociation. The fantasy model proposes that fantasy proneness, cognitive deficits, suggestibility, and sociocultural factors lead to dissociation (Lynn et al., 2014). A thorough review of the research underlying the trauma versus the fantasy models by Dalenberg et al. (2012) concluded that the etiological, cognitive, neurobiological, and treatment evidence consistently supports the trauma model of dissociation.

The debate about whether trauma versus fantasy causes DD is important because of the implications for the treatment of individuals with DD. Trauma model proponents advocate for treatment that attends to resolving trauma, including trauma-related dissociation, whereas fantasy model proponents claim that focusing on trauma and dissociation in treatment can worsen DD patients' symptoms. Fantasy model proponents argue that focusing on trauma and dissociation may create fantasy-based beliefs about dissociative self-states that are non-existent and/or memories of trauma that may never have happened (Lilienfeld, 2007). When the treatment approach for a disorder is debated, treatment providers should turn to expert clinicians, treatment guidelines, and the results of research to determine what methods to use when treating their patients.

Guidelines and Research about the Treatment of DD

The International Society for the Study of Trauma & Dissociation (ISSTD) is the main professional organization focused on educating clinicians about dissociation and its treatment. The ISSTD's panel of experts have developed expert consensus treatment guidelines about the treatment of DD beginning in 1994. The guidelines have been updated three times, based on evolving clinical and research findings. The current version, *Guidelines for Treating Dissociative Identity Disorder in Adults, Third Revision* [henceforth, "the Guidelines"], (ISSTD, 2011) concluded that, despite disagreement between proponents of the fantasy and trauma models of DD, "there is no actual research that shows that the complex phenomenology of DID can be created, let alone sustained over time, by suggestion, contagion, or hypnosis" (ISSTD, 2011, p. 124).

Because individuals with DD often experience frequent suicidal thoughts and/or attempts, self-injurious behavior, and comorbidities that increase risky behavior (e.g. PTSD, substance use disorders), the overall focus of DD treatment is to help patients adapt to daily life through developing skills to establish safety and stability. Informed by the Guidelines and research studies, current DD treatment relies on phasic, trauma-informed treatment including these phases: (1) safety, stabilization, and symptom reduction, (2) trauma focused treatment, and (3) integrated functioning across dissociated self-states. Phases are flexible and determined by the needs of the patient; therefore, treatment is nonlinear and involves returning to previous phases periodically (ISSTD, 2011; Van der Hart, Nijenhuis, & Steele, 2006). In addition, the Guidelines suggest individual psychotherapy that is psychodynamically oriented and includes eclectic techniques (ISSTD, 2011).

DD treatment research has been difficult to conduct due to the recursive, lengthy nature of DD treatment and the complex symptomatology of DD patients, so it is still in its infancy (ISSTD, 2011). However, the extant research demonstrates that trauma-informed treatment with DD patients is associated with a wide range of improvements including reduced dissociation, PTSD symptoms, and self-harm (Brand et al., 2016; Dalenberg et al., 2012).

The effectiveness of phasic trauma treatment for DD consistent with the Guidelines has received preliminary support in research using single-case research designs (e.g., Kellett, 2005; Lloyd, 2016; Pollock, Macfie, & Elledge, 2017). A number of studies have found that psychiatrically hospitalized patients who receive trauma treatment for DD showed improvements across a range of symptoms including dissociation, depression, PTSD symptoms, and suicide attempts, among other improvements (Ellason & Ross, 1997).

Case studies and inpatient studies are easier and less expensive to conduct than outpatient treatment studies, but outpatient DD treatment research has recently been developed. Brand and colleagues (2009) conducted an international prospective, naturalistic study called the Treatment of Patients with Dissociative Disorders (TOP DD) study. The TOP DD naturalistic study (2009) found that patients in later stages of treatment for DD engaged in less self-injurious behavior and experienced fewer symptoms of dissociation and PTSD, among others, than patients in earlier stages of treatment, suggesting that long-term, outpatient treatment for DD may be associated with many improvements. The TOP DD longitudinal naturalistic study (Brand et al., 2013) found that patients reported decreased dissociation, general distress, and PTSD symptoms

over the course of the 30-month study. Patients also reported more frequent social involvement and feeling good as treatment progressed (Brand et al., 2013).

Based on the success of recruiting an international sample for the TOP DD naturalistic study, Brand et al. (under review) developed the TOP DD *Network Study* ('Network study'). This is the first manualized educational intervention for DD patients and their therapists. The Network Study examined the effectiveness of a web-based educational intervention about DD, used in combination with individual psychotherapy. The overall goal of the Network study was to improve symptom management and functioning in patients with DID or DDNOS/OSDD ('DD patients') by educating DD patients and their therapists via an online platform. The Network study also aimed to increase clinicians' awareness of methods for stabilizing DD patients via its web-based educational program for patient-clinician dyads that was completed at an individualized pace over two years. The Network study taught DD patients and their clinicians about symptoms related to complex trauma including dissociation, healthy coping skills with an emphasis on symptom and affect management, and methods to enhance DD patients' safety (TOP DD Study website). Preliminary results indicate that participation was associated with a reduction in symptoms of dissociation and PTSD, higher adaptive capacities, and reduced non-suicidal self-injury. Furthermore, patient groups with higher dissociation showed more improvement than patients with lower dissociation (Brand et al., under review).

Translation of Research to Clinical Practice

Clinicians and researchers have debated how and to what extent to implement the findings of research in practice. This is seen throughout psychology as researchers have

explored the divide between research, guidelines, and practice. For example, Rhodes et al. (2010) found that 90% of clinical staff members reported using established guidelines for treating depression but only 20% of the sample reported confidence in implementing the guidelines. The journal *Epidemiology and Psychiatric Sciences* devoted an issue in 2012 to exploration of the gap between evidence-based guidelines and their implementation. Dozois (2013) addresses the difficulties of “putting evidence into practice and practice into evidence” by highlighting the discrepancy between research & practice and providing potential methods to bridge this gap.

DD treatment researchers have also begun exploring whether community clinicians are following expert recommendations for DD treatment. Brand et al. (2012) surveyed 36 expert DD clinicians as to the treatment activities they believe are important at the stages of DD treatment. For this survey, the stages of treatment were expanded such that the three-stage model was expanded to five stages to allow a more nuanced study of changes in interventions over the years of treatment typically required for DD patients. The authors used the following stages: Stage 1- stabilization and establishing safety; Stage 2 (no description given); Stage 3- processing memories of trauma with emotion and grieving related losses; Stage 4 (no description given); and Stage 5- integration and reconnection within self and with others. Twenty-eight treatment activities were divided into eight rationally derived categories (e.g., assessment and safety, daily functioning skills, emotion regulation, etc.) and the experts reported how often they recommended that clinicians use each activity at each of the five stages of DD treatment. Brand et al. (2012) identified a core set of interventions which the experts frequently recommended across all stages of treatment as well as interventions whose

recommended frequency varied by stage. Experts consistently recommended specific interventions focused on stabilization for early stages of DD treatment, trauma-focused interventions for middle stages of treatment, and more individualized interventions geared toward integrated functioning within themselves at later stages of treatment.

Myrick et al. (2015) compared the use of interventions reported by community clinicians who participated in the first, naturalistic TOP DD Study (Brand et al., 2009) with the experts' recommended use of interventions from Brand et al. (2012). The goal was to determine whether community clinicians implemented interventions with DD patients at the same frequency that the experts recommended. Using profile analysis, Myrick and colleagues found that despite considerable agreement between experts' recommendations and community clinicians' implementation, community clinicians did not report utilizing all interventions as frequently as recommended by experts. Notably, community clinicians treating patients in the first two stages reported often or very often using some interventions which experts recommended should be reserved for middle stages of treatment, such as trauma exposure (e.g., discussing the trauma in extensive detail) and other trauma-focused work. Although trauma exposure work is important in DD treatment, it is critical that trauma exposure is not implemented before DD patients have the stabilization and safety skills necessary to tolerate an intensive focus on trauma. It is important to note that the community clinicians were unlikely to have known the experts' recommendations as the results of the expert survey were published after the first TOP DD study.

TOP DD Network Study. The current study relies on data collected in the TOP DD Network study, so it is discussed in detail. Recognizing that community clinicians are

likely to encounter and treat DD patients but may have limited knowledge about DD treatment, the Network study was developed as a cost-effective method to increase clinicians' knowledge of techniques useful in stabilizing DD patients' symptoms. Participants in the Network Study were recruited via emails obtained from ISSTD listservs, previous TOP DD participants, the Network Study website, Network Study Facebook announcements, and advertising done at trauma and dissociation professional conferences. Participants consisted of patient-clinician dyads in which the clinician was actively treating the patient for a DD. Patients were required to have a diagnosis of DID or DDNOS/OSDD but were not excluded based on comorbid diagnoses. Dyads met the following eligibility criteria. DD patients must have been referred to the study by their individual clinician, who was also willing to participate in the study and the dyad must have been working together for at least 3 months. In addition, patients needed to be able to: read English at the eighth-grade level, tolerate hearing and thinking about general references to stressors including trauma, remain in therapy with the participating clinician, and agree to various time commitments related to the study. If either the clinician or patient discontinued treatment for any reason, neither participant could continue in the study. For more specific information regarding recruitment of participants, see Brand et al. (2009) or the TOP DD Network website.

The Network Study data was collected via online surveys hosted on established password-protected survey hosting websites. Participants first completed a screen to determine if they met eligibility requirements, and if they did, they were enrolled in the study and sent a link to complete the intake survey (intake) prior to being given access to the web-based psychoeducational material. Upon completing the screening and initial

surveys, participants were sent reminder emails to complete subsequent milestone surveys for 2 years after the anniversary of completing their initial survey. These included a survey completed after 12 months (Time 1, T1) and 24 months (Time 2, T2). Clinicians' screen surveys included demographic, treatment, and diagnostic information while intake and subsequent milestone (e.g. T1, T2) surveys included treatment and symptom focused measures such as (but not limited to) the Dissociative Disorder Treatment Activity Questionnaire (DDTAQ) (see measures) and the Progress in Treatment Questionnaire for Therapists (PITQ-t, see measures). Patients' screen surveys included demographic, mental health history, and symptom information while intake and milestone surveys (e.g. T1,T2) included treatment and symptom focused measures such as, but not limited to, the Progress In Treatment Questionnaire for Patients (PITQ-p, see measures), the PTSD Checklist – Civilian (PCL-C) (Weathers, Litz, Huska, & Keane, 1994), and the Dissociative Experiences Scale II (DES-II) (Carlson & Putnam, 1993).

Current Study

The current study aims to expand upon the work of Myrick et al. (2015) by utilizing data from Brand et al.'s (2012) expert survey and the Network Study to further examine community clinicians' use of expert recommended DD treatment interventions. In lieu of conducting profile analyses like Myrick et al. (2015), this study created the Adherence to Dissociative Disorder Treatment Activities Score (ADDTAS, see measures). The ADDTAS is a novel measure of community clinicians' adherence to experts' recommended frequency of interventions and is based on the results of the experts' recommendations from Brand et al. (2012) as well as Network Study clinicians'

responses on corresponding measures. Creation of the ADDTAS, a continuous variable measuring adherence, enabled this study to explore the following hypotheses.

H1. At the start of the study, community clinicians will report using treatment interventions at a frequency below that recommended by experts as indicated by ADDTAS below zero.

H2. This discrepancy will correlate with experience, such that more experienced clinicians will report using interventions at a rate that is more in line with experts' recommendations, i.e. more experienced clinicians will have an ADDTAS closer to zero.

H3. Community clinicians' reported use of interventions compared to experts' recommended use will vary based on the community clinicians' theoretical orientation. Community clinicians with theoretical orientations that are identified by the Guidelines as common DD treatment orientations (psychodynamic and cognitive-behavioral) will report using interventions at a rate that is more in line with experts' recommendations than community clinicians with other orientations (family systems, humanistic/experiential, and 'other').

H4. Community clinicians' adherence to expert recommended activities will increase over the course of the study from intake to the milestone surveys at one year after intake (T1) and two years after intake (T2).

H5. Patient outcomes at the end of the study, as measured by adaptive capacities developed in treatment as well as dissociative and trauma symptoms, will be predicted by their clinicians' level of adherence to experts' recommended use of interventions over the course of the study.

Method

The current study utilizes data from two studies of DD previously conducted by Brand and colleagues: an archival dataset used in Brand et al.'s (2012) survey of expert recommended treatment interventions for treating DID and DDNOS ('experts') and a subset of the data from the TOP DD Network Study ('community clinicians' and 'patients'). Both studies were approved by the institutional review board of Towson University. All participants provided informed consent prior to participation and were not compensated for participation.

In this study, expert data was used in the creation of the ADDTAS and for exploratory, descriptive analysis related to interpreting the findings of the current study. Expert data was not directly included in analyses beyond calculation of the ADDTAS. For details about the expert sample, selection criteria, and method, refer to Brand et al. (2012). Participants in the current study are a subset of the Network study participants; they were selected based on criteria that are described here.

Participants

Community clinicians were included in the current study if they met Network Study requirements and completed the screen and intake surveys as well as either or both milestone surveys (one year, T1; two years, T2). In addition, clinicians' patients must have also completed the screen and intake surveys as well as at least one milestone survey (T1 and/or T2). Dyads in which the clinician also completed the expert survey ($n = 2$) were not excluded from this study because they did not significantly differ from community clinicians on ADDTAS at intake, $t(87) = 0.58, p = .566, d = 0.43$. However, Hypothesis 2 was tested with ($n = 89$) and without ($n = 87$) expert clinicians in the

current sample because years of experience treating DD were part of the Expert Study inclusion criteria. These criteria resulted in a sample of 89 patient-clinician dyads at intake. Because neither clinicians nor patients were excluded from this study for missing one milestone survey, missing data led to reduced sample size in analyses that included more than one timepoint.

Community clinicians and their patients hailed from numerous countries across four continents including the United States, Norway, Canada, Australia, and more (see Table 1). The majority of clinicians were female (78.7%, $n = 70$) and identified predominantly as Caucasian (86.5%, $n = 77$) (see Table 1). Most community clinicians identified their theoretical orientation as psychodynamic with others identifying as cognitive behavioral, humanistic/experiential, and more (see Table 2). Patients were mostly female (89.9%, $n = 80$) and predominantly identified as Caucasian (87.6%, $n = 78$) (see Table 1).

Clinician Variables

Adherence to Dissociative Disorder Treatment Activities Score (ADDTAS).

The Adherence to Dissociative Disorder Treatment Activities Score (ADDTAS) was created for this study to measure community clinicians' adherence to the recommended treatment activity frequencies identified by the Expert Survey. The ADDTAS is based on the Dissociative Disorder Treatment Activities Questionnaire (DDTAQ) utilized in the Expert Survey (Brand et al., 2012), the first TOP DD Study (Brand et al., 2009), and the Network Study (Brand et al., under review).

The DDTAQ is a measure of 26 therapeutic activities recommended for DD treatment based on the interventions discussed in the ISSTD's *Guidelines for Treating*

Dissociative Identity Disorder in Adults (Chu et al., 2005). In the Expert Survey, the DDTAQ asked expert clinicians to indicate how often they recommend using each treatment activity with DD patients at each of five stages of treatment. That is, each expert clinician rated each treatment activity five times, once for each stage of treatment (Brand et al., 2012). The Expert Survey response data was used in the current study to calculate a stage-specific mean expert recommended frequency (“recommended frequency”) for each treatment activity, e.g. treatment activity “establishing safety” had five expert recommended frequencies: Stage 1 recommended frequency, Stage 2 recommended frequency, etc. At each time point in the Network Study, community clinicians completed the DDTAQ by reporting the frequency at which they used each treatment activity over the last six months (“reported frequency”). Community clinicians in the Network Study reported their patients’ stage of treatment at each time point and reported the frequency with which they used each activity. Both expert and community clinicians rated the frequency for each treatment activity on a scale of 0 (never) to 4 (very often). Community clinician DDTAQ responses in the Network Study were used to calculate their ADDTAS as described below.

The ADDTAS was calculated by subtracting the appropriate stage-specific recommended frequency from their reported frequency for each treatment activity on the DDTAQ. The differences for all 26 treatment activities were summed to create the community clinicians’ ADDTAS, which could range from -104 to 104, with zero representing exact adherence to expert recommended frequency of treatment activities. This process was repeated for each time point such that each community clinician had an ADDTAS at intake, T1 ADDTAS, and T2 ADDTAS. The current study theorized that by

using the recommended frequency for the reported stage of treatment at each time point, the ADDTAS would account for variability in stage of treatment within and between community clinicians over the course of the study. Additionally, it was theorized that accounting for stage of treatment and using all treatment activities on the DDTAQ would enable the ADDTAS to provide an overall measure of adherence to recommended frequencies. Since ADDTAS was calculated by subtracting the expert recommended frequency from the clinician reported frequency, it could be interpreted as follows: negative ADDTAS indicated the clinician was utilizing activities at a frequency less than recommended, positive ADDTAS indicated the clinician was utilizing activities at a frequency greater than recommended, and ADDTAS equal to zero indicated the clinician was utilizing activities at the recommended frequency. The ADDTAS showed good internal consistency at each time point (intake, Cronbach's $\alpha = .88$; T1, Cronbach's $\alpha = .91$; T2, Cronbach's $\alpha = .89$). This suggests that the items included in the ADDTAS appear to measure one general construct.

Experience. At intake, community clinicians self-reported the number of years that they had treated DD patients, treated traumatized patients, and practiced therapy. The number of years treating DD patients was selected to test Hypothesis 2.

Theoretical Orientation. While most of the clinicians in the Network study reported a psychodynamic orientation, they reported a variety of theoretical orientations (see Table 2). Clinicians who selected "other" reported orientations including but not limited to eclectic (or multiple) approaches, Eye Movement Desensitization and Reprocessing (EMDR) therapy, sensorimotor approaches, and feminist. Hypothesis 3 was tested using clinicians' self-reported theoretical orientation.

Patient Outcome Measures**Progress in Treatment Questionnaire, therapist version (PITQ-t).** The

Progress in Treatment Questionnaire, therapist version (PITQ-t) was developed as an updated version of the Progress in Treatment Questionnaire (PITQ) which was developed for the original TOPDD study (Brand et al., 2009; Schielke, Brand, & Marsic, 2017). Both measures were based upon the ISSTD Guidelines for Treating Dissociative Identity Disorder in Adults (Chu et al., 2005). Schielke and colleagues (2017) slightly modified the measure for the Network Study by adding a question regarding dissociative self-states (DSS) which determines whether clinicians respond to the 6 items about the clients' DSS. The PITQ-t consists of 29 items which measure capacities developed throughout the stages of treatment for DD, including but not limited to affect tolerance, impulse control, PTSD & dissociative symptom management skills, ability to tolerate fully knowing about and experiencing emotional and sensory experiences related to trauma, and DSS when applicable. For example, two items were "The patient is aware that the abuse was not his or her fault" and "The patient knows and uses containment strategies (hypnotic or imagery techniques used to contain intrusive PTSD symptoms) when they are needed." Using a 10-point scale (0 = 0% - never to 100 = 100% - always), community clinicians estimated what percentage of the time their patient demonstrates each capability over the past six months. The PITQ-t is scored by taking the mean of completed items (23 if no self-states, 29 if self-states). In a study of its psychometric properties, the PITQ-t showed good internal reliability (Cronbach's $\alpha = .91$) as well as convergent validity as measured by significant correlations with measures of dissociation, PTSD, and behaviors associated

with DD (Schielke et al., 2017). The PITQ-t is available online at TOPDDStudy.com/PITQ-t.

Progress in Treatment Questionnaire, patient version (PITQ-p). The Progress in Treatment Questionnaire, Patient (PITQ-p) is the counterpart to and was developed in tandem with the PITQ-t by Schielke and colleagues (2017). Like its counterpart, the PITQ-p was modified slightly for the Network Study to include a new dichotomizing question regarding DSS while retaining the original scored items which measure capacities developed throughout the stages of treatment for DD. Using a 10-point scale (0 = 0% - never to 100 = 100% - always), patients rated what percentage of the time they demonstrated a behavior during the past week. The PITQ-p consists of 32 possible items, with the 6 DSS items only answered by patients endorsing DSS. Like the PITQ-t, the PITQ-p is scored by taking the mean of completed items (26 if no self-states, 32 if self-states) and showed good internal reliability (Cronbach's $\alpha = .92$) as well as convergent validity as measured by significant relationships with measures of dissociation, PTSD, and behaviors associated with DD (Schielke et al., 2017). The PITQ-p is available online at TOPDDStudy.com/PITQ-p.

Dissociative Experiences Scale II (DES-II). The Dissociative Experiences Scale II (DES-II) was developed to provide a measure of patients' experiences of dissociation (Carlson & Putnam, 1993). It consists of 28 items in which patients use a 10-point scale (0% - never to 100% - always) to rate the percentage of time that they have had each experience, e.g. "Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them

before.” The DES-II score is calculated by taking the mean of all items and showed good reliability in the Network Study sample (Cronbach's $\alpha = .96$).

Posttraumatic Stress Checklist – Civilian Form (PCL-C). The Posttraumatic Stress Checklist – Civilian Form (PCL-C) is a 17-item self-report measure of the symptoms of PTSD as defined in the DSM-IV-TR in the past month (Weathers, Litz, Hushka, & Keane, 1994). While Weathers and colleagues have published an updated version of this measure to reflect the DSM-5, the Network Study began prior to its publication and thus the PCL-C was utilized. The items on the PCL-C measure how often the respondent is bothered by each symptom in the past month on a 5-point severity scale of 1 = Not at all to 5 = Extremely. The PCL-C is scored by summing the responses to each item, with higher scores indicating greater distress and cutoffs for diagnosis varying depending on the prevalence of PTSD in a sample (Weathers & Ford, 1996). The PCL-C has strong test-retest reliability (.96 in a 2-3 day interval; Weathers et al., 1994), high overall diagnostic efficiency (0.90; Blanchard, Jones-Alexander, Buckley, & Forneris, 1996), and showed good internal reliability in the Network Study sample (Cronbach's α ranged from .88 to .92).

Results

Data Analysis

All analyses were conducted using SPSS v.23. The assumption that the ADDTAS accounted for stage of treatment was tested with an independent samples *t*-test at each time point prior to testing hypotheses. Hypothesis 1 was tested with a one sample *t*-test comparing ADDTAS at intake to zero. Hypothesis 2 was tested using a bivariate correlation of experience with ADDTAS at intake. Hypothesis 3 was tested with a one-

way analysis of variance (ANOVA) and a significant omnibus was followed up with contrast analysis. Hypothesis 4 was tested using a repeated measures ANOVA and a significant omnibus was followed up with contrast analysis. Hypothesis 5 was tested using hierarchical multiple regression analyses in which patients' outcome measures were predicted by clinicians' adherence and any relevant covariates based on the previous hypotheses; adherence was dummy coded to account for time point in the study. A Bonferroni correction controlled for familywise error in Hypothesis 5.

ADDTAS Assumption Test

The current study assumed that the ADDTAS would account for variability in stage of treatment within participants over time and between participants at each time point because ADDTAS was calculated with stage-specific expert recommended frequencies. If this assumption was true, then ADDTAS would not vary based on stage of treatment and excluding stage of treatment as a variable in each hypothesis test was justified. Therefore, the ADDTAS assumption was tested at each time point with independent samples *t*-tests with a Bonferroni correction for familywise error; $\alpha = .02$ for these three *t*-tests.

Throughout the study, most clinicians' ADDTAS were less than zero. At intake, clinicians' ADDTAS ranged from -71.86 to 8.6 ($n = 89$, $M = -27.28$, $SD = 14.86$) and 75% of the sample had an ADDTAS less than -17.63. Four clinicians' ADDTAS at intake was greater than zero. One year after intake (T1), clinicians' ADDTAS ranged from -69.86 to 10.6 ($n = 55$, $M = -25.05$, $SD = 16.32$) and 75% of the sample had an ADDTAS less than -12.4. Three clinicians' T1 ADDTAS was greater than zero. Finally, two years after intake (T2), clinicians' ADDTAS ranged from -59.68 to 12.17 ($n = 76$, $M = -26.15$,

$SD = 14.05$) and 75% of the sample had an ADDTAS less than -19.86 . Six clinicians' T2 ADDTAS was greater than zero. Two clinicians in the sample also completed the Expert Survey (Brand et al., 2012) while the remainder ($n = 87$) did not. The two expert clinicians' ADDTAS did not fall outside of the range of community clinicians' ADDTAS at any time point.

Sample sizes vary by time point because some clinicians and patients did not complete T1 and T2 surveys. Attrition data were not available but possible reasons for missing surveys include dropout from the study, patient or clinician terminating treatment, and disrupted communication. For example, some participants changed their email addresses but did not notify the study in a timely manner and thus may have missed communications regarding milestone surveys.

Intake. On average, community clinicians treating patients in Stage 2 at intake reported more adherence to expert recommended frequency ($n = 43$, $M = -24.14$, $SD = 15.48$) than community clinicians treating patients in Stage 1 at intake ($n = 33$, $M = -33.83$, $SD = 13.34$). This difference was significant $t(74) = -2.87$, $p = .005$, and represented a medium effect, $d = 0.67$.

One Year (T1). On average, community clinicians treating patients in Stage 2 at T1 reported more adherence to expert recommended frequency ($n = 29$, $M = -19.23$, $SD = 13.96$) than community clinicians treating patients in Stage 1 at T1 ($n = 9$, $M = -38.19$, $SD = 18.93$). This difference was significant $t(36) = -3.27$, $p = .002$, and represented a large effect, $d = 1.14$.

Two Years (T2). On average, community clinicians treating patients in Stage 2 at T2 reported more adherence to expert recommended frequency ($n = 38$, $M = -26.69$, $SD =$

11.58) than community clinicians treating patients in Stage 1 at T2 ($n = 12$, $M = -29.86$, $SD = 11.34$). This difference was not significant $t(48) = -0.83$, $p = .411$, and was only a small effect, $d = 0.28$.

Although the assumption that ADDTAS would measure overall adherence regardless of stage of treatment was violated at two of the three time points (intake and T1), hypotheses were conducted using all community clinicians regardless of stage of treatment. Follow-up exploratory analyses that examined ADDTAS scores within Stages 1 and 2 were considered after testing and interpreting the original hypotheses.

Hypothesis Tests

Hypothesis 1. A one-sample t -test indicated that, on average, community clinicians' ADDTAS at intake was significantly lower than zero, $t(88) = -17.32$, $p < .001$, $d = -1.84$. This finding suggests that on average, community clinicians at intake were using treatment activities less frequently than experts recommended.

Hypothesis 2. Because years of experience treating DD were part of the inclusion criteria for the Expert Survey (Brand et al., 2012), this hypothesis was tested twice: once including the two clinicians who completed the Network Study as well as the Expert Survey and once excluding these two clinicians who participated in both studies ('experts'). For all clinicians in the sample (i.e. including the two experts), clinicians had an average of 11.77 years of experience treating DD ($n = 86$, $M = 11.77$, $SD = 7.97$, Range: (<1, 30). Excluding the two expert clinicians, community clinicians had an average of 11.53 years of experience treating DD ($n = 84$, $M = 11.53$, $SD = 7.83$, Range: (<1, 30). While the two experts' experience treating DD fell within the range of

community clinicians' experience, 15 and 29 years respectively, their inclusion in the hypothesis test altered the significance of this test.

A bivariate correlation including all clinicians ($n = 86$) found that clinicians' ADDTAS at intake was significantly correlated to their years of experience treating DD, $r = .21, p = .024$. However, a bivariate correlation excluding expert clinicians ($n = 84$) found that community clinicians' ADDTAS at intake was not significantly correlated to their years of experience treating DD, $r = .19, p = .077$.

Hypothesis 3. A one-way analysis of variance was used to test the hypothesis that community clinicians' adherence to expert recommended frequency (as measured by the ADDTAS) would vary based on the clinicians' self-reported theoretical orientation. This analysis was not significant, $F(4, 81) = 1.01, p = .408$. However, this analysis was not sound because of uneven sample sizes between levels of clinicians' theoretical orientation (e.g. Cognitive-Behavioral, $n = 10$; Psychodynamic, $n = 35$; Family Systems, $n = 6$).

Hypothesis 4. The hypothesis that community clinicians' adherence to expert recommended frequencies would change over the course of the study was tested using a repeated measures analysis of variance. This change was not significant, $F(2, 82) = 1.99, p = .144$, partial $\eta^2 = .05$, suggesting that community clinicians' adherence to expert recommended frequencies did not change over the course of the study and thus follow up analysis of contrasts was not completed.

Hypothesis 5. Because Hypothesis 4 was not significant, suggesting that community clinicians' adherence was not affected by time, time was removed from the analyses for Hypothesis 5. Because community clinicians' adherence did not differ across

time points of the study, ADDTAS at intake was selected for this analysis because of its clinical relevance to interpreting the results and to maximize sample size. Community clinicians' years of experience treating DD was added as a covariate in the analysis of Hypothesis 5 because all clinicians were included in this analysis and Hypothesis 2 was significant when all clinicians were included.

A series of multiple regression analyses was used to determine if community clinicians' ADDTAS at intake predicted patient outcomes at T2 while controlling for clinicians' years of experience treating DD. As seen in Table 3, the results of these analyses were not significant and suggest that clinicians' adherence at the beginning of the study did not predict their patients' outcomes at the end of the study. These findings were not affected by exclusion of the two expert clinicians or removing years of experience treating DD from the equation (results not shown).

Experts. Due to the change in significance of Hypothesis 2 based on the inclusion or exclusion of the two clinicians who completed both the Expert Survey and the Network Study, the analyses for Hypotheses 1, 3, 4, and 5 were also conducted without the two expert clinicians. Analyses for Hypotheses 1, 3, 4, and 5 did not change in significance based on exclusion of the two experts (results not shown).

Exploratory Analysis 1. Hypothesis 2 was re-tested with a sample of clinicians that excluded anyone in the lower quartile of years treating DD. That is, the sample included only clinicians with more than five years of experience treating DD ($n = 64$). A bivariate correlation with this sample found that their ADDTAS at intake showed a trend towards correlating with years treating DD, $r = .23$, $p = .066$ but this was slightly below statistical significance at $p = .05$, and it indicates a small effect.

Exploratory Analysis 2. Hypothesis 2 was re-tested with a sample that included clinicians with more than three years of experience treating DD ($n = 73$). A bivariate correlation with this sample found that ADDTAS at intake was significantly correlated to years treating DD, $r = .28, p = .017$, which is a small but significant effect

Exploratory Analysis 3. Because Exploratory Analysis 2 was significant, Hypothesis 5 was re-tested using only clinicians with more than 3 years of experience treating DD ($n = 57$). A multiple regression model of T2 PITQ-p predicted by years treating DD patients was not significant. A multiple regression model of T2 PITQ-p predicted by years treating DD patients and ADDTAS at intake approached significance, $F(2, 54) = 2.67, p = .079$. The coefficient of ADDTAS at intake in this model, $\beta = -.31, t = -2.31, p = .03$, was significant while years treating DD was not, so a correlation of ADDTAS at intake with each measure of patient outcomes was conducted (see Table 4). Although ADDTAS at intake was significantly correlated with T2 PITQ-p at $\alpha = .05, r = -.29, p = .025$, this finding was not significant when familywise error was accounted for using a Bonferroni correction, $\alpha = .05/4 = .013$. This finding suggests a possible trend toward significance for the relationship between clinicians' adherence and patient reported progress in treatment.

Discussion

The findings of this study suggest a complex relationship between community clinician factors such as experience and adherence to recommended treatment activities, treatment factors such as stage of treatment, and DD patient outcomes. The implications of the findings in this study are explored in groups of hypotheses.

Hypotheses 1, 2, and 3. Consistent with previous DD research (e.g. Myrick et al., 2015), significant results for Hypothesis 1 suggest that there is a discrepancy between treatment activity frequency as reported by community clinicians and the frequency experts recommend. However, significant results for Hypothesis 2 suggest a weak, positive relationship between years of experience treating DD and increased adherence to expert recommended frequency of activities. That is, clinicians' adherence to expert recommended treatment activities may increase as they gain experience treating DD, and vice versa. While this is consistent with logical expectations, the two factors account for a small portion of variance and the direction of this relationship cannot be determined from these results. Furthermore, the correlation between ADDTAS and years of experience treating DD was not significant when the two clinicians who participated in the Expert Survey and the Network Study were excluded from the analysis. The mixed results for Hypothesis 2 are consistent with Lofholm, Eichas, and Sundell's (2014) finding that an increase in a treatment teams' years of experience predicted an increase in therapists' adherence to treatment, but a therapist's experience did not predict treatment adherence.

The mixed results for Hypothesis 2 are difficult to interpret due to the two expert clinicians' years of experience falling within the range of community clinicians' years of experience treating DD. Similarly, their ADDTAS at intake are also well within the range of community clinicians' scores. Thus, the expert clinicians are not outliers or easily distinguished from non-experts on the two variables considered and thus reasonably included in the test of Hypothesis 2. This may suggest that adherence to expert recommended frequency of treatment activities is only related to years of experience treating DD after a certain amount of experience with DD.

The findings of Exploratory Analyses 1 and 2 support this interpretation because the correlation approached significance when the lower quartile of years treating DD (<5 years) was excluded from the analysis and became significant when clinicians with less than three years of experience treating DD were excluded from analysis. These findings fit with the logic that a person with little experience treating DD may or may not adhere to recommended practices, which is consistent with Tschuschke et al.'s (2015) finding that therapists' adherence to treatment was predicted by their professional experience.

Relatedly, Lange, van der Rijken, Busschbach, Delsing, and Scholte (2017) found a complex relationship between therapist adherence to treatment, therapist experience, patient outcome, and country-wide experience (how long the country has been using the treatment) for Multisystemic Therapy (MST) to treat antisocial behavior. Lange et al. (2017) suggested that the effect of country-wide experience, which was mediated by therapist adherence, may reflect increasing availability of training and support for therapists using MST. Considering Lange et al. (2017) also found that therapist adherence mediated the association between therapist experience and treatment outcomes, the mixed results of Hypothesis 2 and Exploratory Analyses 1 and 2 in the current study may reflect a relative lack of training and support for clinicians treating DD. Perhaps therapists who are new to treating DD have not yet been exposed to enough training or research on DD to be aware of the interventions that are most likely to stabilize these patients. On the one hand, a neophyte DD clinician may seek additional supervision, resources, and knowledge regarding a new area of practice as suggested in the competency sections of the APA Code of Ethics and thus adhere closely to expert recommendations. On the other hand, it also makes sense that a neophyte DD clinician may begin treating a patient with

DD concurrently with the acquisition of DD knowledge and therefore only utilize expert recommended DD treatment activities by chance. The multiple interpretations of all analyses of Hypothesis 2 are revisited in the discussion of Hypothesis 5.

The Guidelines for DD treatment report that a psychodynamic, eclectic oriented approach is the most commonly recommended treatment orientation for DD treatments. The findings in Hypothesis 3 suggest that there was not a significant difference in adherence based on clinicians' theoretical orientation. However, the analysis of Hypothesis 3 was limited by uneven sample sizes between the levels of clinicians' self-reported theoretical orientation so future research with a larger sample may or may not yield different results.

Hypotheses 4 and 5. Because the Network Study features a two-year online intervention focused on safety and stabilization in DD treatment for clinician-patient dyads, it was theorized that participation in the Network Study would have a two-fold effect: first, patients would show improved symptoms and safety over the course of the study; second, clinicians would learn and utilize the techniques taught in the study, which are consistent with expert recommended interventions for treating early stage DD patients. Regarding the first effect, Brand et al. (2018, under review) found that patients showed improved symptoms and reduced self-harm over the course of the study based on intake, one year, and two-year data. Hypothesis 4 of the current study explored a portion of the second effect by testing whether community clinicians' adherence to the expert recommended frequency of DD treatment activities changed over the course of the study. Unfortunately, there was no difference in adherence between time points, suggesting the possibility that neither two years of experience treating DD nor participation in the

Network Study had an impact on adherence to recommended frequency of interventions. This finding is somewhat surprising in the context of extant literature. The results of research examining treatment outcomes in relation to therapist adherence are mixed, but a study of cognitive behavioral therapy (CBT) for bulimia nervosa by Folke et al. (2017) found that therapist adherence to treatment protocols decreased over the course of treatment. Furthermore, Folke et al. (2017) found that higher adherence earlier in treatment was associated with improvement at the end of treatment. This stands in contrast to the current study in which adherence was consistently low and did not appear to change over treatment.

However, there are many possible interpretations of the results of Hypothesis 4 due to the distribution of ADDTAS at each time point. ADDTAS was based on difference scores for 26 items rated on a scale of 0 (never) to 4 (very often) and the mean ADDTAS at intake, T1, and T2 was -27.28, -25.05, and -26.15, respectively. On average, clinicians consistently reported using interventions less frequently than experts recommended throughout the study. This could suggest that community clinicians simply are not adhering to the expert recommended frequency of interventions and more training is warranted. It may also suggest that the standard has been set too high and the expert recommended frequencies are unrealistic. The consistently low adherence scores could also indicate a problem with how adherence was measured in this study (see ADDTAS Assumptions).

A final possibility is that adherence to recommended frequency did not change because frequency of activities is not as important as the quality with which the activities are conducted with patients. This interpretation is consistent with Campos-Melady,

Smith, Meyers, Godley, and Godley's (2017) finding that therapist competence was significantly predictive of improved patient outcomes in their full sample while therapist adherence was not predictive of outcomes in the full sample. The methodology of the current study is not able to determine whether there was a possible change in quality of the application of the interventions, thus providing a possible avenue for future research. Furthermore, clinicians' reports of their use of interventions may not be accurate in reflecting the actual frequency of use of the interventions.

Given the result of Hypothesis 4, Hypothesis 5 was modified to answer the question: while controlling for experience treating DD, does community clinicians' adherence at intake predict their patients' outcomes two years later? The lack of significant results for Hypothesis 5 may suggest that community clinicians' adherence is not significantly related to their patients' outcomes. Taken together, the findings for Hypotheses 2, 4, and 5 seem to imply that the relationship between experience and adherence may be statistically but not clinically significant. This was further examined with Exploratory Analysis 3 due to the significant findings of Exploratory Analysis 2.

Exploratory Analysis (EA) 3 showed that when a clinician had more than 3 years of experience treating DD at intake, their adherence to expert recommended treatment activities at intake correlated with their patients' progress in treatment at the end of the Network Study. Interestingly, the negative correlation between these variables suggests that less adherence at intake correlated with higher patient report of adaptive capacities developed in treatment at T2. Because this finding was significant at the trend level, conclusions should not be drawn. EA 3 complicates the previous findings and suggests that additional research on the factors examined in this study is required before a

conclusion can be drawn. Furthermore, the interpretation of all findings, particularly those for Hypotheses 2, 4, and 5, is complicated and limited by the significant result of the ADDTAS Assumption Tests.

ADDTAS Assumptions. The hypotheses in this study were built on the assumption that the ADDTAS, a score created for this study, would measure overall adherence to recommended DD treatment activities regardless of stage of treatment. If this assumption were true, the ADDTAS would not significantly differ based on the stage of treatment and all community clinicians could be appropriately analyzed as a single group. Unfortunately, this assumption was not met at all time points of the study and the stage of treatment was probably not adequately accounted for in the Hypothesis analyses. Given the known impact of stage of treatment on the types and frequency of interventions used to treat DD, and the ADDTAS' failure to adequately account for stage of treatment, exclusion of stage of treatment as a variable was a major limitation of the study.

As a result, exploratory analyses which included stage of treatment as a variable were considered but untenable. The recursive nature of DD treatment and attrition from the study resulted in large reductions in sample size when stage of treatment was used to create cross-sectional and/or longitudinal groups. For example, there were only 10 clinician-patient dyads who remained in the study for two years and were in Stage 2 at each time point. This sample size is inadequate for analyses. The sample size was a limitation of the study, as was the failure of the ADDTAS to adequately account for stage.

As it was calculated in this study, the ADDTAS had good internal reliability as well as adequate face validity. However, closer inspection of the expert survey data used

to calculate the ADDTAS revealed room for improvement. In the Expert Survey, the top ten interventions were identified as the ten interventions which had the most “Use Very Often” ratings. There was significant overlap in the top ten interventions at Stage 1 and Stage 2: eight of the top ten interventions at Stage 1 are also in the top ten interventions at Stage 2. Four of these eight interventions are also recommended in the top ten interventions at Stage 5. However, the average expert recommended frequency for the top ten interventions at Stages 1, 2, and 5 are 3.86, 3.42, and 2.89 respectively. Furthermore, additional inspection of the Expert Survey data revealed that the percentage of experts endorsing “Use Very Often” for the top 10 interventions for each stage decreased dramatically from Stage 1 to Stage 5. At Stage 1, the top ten interventions were endorsed “Use Very Often” by an average of 89% of experts (range: 77% to 100%); at Stage 5, an average of 46% of experts (range: 40% to 57%) endorsed the top ten interventions as “Use Very Often.” These descriptive statistics highlight the importance of stage of treatment as well as the variation in activities at each stage. This finding supports the ISSTD’s Guidelines’ conceptualization of a staged approach to treating DD.

This has two important implications for this study and the ADDTAS. First, the range of experts recommending that each intervention be used “very often” within each stage suggests that using all 26 interventions to calculate the ADDTAS at each stage was inappropriate. The variation in which treatment activities should be used most often at each stage as well as variation in experts’ recommended frequency likely contributed to the ADDTAS’ ability to distinguish, rather than account for, clinicians’ report of patients’ stage of treatment. Second, the decrease in percentage of experts endorsing use of the top ten interventions “very often” from Stage 1 to Stage 5 reiterates Brand et al.’s (2012)

assertion that activities relevant to later stages of treatment are less well-defined (i.e. more individualized) than those important to early stages of treatment. Thus, a better measure of adherence may have been obtained by limiting the ADDTAS to the top ten interventions at each stage of treatment rather than including all 26 items. Future research should explore alternative methodologies for calculating the ADDTAS as well as clarifying the interventions important to later stages of DD treatment.

Areas for Future Research

There are many avenues for future research based on the findings of this study. First, the results of the hypothesis and exploratory analyses suggest that the ADDTAS, as it was currently scored, may not have been measuring the construct it was designed to measure (adherence). This limited the conclusions that can be drawn about the ADDTAS regarding community clinicians' adherence or its relationship to DD patient treatment outcomes. Examination of the Expert Survey data showed that alternative methods for measuring adherence are not only possible but potentially more valid. Examination of the expert data also suggests that even if the ADDTAS can be calculated to better account for stage of treatment, there may still be too much variation between the stages of treatment to collapse them into a single group to protect sample size. Second, attrition from the study resulted in missing data, which in turn prevented making comparisons within stages of treatment across time. One possibility for future research is to find a way to account for stage of treatment in a way that does not limit sample size. Third, it is possible that despite some statistically significant findings, adherence is not as clinically relevant to patient outcomes as other factors which were not accounted for in this study. For example, the ability to effectively implement treatment interventions may be more

important than reported adherence to expert recommended frequency of treatment interventions. Future research should explore improved methods for determining community clinicians' adherence to expert recommended treatment interventions in addition to other clinician factors which may impact patient outcomes.

Figures

Table 1

Participant Demographic Information

Characteristic	Clinicians		Patients	
	<i>n</i>	%	<i>n</i>	%
Country				
United States	34	38.2	36	40.4
Canada	6	6.7	6	6.7
United Kingdom	3	3.4	2	2.2
Australia	6	6.7	6	6.7
Netherlands	5	5.6	5	5.6
New Zealand	1	1.1		
Norway	21	23.6	20	22.5
Spain	1	1.1	1	1.1
Sweden	4	4.5	4	4.5
India	2	2.2		
Israel			1	1.1
Other	3	3.4	8	9
Gender				
Female	70	78.7	80	89.9
Male	16	18	9	10.1
Ethnic Background				
Caucasian (White)	77	86.5	78	87.6
Asian	2	2.2	2	2.2
Latino/Hispanic	1	1.1	3	3.4
African (Black)			1	1.1
Other	6	6.7	5	5.6

Note. For Clinicians and Patients, $N = 89$.

Table 2

Clinician Theoretical Orientation

Orientation	<i>n</i>	%
Cognitive-Behavioral	10	11.2
Psychodynamic	35	39.3
Family Systems	6	6.7
Humanistic/Experiential	10	11.2
Other	25	28.1

Table 3

*Standardized Coefficients of Hierarchical Multiple Regression Analyses
Predicting Patient Outcomes from Clinician Experience and Adherence*

	Patient Outcome Measure			
	PITQ-t _{T2} (n = 73)	PITQ-p _{T2} (n = 67)	DES _{T2} (n = 67)	PCL-C _{T2} (n = 67)
Block 1				
Experience Treating DD	.19	-.03	-.10	.00
Block 2				
Experience Treating DD	.20	-.01	-.08	.01
ADDTAS _t	-.01	-.11	-.08	-.02

Note. No coefficients were significant at $\alpha = .05$

Table 4

*Patients' T2 Outcome Measures Correlated with
Clinicians' Adherence at Intake*

	PITQ-t _{T2}	PITQ-p _{T2}	DES _{T2}	PCL-C _{T2}
<i>r</i>	.00	-.29*†	-.00	.13
<i>p</i>	.989	.026	.996	.345
<i>n</i>	63	57	57	57

* Correlation is significant at $\alpha = .05$ (2-tailed); †Correlation is not significant with Bonferroni Correction for familywise error, $\alpha = .05/4 = .013$.

IRB Approval Forms


TOWSON
UNIVERSITY

APPROVAL NUMBER: 14-A091

To: Bethany Brand
8000 York Road
Towson MD 21252

From: Institutional Review Board for the Protection of Human
Subjects Debi Gartland, Chair

Date: Monday, June 02, 2014

RE: Application for Approval of Research Involving the Use of
Human Participants



Office of Sponsored Programs
& Research
Towson University
8000 York Road
Towson, MD 21252-0001
t. 410 704-2236
f. 410 704-4494
www.towson.edu/ospr

Thank you for submitting an Application for Approval of Research Involving the Use of Human Participants to the Institutional Review Board for the Protection of Human Participants (IRB) at Towson University. The IRB hereby approves your proposal titled:

Treatment of Patients with Dissociative Disorders (TOP DD) Network Study

If you should encounter any new risks, reactions, or injuries while conducting your research, please notify the IRB. Should your research extend beyond one year in duration, or should there be substantive changes in your research protocol, you will need to submit another application for approval at that time.

We wish you every success in your research project. If you have any questions, please call me at (410) 704-2236.

CC: 11 Co-PI's
File



June 24, 2015

To: Bethany Brand
Department of Psychology
Modifications to TU IRB project 14-A091

Dr. Brand,

Thank you for informing the Towson IRB of your modifications to project 14-A091 "Treatment of Patients with Dissociative Disorders (TOP DD) Network Study".

The Towson University Institutional Review Board for the Protection of Human Participants has reviewed and approved your modification for this project. However, this modification approval does not change the expiration date of the original approval, which will need to be renewed one year from the date of approval if the research is ongoing.

If any other modifications are made to this project, or if any new risks are discovered, please inform the Board immediately.

Should you have any questions, please do not hesitate to contact me at 410-704-2236.

Sincerely,

A handwritten signature in blue ink that reads "Amy Taylor for -".

V. Denise Spears, MPA

Compliance Administrator, On Behalf of Towson University Institutional Review Board for the Protection of Human Participants

CC:
File

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& Research

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Consent Forms

Treatment of Patients with Dissociative Disorders (TOP DD) Network Study

Principal investigator: Dr. Bethany Brand

email: bbrand@towson.edu

Phone Number: (410) 704-3067

email: TOPDD@towson.edu

Patient Consent Form

You are invited to participate in the Treatment of Patients with Dissociative Disorders (TOP DD) Network study. Participation in the study affords access to a year-long web-based educational program (The TOP DD Network) for patients diagnosed with a dissociative disorder (DD) as well as their therapists. The TOP DD Network is designed to provide educational information that will help DD patients learn how to manage trauma-related symptoms and improve their safety. Both the DD patient and their therapist must agree to enroll together in the study so that patients have a clinician to help them if they experience safety problems or other difficulties.

TOP DD Network access: Eligible study participants will be given an access code that will allow them to sign in to the secure TOP DD Network website. The TOP DD Network site will provide participants with access to educational videos, written exercises, and practice exercises. There will be no charge to participants for accessing these materials, which have been designed by the TOP DD team specifically to help dissociative patients learn how to improve their safety and enhance their ability to manage complex trauma related symptoms.

Participation eligibility:

- The Patient and Therapist must be 1) over the age of 18 and 2) patients must meet DSM-IV-TR or DSM-5 criteria for one of the following Dissociative Disorders: Dissociative Disorder Not Otherwise Specified (DDNOS; DSM-IV-TR), Other Specified Dissociative Disorder (OSDD; DSM-5), or Dissociative Identity Disorder (DID; DSM-IV-TR or DSM-5)
- The Patient and Therapist must be able to tolerate non-detailed references to: Childhood and adult trauma; safety struggles and underlying reasons for these struggles; dissociation; and occasional brief discussions of “parts of self”, even if this term does not apply to them

- The Patient and Therapist must be able to watch videos and Patients must be able to do written reflections and experiential exercises without being at risk for becoming highly overwhelmed
- The Patient-Therapist pair must have been actively engaged in treatment for at least three months
- Both Patient and Therapist must have reliable high speed access to the Internet (and if using a phone for access, have a data plan that can accommodate heavy data use)
- Both Patient and Therapist must be willing to share an existing email address or create and check a new address in order to receive links to study questionnaires and opt in (or out) to receiving activity reminders
- Both Patient and Therapist must be able to read English at the eighth grade level.

Patients and therapists will complete screening questionnaires to confirm eligibility and to assess initial symptoms. If the patient meets criteria to be enrolled, both the patient and therapist will be emailed a link to complete the initial surveys. Upon completion of these, they will be given access to the TOP DD Network website as described above.

Participation Requirements: To participate, patients need to commit to doing about 2 ½ hours of work per week for one year, including: Watching short educational videos (between 5-10 minutes most weeks), completing weekly program and progress feedback and awareness-raising surveys, completing weekly writing exercises, and practicing recovery-focused skill exercises each day. (Note: The TOP DD team will not collect the patients' written reflection exercises. The written reflections are for the patient's own learning. We encourage patients to share what they are learning about themselves with their therapists.) In addition, patients need to commit to completing six survey questionnaires, each requiring between 2 and 2 and 1/4 hours. Completion of the (1) screening and (2) initial questionnaires will be required before beginning involvement with the TOP DD Network; additional questionnaires follow: (1) six months later (to assess patients' progress), (2) at the program's end at 12 months (to assess program effectiveness), and (3) six months and (4) one year after completing the program (to assess the durability of results). The questionnaires included in this study are essential to assessing how effective the TOP DD Network program is; they will also help us improve the TOP DD Network.

Therapists will need to commit to spending approximately 15-30 minutes each week for one year in order to participate. Therapists' weekly involvement will require watching the same weekly videos that patients watch, and providing feedback about the program and their patients' reactions

to the program. Therapists are also strongly encouraged, but not required, to review patients' program work. Therapists must also be willing to commit to completing 6 research surveys requiring 1-1.5 hours each for completion: a screening survey, an initial survey upon admission to the study, and then one survey every six months thereafter (i.e., at 6, 12, 18, and 24 months) to gather their assessment of their patient's progress.

Optional: There are two optional 25-minute surveys offered at weeks 20 and 24 that patients may opt to complete if they so choose. These optional surveys ask brief questions about traumas, attachment and violence. This information may be useful for therapists to know about and process with the patient, so these two surveys might be useful to complete when the client is with the therapist. However, these two surveys are optional, as is doing them together in a therapy session. Finally, participants from Norway will be offered the opportunity to answer a few specific questions related to treatment they received in Norway.

TOP DD Network Overview: There are 5 videos that introduce participants to the TOP DD Network (including what participants will need to do each week) and provide information about trauma and its impact. After watching these 5 videos at their preferred pace, the participants will be given access to one educational video per week along with that week's written and practice exercises. (This constraint is intended to ensure that participants have the opportunity to get sufficient practice with the material presented.) Patients will also complete brief questions each week about their symptoms and progress in learning the skills taught in the videos. These weekly questions are intended to help DD patients learn to identify how they are doing regarding symptoms and in their learning and remembering to use healthy coping skills to actively manage these symptoms. There are 40 weekly videos (in addition to the 5 introduction videos); videos can be watched more than once, if desired, and written transcripts of the videos will also be available. The next week's material will become available once the prior week's tasks have been completed. The program is designed to enable participants to be able to take up to seven weeks off from the TOP DD Network program as needed (e.g., for holidays, illness).

The TOP DD team is not able to provide consultation, treatment, or feedback on any participant, nor will the team be able to provide information on any patient's progress, or return calls or emails seeking clinical advice. This limitation in our role is the reason we require patients to be in individual therapy: **Patients should discuss questions about the topics in the study, problems or issues in their lives, and/or psychiatric crises with their therapists.**

Potential Benefits: The TOP DD team believes that participants will learn ways to improve safety and manage emotions and symptoms in healthy ways. In addition, future dissociative patients and their therapists will benefit from the participants' feedback about the study's educational materials, as well as from the research publications that will be based on the study. We expect that therapist participants will learn more about helping DD patients in general as well as about their particular DD patient who is participating in the study. We hope that participating in this study as a team will also strengthen the working relationship between patients and their therapists, which research suggests is likely to improve the patient's progress in treatment.

Potential Risks: We have had individuals who are diagnosed with DID review the TOP DD Network materials and provide feedback about the best way to present the information. We took this step to ensure that the study is as helpful to participants as possible. While we do not anticipate significant difficulties for participants, this program asks participants to think about their feelings, reasons for being unsafe, symptoms, and related clinical issues. This may be uncomfortable for participants. We encourage clients to discuss their reactions with their therapists, particularly if they become upset by anything in the study. If any element of the study is distressing, we suggest patients take a break and do something that is safe and calming, and discuss their reaction with their therapist. We encourage clients to find a pace that feels most comfortable for them when working on the study's materials.

All information will remain strictly confidential. Therapists and patients will only know one another's answers if they choose to share these with one another. If you are a DD patient and prefer to not use your own name when you sign the consent form below, you can instead refer to yourself as your therapist's patient. For example, if your therapist's name is Jane Smith, you could type "Jane Smith's patient." Information obtained in this study will be recoded with a code number so that you cannot be identified. Although findings may be published, no names or identifying information will be used. This study has been approved by the Institutional Review Board at Towson University.

Your participation in this study is completely voluntary. You are free to choose not to participate, and if you do choose to participate, you are free to change your mind and withdraw from the study at any time. There is no penalty for leaving the study early. Should you choose to end your involvement with the study, please let us know right away by emailing us through the study's website or at TOPDD@towson.edu.

Patients, please note: The study's requirement that patients be in individual therapy means that discontinuing therapy with your current therapist would make you ineligible to continue in the study. You may be taken out of the study early if you or your therapist determines that staying in the study could be harmful for you or if your therapist stops participating in the study.

1. I have read this form and decided that I will participate in the study described above. Its general purpose, the tasks I will be involved in, and possible risks and benefits have been explained to me to my satisfaction.

- Printed name:

- OR Patient of:

2. Date:

If you have questions about this project or your rights as a research participant, or if you have a research related problem, please contact the principal investigator, Dr. Bethany Brand at (410)704-3067, or contact Dr. Debi Gartland, Chairperson of the Institutional Review Board for the Protection of Human Participants at Towson University at (410) 704-4110.

3. Please enter the email address that you will use for this study into the field below.

Please note that if you need to take a break, you can return to the survey (and not lose your progress) by either a) leaving your browser window open and returning when you are ready or b) using the same link you were sent by email in the same browser in which you started the survey.

Treatment of Patients with Dissociative Disorders (TOP DD) Network Study**Principal investigator:** Dr. Bethany Brand**email:** bbrand@towson.edu**Phone Number:** (410) 704-3067**email:** TOPDD@towson.edu**Therapist Consent Form**

You are invited to participate in the Treatment of Patients with Dissociative Disorders (TOP DD) Network study. Participation in the study affords access to a year-long web-based educational program (The TOP DD Network) for patients diagnosed with a dissociative disorder (DD) as well as their therapists. The TOP DD Network is designed to provide educational information that will help DD patients learn how to manage trauma-related symptoms and improve their safety. Both the DD patient and their therapist must agree to enroll together in the study so that patients have a clinician to help them if they experience safety problems or other difficulties.

TOP DD Network access: Eligible study participants will be given an access code that will allow them to sign in to the secure TOP DD Network website. The TOP DD Network site will provide participants with access to educational videos, written exercises, and practice exercises. There will be no charge to participants for accessing these materials, which have been designed by the TOP DD team specifically to help dissociative patients learn how to improve their safety and enhance their ability to manage complex trauma related symptoms.

Participation eligibility:

- The Patient and Therapist must be 1) over the age of 18 and 2) patients must meet DSM-IV-TR or DSM-5 criteria for one of the following Dissociative Disorders: Dissociative Disorder Not Otherwise Specified (DDNOS; DSM-IV-TR), Other Specified Dissociative Disorder (OSDD; DSM-5), or Dissociative Identity Disorder (DID; DSM-IV-TR or DSM-5)
- The Patient and Therapist must be able to tolerate non-detailed references to: Childhood and adult trauma; safety struggles and underlying reasons for these struggles; dissociation; and occasional brief discussions of “parts of self”, even if this term does not apply to them

- The Patient and Therapist must be able to watch videos and Patients must be able to do written reflections and experiential exercises without being at risk for becoming highly overwhelmed
- The Patient-Therapist pair must have been actively engaged in treatment for at least three months
- Both Patient and Therapist must have reliable high speed access to the Internet (and if using a phone for access, have a data plan that can accommodate heavy data use)
- Both Patient and Therapist must be willing to share an existing email address or create and check a new address in order to receive links to study questionnaires and opt in (or out) to receiving activity reminders
- Both Patient and Therapist must be able to read English at the eighth grade level.

Patients and therapists will complete screening questionnaires to confirm eligibility and to assess initial symptoms. If the patient meets criteria to be enrolled, both the patient and therapist will be emailed a link to complete the initial surveys. Upon completion of these, they will be given access to the TOP DD Network website as described above.

Participation Requirements: To participate, patients need to commit to doing about 2 ½ hours of work per week for one year, including: Watching short educational videos (between 5-10 minutes most weeks), completing weekly program and progress feedback and awareness-raising surveys, completing weekly writing exercises, and practicing recovery-focused skill exercises each day. (Note: The TOP DD team will not collect the patients' written reflection exercises. The written reflections are for the patient's own learning. We encourage patients to share what they are learning about themselves with their therapists.) In addition, patients need to commit to completing six survey questionnaires, each requiring between 2 and 2 and 1/4 hours. Completion of the (1) screening and (2) initial questionnaires will be required before beginning involvement with the TOP DD Network; additional questionnaires follow: (1) six months later (to assess patients' progress), (2) at the program's end at 12 months (to assess program effectiveness), and (3) six months and (4) one year after completing the program (to assess the durability of results). The questionnaires included in this study are essential to assessing how effective the TOP DD Network program is; they will also help us improve the TOP DD Network.

Therapists will need to commit to spending approximately 15-30 minutes each week for one year in order to participate. Therapists' weekly involvement will require watching the same weekly videos that patients watch, and providing feedback about the program and their patients' reactions

to the program. Therapists are also strongly encouraged, but not required, to review patients' program work. Therapists must also be willing to commit to completing 6 research surveys requiring 1-1.5 hours each for completion: a screening survey, an initial survey upon admission to the study, and then one survey every six months thereafter (i.e., at 6, 12, 18, and 24 months) to gather their assessment of their patient's progress.

Optional: There are two optional 25-minute surveys offered at weeks 20 and 24 that patients may opt to complete if they so choose. These optional surveys ask brief questions about traumas, attachment and violence. This information may be useful for therapists to know about and process with the patient, so these two surveys might be useful to complete when the client is with the therapist. However, these two surveys are optional, as is doing them together in a therapy session. Finally, participants from Norway will be offered the opportunity to answer a few specific questions related to treatment they received in Norway.

TOP DD Network Overview: There are 5 videos that introduce participants to the TOP DD Network (including what participants will need to do each week) and provide information about trauma and its impact. After watching these 5 videos at their preferred pace, the participants will be given access to one educational video per week along with that week's written and practice exercises. (This constraint is intended to ensure that participants have the opportunity to get sufficient practice with the material presented.) Patients will also complete brief questions each week about their symptoms and progress in learning the skills taught in the videos. These weekly questions are intended to help DD patients learn to identify how they are doing regarding symptoms and in their learning and remembering to use healthy coping skills to actively manage these symptoms. There are 40 weekly videos (in addition to the 5 introduction videos); videos can be watched more than once, if desired, and written transcripts of the videos will also be available. The next week's material will become available once the prior week's tasks have been completed. The program is designed to enable participants to be able to take up to seven weeks off from the TOP DD Network program as needed (e.g., for holidays, illness).

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Potential Benefits: The TOP DD team believes that participants will learn ways to improve safety and manage emotions and symptoms in healthy ways. In addition, future dissociative patients and their therapists will benefit from the participants' feedback about the study's educational materials, as well as from the research publications that will be based on the study. We expect that therapist participants will learn more about helping DD patients in general as well as about their particular DD patient who is participating in the study. We hope that participating in this study as a team will also strengthen the working relationship between patients and their therapists, which research suggests is likely to improve the patient's progress in treatment.

Potential Risks: We have had individuals who are diagnosed with DID review the TOP DD Network materials and provide feedback about the best way to present the information. We took this step to ensure that the study is as helpful to participants as possible. While we do not anticipate significant difficulties for participants, this program asks participants to think about their feelings, reasons for being unsafe, symptoms, and related clinical issues. This may be uncomfortable for participants. We encourage clients to discuss their reactions with their therapists, particularly if they become upset by anything in the study. If any element of the study is distressing, we suggest patients take a break and do something that is safe and calming, and discuss their reaction with their therapist. We encourage clients to find a pace that feels most comfortable for them when working on the study's materials.

It is possible that some therapists will find the study distressing. Sometimes focusing on patients' safety struggles can increase their awareness of their problems with safety and may even increase unsafe urges for some patients, although if discussed carefully in treatment, these increased difficulties are typically resolved. It is well-documented in the professional literature that therapists can become distressed about clients' safety struggles. If this occurs, we encourage therapists to seek out professional support, training in treating severely traumatized patients, consultation, supervision, and/or withdrawing from the study. Therapists can review blank copies of all the questionnaires that patients will be asked to complete on our website page at web address "<https://topddstudy.net/network/surveys>". The user name to access this site is: "topddnetwork". The password is: "5urvey5".

All information will remain strictly confidential. Therapists and patients will only know one another's answers if they choose to share these with one another. If you are a DD patient and prefer to not use your own name when you sign the consent form below, you can instead refer to

yourself as your therapist's patient. For example, if your therapist's name is Jane Smith, you could type "Jane Smith's patient." Information obtained in this study will be recoded with a code number so that you cannot be identified. Although findings may be published, no names or identifying information will be used. This study has been approved by the Institutional Review Board at Towson University.

Your participation in this study is completely voluntary. You are free to choose not to participate, and if you do choose to participate, you are free to change your mind and withdraw from the study at any time. There is no penalty for leaving the study early. Should you choose to end your involvement with the study, please let us know right away by emailing us through the study's website or at TOPDD@towson.edu.

Patients, please note: The study's requirement that patients be in individual therapy means that discontinuing therapy with your current therapist would make you ineligible to continue in the study. You may be taken out of the study early if you or your therapist determines that staying in the study could be harmful for you or if your therapist stops participating in the study.

1. I have read this form and decided that I will participate in the study described above. Its general purpose, the tasks I will be involved in, and possible risks and benefits have been explained to me to my satisfaction.

Printed name:

2. Date:

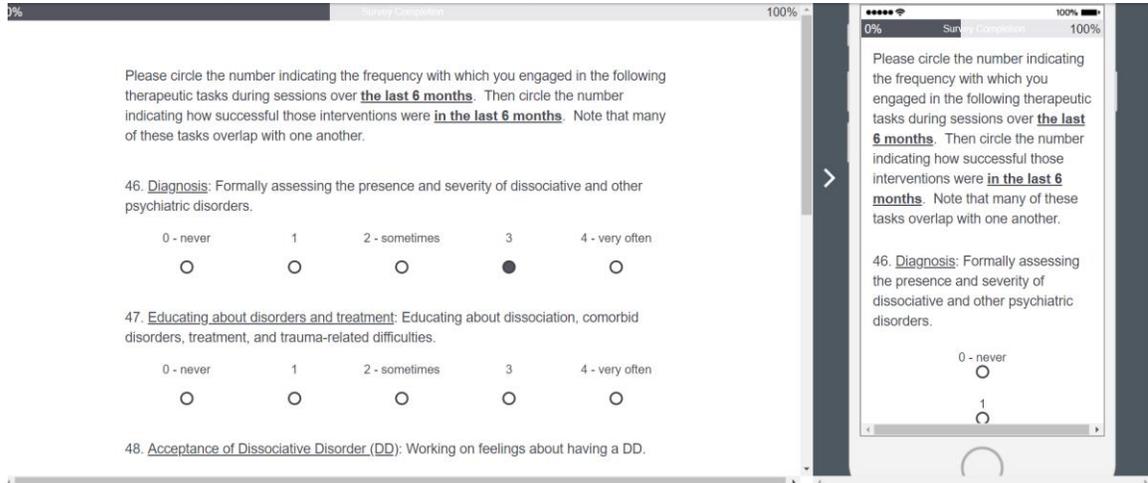
If you have questions about this project or your rights as a research participant, or if you have a research related problem, please contact the principal investigator, Dr. Bethany Brand at (410)704-3067, or contact Dr. Debi Gartland, Chairperson of the Institutional Review Board for the Protection of Human Participants at Towson University at (410)704-4110.

3. Please enter the email address that you will use for this study into the field below.

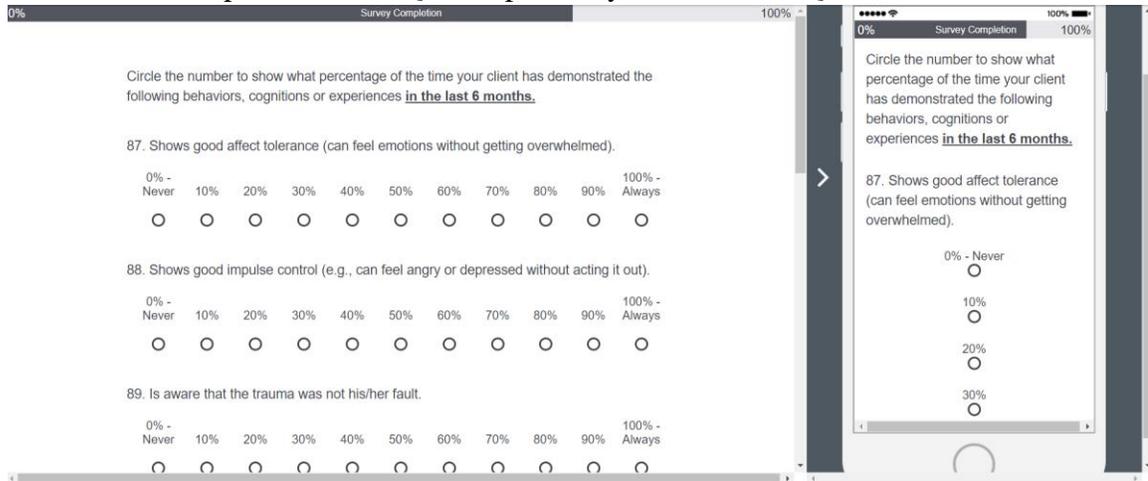
Please note that if you need to take a break, you can return to the survey (and not lose your progress) by either a) leaving your browser window open and returning when you are ready or b) using the same link you were sent by email in the same browser in which you started the survey.

Survey Examples

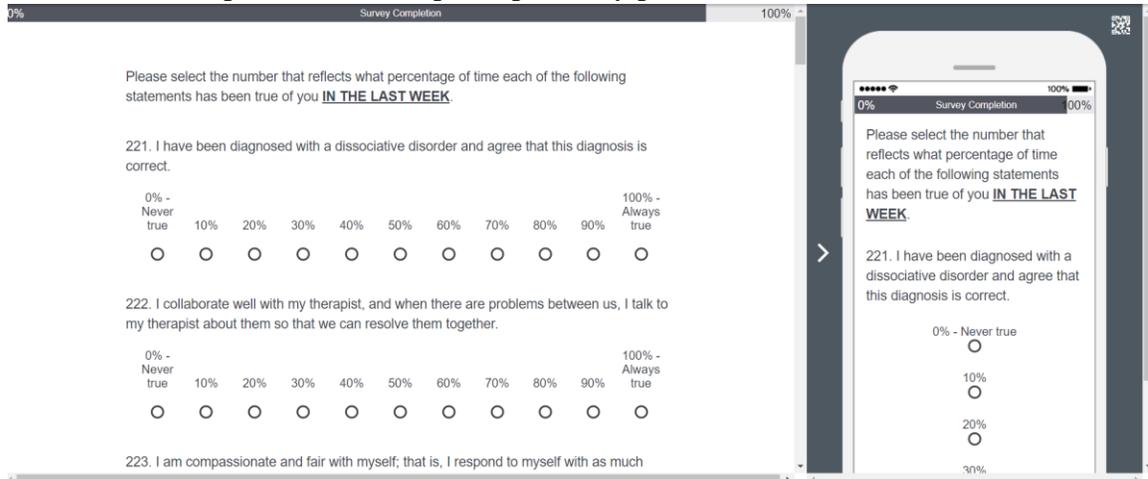
Screenshot example of the DDTAQ completed by clinicians on Qualtrics.



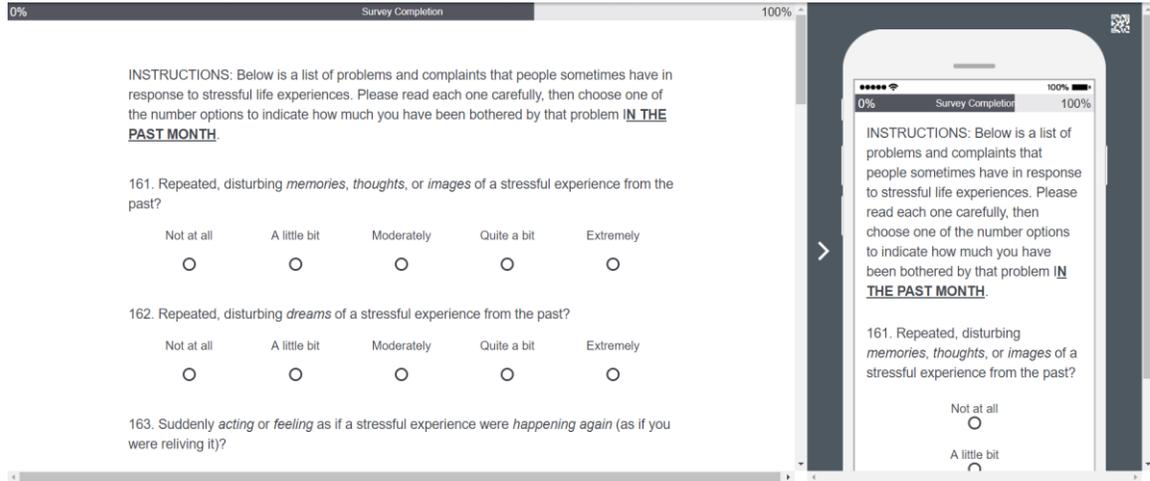
Screenshot example of the PITQ-t completed by clinicians on Qualtrics.



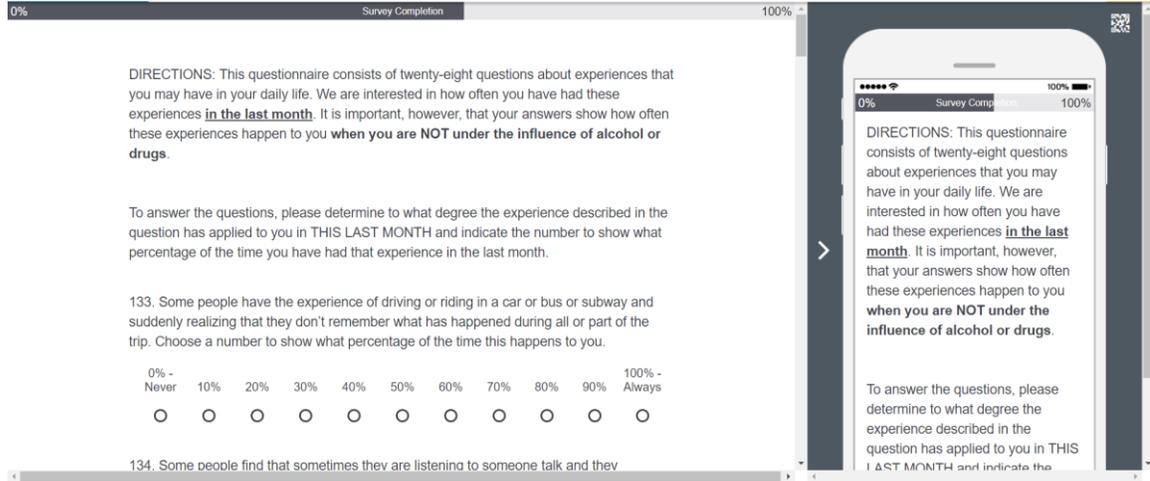
Screenshot example of the PITQ-p completed by patients on Qualtrics.



Screenshot example of the PCL-C completed by patients on Qualtrics.



Screenshot example of the DES completed by patients on Qualtrics.



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Curriculum vitae**SARAH TAKAKO SANCHEZ**

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Baltimore County Fire Department
 Public Safety Building

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EDUCATION

- MA** Towson University, Clinical Psychology May 2018
 Thesis: Dissociative Disorder Treatment in Practice: An Exploration of Community
 Clinicians' Adherence to Expert Recommended Frequency of Interventions
 Committee: Dr. Bethany Brand (chair), Dr. Jeff Kukucka, Dr. Sandra Llera
- BA** Johns Hopkins University, Psychology May 2010
 Dean's List

HONORS AND AWARDS

- Anderson-Parente Scholar** 2016
- Charles D. Miller Scholar** 2006 - 2010

RESEARCH PROJECTS AND EXPERIENCE

Dissociative Disorder Treatment in Practice: An Exploration of Community Clinicians' Adherence to Expert Recommended Frequency of Interventions, Thesis, Towson University, Towson, Maryland
 Advisor: Bethany Brand

Effects of Boundary Modifications and Therapist Orientation in Dissociative Disorder Treatment, Research Paper, Towson University, Towson, Maryland

Treatment of Patients with Dissociative Disorders *Network Study*
 Towson, Maryland 2016 to present
Research Assistant

- Built, maintained, and regularly updated SPSS databases of participant data
- Utilized multiple software packages in coordination to develop an efficient data collection & cleaning process including the use of syntax to reduce error
- Assisted with data collection and participant communication via email follow-ups
- Conducted descriptive and inferential statistical analyses as requested to assist principal investigators

PROFESSIONAL EXPERIENCE

Baltimore County Fire Department, Towson, Maryland Feb. 2018 to present
Statistical Analyst, Office of the Fire Chief

- Serves as database administrator for National Fire Incident Reporting System (NFIRS)
- Maintains and updates a database for Fire Department Computer-Aided Dispatch (CAD) data
- Tabulates statistics relevant to departmental resources and funding
- Develops methods to improve data collection and use; collaborates with department leadership to achieve goals
- Provides information and statistics regarding fire and medical incidents as requested by BCFD personnel as well as the public

Johns Hopkins University, Baltimore, Maryland Dec. 2011 to May 2014
Program Coordinator, Office of Multicultural Affairs

- Mentored and supervised an intern
- Coordinated the CultureShow, managing 200+ student performers & 15 volunteers
- Planned, organized, and executed educational, cultural, and social programs such as seminars, round tables, & lectures
- Developed, built, and maintained an Access Web Database that allowed staff to track their meetings with students and share confidential information securely with staff members also meeting with the students

Baltimore County Police Department, Towson, Maryland Aug. 2010 to Jul. 2011
Juvenile Crime & Victimization Statistical Analyst, Crime Analysis Unit

- Analyzed & reported statistics related to juvenile arrests and crimes
- Assisted BCPD Counseling Team with analysis & reporting of counseling services
- Conducted a detailed study of juvenile crime and victimization trends in Baltimore County from 2005 to 2010
- Explored possible relationship between juvenile offender data and school performance measures

CLINICAL EXPERIENCE

Key Point Health Services, Catonsville, Maryland Aug. 2016 to Aug. 2017
Therapist Intern, Catonsville Outpatient Mental Health Clinic

- Managed a caseload of up to 11 adult clients including scheduling, coordination of care, treatment planning, documentation, and providing individual psychotherapy
- Developed rapport and effective therapeutic relationships with clients using a client centered approach which incorporated cognitive behavioral, motivational interviewing, and mindfulness techniques
- Retained most clients through the duration of the internship, average treatment duration >5 months
- Addressed clinical issues including but not limited to PTSD, mood disorders, anxiety disorders, traumatic brain injury, substance use disorders, personality disorders

PROFESSIONAL AFFILIATIONS

Maryland Psychological Association of Graduate Students, 2015-Present

COMMUNITY SERVICE

American Cancer Society DetermiNation Marathon Event

Runner & Fundraiser, Rock 'n' Roll Savannah Marathon, Nov. 3, 2012

- Top Ten DetermiNation Fundraiser program-wide (#6, raising over \$5,000) and Top Fundraiser from Baltimore
- Completed first ever marathon despite a stress fracture at Mile 22

Mentoring Assistance Peer Program, The Johns Hopkins University

Student Leader, Baltimore, MD, 2008 to 2010

- Organized, designed, and oversaw major events including training programs
- Interviewed candidates for new Student Leaders and Mentors

Mentor, Baltimore, MD, 2007 to 2010

- Rookie of the Year Award (2007), Committee Chair of the Year Award (2007)
- Served as a mentor and role model to incoming freshmen throughout their first year at Hopkins via one-on-one and group programming designed to facilitate the transition from high school to college

COMPUTER SKILLS

Statistical & Database Packages: IBM SPSS Statistics v. 23, Microsoft Access

Programming & Platforms: SQL, Windows 97 through Windows 10

Additional Software: Microsoft Office Suite, ArcGIS, FireHouse Software, Crystal Reports, Adobe Creative Suite

OTHER

Avid distance runner; completed 1 marathon, 9 half marathons, numerous shorter races
Manager, coach, player of co-ed recreational softball team
Currently learning Japanese; Hiragana and Katakana

REFERENCES

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Catonsville, Maryland 21228
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