A phenomenological study detailing psychotherapeutic perspectives of psychotherapists who treat individuals living with pathological dissociative practices

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Department of Community Care and Counseling, Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

Liberty University

2024

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Abstract

The present phenomenological study endeavors to offer a comprehensive and profound insight into the phenomenon of pathological dissociation and the working experiences of psychotherapists who specialize in treating individuals with this condition. The primary objective of this study is to shed light on the intricate nature of pathological dissociation and provide a better understanding of the challenges that psychotherapists encounter during the therapeutic process. Nine licensed psychotherapists agreed to share their expertise and experiences in working with pathological dissociation. The trauma model was used as the theoretical framework to interpret reported pathological dissociative experiences. Based on participant reports, this theory asserts that a significant contributor to pathological dissociation is the experience of trauma. Two methods used for recruiting participants were snowball sampling and social media recruitment. Data was collected through semi-structured interviews by psychotherapists with experience in treating pathological dissociation. The participants in the discussion provided an elaborate account of their experiences with treating pathological dissociation while validating the existing literature that acknowledges the fear and apprehension associated with providing treatment to this population. The discussion also highlighted the need to clarify and rectify the barriers that psychotherapists may experience when engaging with individuals who experience pathological dissociation. Thematic analysis was utilized to identify, examine, and refine main themes to gain a deeper understanding of the data. The findings of this study can contribute to the limited literature regarding the education and treatment of pathological dissociation.

Keywords: dissociation, trauma, pathological dissociation, psychotherapist, psychotherapy

Dedication

With extreme honor and humility, I dedicate this manuscript to everyone who dares to dream, fight for their dream, and brave periods of loneliness to accomplish their purpose. Continue to persevere while walking in humility. What a privilege to be of service and to declare dedication to legacies.

Acknowledgments

I am pleased to express my deepest gratitude and thanks for the process and the ability to share my completed work. I honor the Most High God, My Lord and Savior, Jesus Christ, and the Holy Spirit for the ability to do the work and remain committed to the process. I want to thank my husband, Oswaldo Martinez. Sir, you are beyond appreciated. To my children, Christian, Aidan, and Nadia, you three are the motivation. I love you three so very much. To my mother, Ida Palmer, thank you for holding space for my weirdness while celebrating all the things I could hardly express with words due to my excitement throughout this process. To Dr. Thomas Vail and Dr. Debra Perez, I greatly appreciate your feedback and support throughout the process.

Table of Contents

List of Figures

List of Tables

List of Abbreviations

Adverse Childhood Experience (ACE)

American Counseling Association (ACA)

American Psychiatric Association (APA)

Anterior Cingulate Cortex (ACC)

Apparently Normal Part (ANP)

Cognitive Behavioral Therapy (CBT)

Cognitive Processing Therapy (CPT)

Complex Post-Traumatic Stress Disorder (C-PTSD)

Depersonalization/Derealization Disorder (DDD)

Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (DSM-III)

Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. (DSM-IV)

Diagnostic and Statistical Manual of Mental Disorders, 5th Edition Text Revision (DSM-5-TR)

Dialectical Behavioral Therapy (DBT)

Dissociative Amnesia (DA)

Dissociative Fugue (DF)

Dissociative Experience Scale – II (DES-II)

Dissociative Identity Disorder (DID)

Dissociative Disorders Interview Schedule (DDIS)

Emotional Part (EP)

Eye Movement Desensitization Reprocessing (EMDR)

Institutional Review Board (IRB)

Internal Family Systems (IFS)

Multidimensional Inventory of Dissociation (MID)

Non-suicidal Self-harming Injuries (NSSI)

Pathological Dissociation (PD)

Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder Subtype Derealization/Depersonalization (PTSD + DS)

Research Question (RQ)

Socio-cognitive model (SCM)

Somatic Experiencing (SE)

Structured Clinical Interview for DSM-5 Dissociative Disorders (SCID-D)

Trauma-Focused Cognitive Behavior Therapy (TF-CBT)

Trauma Model (TM)

Substance Abuse and Mental Health Services Administration (SAMHSA)

Chapter One: Introduction

Overview

The topic of dissociative symptoms and their treatment has piqued human curiosity for centuries. As early as 1586, scholars delved into researching and treating pathological dissociative symptoms (PD) (Brand et al., 2016). In the late 1700s, these symptoms began to captivate the public, and by the early 1800s, psychiatrists were dedicating their efforts to finding effective treatments (Brand et al., 2016; Loewenstein, 2018). However, while psychiatric treatment has been present since the 19th century, the understanding, provision of treatment, and knowledge of competent practices toward pathological dissociative symptoms remain concerning and are recognized as lacking (Mychailyszyn et al., 2020). This chapter provides a concise overview of the intricate nature of PD symptoms and the various treatment challenges that individuals grappling with this mental health condition encounter. This chapter examines the historical presentation of dissociation, the progress of structural treatment of dissociation, and the recognized need for further assistance and advancement in treating PD symptoms. The problem statement clearly defines the problem, its relevance, and potential outcomes. The study aims to explore psychotherapists' views on treating individuals with PD symptoms during psychotherapy. The research questions provide a clear focus and direction for this study. The definition of pertinent terminology is provided to add context and insight. Finally, the summary provides a complete synthesis of the focal points in this chapter.

Background

The desire to understand and treat PD has been a paradigm since it was first identified in 1586 (Brand et al., 2016). However, the success in positive outcomes for treating PD symptoms continues to falter (Mychailyszyn et al., 2020). Many renowned theorists, such as Dr. Pierre

Janet, Dr. Sigmund Freud, and Dr. Alfred Binet, were intrigued by this phenomenon. Janet is widely acknowledged as the foremost contributor to the foundational and theoretical principles currently employed for identifying and treating PD, previously called hysteria and multiple personalities (Brand et al., 2016). Janet's research established a psychological framework that notes that the subconscious mind contains information that the conscious mind may not be aware of due to trauma, now commonly known as the trauma framework (Perrella et al., 2016; Saillot, 2018). The trauma model emphasizes the effects of a wounded psychological presence that alters holistic functionality (Schimmenti, 2017; Schimmenti & Caretti, 2016; Van der Hart, 2021). The trauma model suggests that dissociation is a harmful and abnormal phenomenon that occurs when an individual relies on dissociative structures to cope with stress. This can negatively affect their psychological and physical well-being and may contribute to the development of psychiatric disorders (Schimmenti, 2017; Schimmenti & Caretti, 2016).

PD has been recognized as a mediator for trauma and psychotic presentations, leading to its classification as a trauma-coping or defense mechanism (Kecala et al., 2022; Schimmenti, 2017; Varese et al., 2021). Research categorizes dissociation as cognitive, emotional, and somatosensory processing that aids in minimizing the appearance of traumatic stress and discomfort (Carlson et al., 2016; Polizzi et al., 2022; Schimmenti, 2017; Varese et al., 2021). PD, a phenomenon that cuts across cultural beliefs and practices (de Oliveira Maraldi et al., 2017; Krüger, 2019), remains challenging to define and treat in clinical settings despite its growing recognition in the academic world (Brand, 2016). A lack of empirical evidence and a standardized treatment approach hinders the understanding and ability to provide effective interventions for individuals affected by PD. Given the limited knowledge of how to treat PD

clinically, it is acknowledged that positive outcomes and access to dissociation-informed treatment practices are also restricted (Brand, 2016).

Among individuals with post-traumatic stress traits, the prevalence of dissociative presentations ranges from 12-30% (Hill et al., 2020; Nicholson et al., 2015). This data is problematic as few psychotherapists admit to receiving training for dissociative presentations, resulting in limited access to appropriate care and treatment (Brand, 2016). According to Brand, psychotherapists play a critical role in ensuring quality care and positive outcomes for individuals experiencing dissociation by being trained to identify and comprehend subtle dissociative behaviors, which are often transitional. It is estimated that approximately 85% of these behaviors are transitional. Hoeboer et al. (2020) also highlight the significance of effective psychotherapies when treating dissociative symptoms, as dissociation is common in post-traumatic disorder subtypes. Effective treatment geared toward individuals with dissociation has demonstrated decreased depression, anxiety, dissociative presentations, increased functionality, and positive outcomes (Brand, 2016).

The treatment of any mental health disorder is targeted to be effective. Effective psychotherapy can be characterized by a few key elements (Munder et al., 2019). Munder et al. documented that first, it entails a long-term connection between two or more individuals. Secondly, at least one person has specialized training in managing human relationships. Thirdly, one or more participants seek assistance for emotional and/or interpersonal difficulties. Fourthly, psychological techniques like explanation, suggestion, and persuasion are employed. Fifthly, the therapist's approach is influenced by a formal theory about mental health disorders and the patient's particular disorder. Lastly, the process aims to alleviate the problems that prompted the patient to seek assistance.

Regarding the criteria above, the question arises as to how this is comprehended and exhibited when providing therapy to individuals coping with PD. Itzkowitz (2015) highlighted effective treatment methods for individuals with PD by incorporating vital critical elements for successful psychotherapy, as listed above. The psychotherapist is skilled in integrating and executing techniques that promote presence despite stressors, resulting in legitimacy, individuality, and mindfulness (Boon et al., 2011). The psychotherapist aims to equip clients with education and skills that facilitate understanding dissociative behaviors, which can result in healing and decrease negative presentations (Boon et al., 2011; Itzkowitz, 2015). By utilizing this concept and implementing empirical and research-driven psychotherapeutic practices, positive outcomes and reduced functional impairment have been observed in individuals suffering from PD (Kleindienst et al., 2016).

Despite the established decline in psychotherapists' understanding of effective treatment methods for individuals with PD, further research in this area is still necessary, and the available resources for addressing it still need to be improved. Schmidt et al. (2023) highlighted the detrimental effects of unchecked dissociation caused by a lack of screening and understanding of dissociative symptoms. Boyer et al. (2022) expounded on the significant public health risk associated with PD and the approximate 5 to 12.4-year average of inaccurate treatment practices before engaging in effective psychotherapy applications. The need for up-to-date and solution-focused information regarding the effective treatment of individuals living with PD is great (Boyer et al., 2022).

Situation to Self

The drive to complete this study aimed to gain insight and awareness regarding the experiences of psychotherapists who provide psychotherapy to individuals living with PD. This

study aimed to highlight the practice and execution of treatment by psychotherapists and their processes associated with providing therapy for individuals living with pathological detachment. As a practicing psychotherapist working with various trauma subtypes, I learned that trauma-informed care is diverse and requires intentionality. The challenge I face is to comprehend and acquire the information necessary to provide effective support to those who dissociate as a mechanism for coping with trauma. I have observed individuals who have attempted to confront their trauma triggers and manage their responses directly. However, avoidance and dissociative behaviors were commonly reported to me as familiar and comfortable. This sparked curiosity and fostered a desire to gain insight into the experiences of therapists who work with individuals struggling with PD.

In my experience and training, dissociative presentations have been discussed in a general overview. However, in my experience working with individuals who have experienced traumatic events, dissociative behaviors are more prevalent than what I had initially anticipated. This was concerning for me, as it highlights that the issue is also noted in the literature, which helps me understand why dissociative treatment remains vastly uncharted due to the demands for adequate care. This study highlights the significance of tackling this issue and encouraging researchers and therapists to create effective treatment plans. Furthermore, this study provides insights into the practices of other psychotherapists and their approaches to treating patients with PD. A theoretical and philosophical perspective will be employed to gain insight through both

interpretivism and positivism, with the understanding that individual experiences give rise to individual interpretations of observable and experienced facts.

Problem Statement

The problem lies in the fact that only a limited number of psychotherapists report proficiency in handling dissociative symptoms. Nevertheless, there is a need for trauma-informed psychotherapists to provide treatment for PD presentations with little to no solution-focused options that can alleviate this serious concern (Brand, 2016; Cronin et al., 2014). Cronin et al. elaborated on the deficits associated with a lack of treatment availability, training, and understanding of the risks associated with treating PD. These deficits highlight an increase in inaccurate diagnoses and the use of ineffective treatment practices for individuals living with PD. Competency as a psychotherapist is a fundamental ethical principle taught throughout the graduate school curriculum (Overholser, 2017) and is an ongoing expectation for licensed mental health professionals (American Counseling Association, 2014). Students and licensed psychotherapists are taught the value and necessity of engaging in peer-reviewed and empirical-based research interventions (ACA, 2014) when engaging with clients during therapeutic interactions. A noted concern regarding treatment outcomes in individuals who have experienced or witnessed a type of trauma is dissociative presentations and the recognized limited accessibility to training/application of interventions that aid with successful outcomes for individuals living with dissociative symptoms (Cronin et al., 2014; Sansen et al., 2019).

Purpose Statement

This phenomenological study aimed to explore the experiences of psychotherapists when treating patients with dissociative disorders by examining their subjective viewpoints. The central phenomenon of this study will entail six to ten participants providing psychotherapy to

individuals living with PD. PD is characterized as an unconscious defense mechanism that alters an individual's conscious awareness in response to overwhelming psychological distress, often resulting from trauma. This defensive response impairs an individual's psychological capacities, particularly their identity, consciousness, motor control, and memory (Atchley & Bedford, 2021; Lloyd, 2015; Parlar et al., 2016). On the other hand, non-pathological dissociation does not negatively impact an individual's ability to function correctly. The theory guiding this study is Dr. Pierre Janet's theoretical framework, which explains the effects of trauma on psychological processes and physiological manifestations.

Significance of the Study

This study will contribute to the present literature through the reported experiences of psychotherapists who actively offer treatment to individuals living with PD. The documented concern about the lack of knowledge and training among psychotherapists in trauma-informed skills for treating individuals with PD has been identified as a critical issue with severe consequences for treatment outcomes (Cronin et al., 2014). Despite the problem being identified, there is ongoing support in the literature for strategies that perpetuate the restrictive nature of effective trauma-informed psychotherapy for individuals living with PD. This study aimed to present the perspectives and insights of practicing psychotherapists regarding their methods for treating individuals with PD. This study may contribute to effective and supportive protocols and

strategies that may aid in increasing accessibility to care and pathways to effective trauma-informed practices.

Research Questions

This study explored psychotherapists' experiences working with individuals living with PD. Three questions were presented to provide insight into the processes practiced for treating individuals living with PD:

RQ1: What are the experiences of psychotherapists providing therapy to individuals with pathological dissociation?

RQ2: What experiences do psychotherapists have with implementing interventions for individuals diagnosed with pathological dissociation?

RQ3: What are the psychotherapists' experiences involving supervision/consultation when working with pathological dissociation?

Definitions

1. *Pathological Dissociation*: Pathological dissociation is an unconscious defensive alteration in conscious awareness, developed as an avoidance response to overwhelming, often post-traumatic, psychological distress that impairs the functionality of an individual's psychological capacities, with an emphasis on identity, consciousness, motor control, and memory (Atchley & Bedford, 2021; Lloyd, 2015; Parlar et al., 2016).

2. *Dissociation* - Dissociation is defined as a disruption to an individual's identity, consciousness, perception, or memory (Brand & Stadnik, 2013)

3. *Trauma* – Trauma, which is originally derived from the Greek meaning of wound, is defined as a direct or indirect exposure to an experienced or implied distressing event/situation that held the capacity to render an individual helpless, fearful, and altered in a negative psychological manner (Sanderson, 2013; Schimmenti, 2017)
4. *Complex Trauma* – Complex trauma is defined as severe, prolonged, and repetitive experiences that result in psychological impairment in interpersonal interactions that affect regulations, identity, and boundary awareness (Briere & Scott, 2015)
5. *Psychotherapist* – A psychotherapist is a clinically trained agent of change and healing who integrates research and empirical interventions for individuals with psychological impairments and moral problems (London, 2014).
6. *Psychotherapy*: Psychotherapy is defined as the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles to aid individuals in modifying their cognitions, emotions, perceptions, and behaviors that the elicited individual expresses as more desirable (Prochaska & Norcross, 2018).

Summary

This hermeneutical phenomenological study focused on the reported experiences of psychotherapists who provide psychotherapy to individuals living with PD. There is a problem in that only a small number of psychotherapists have reported being skilled in managing dissociative symptoms. This hermeneutical phenomenological study aimed to gain insight into the experiences of psychotherapists who provide psychotherapy to individuals living with PD. Effective psychotherapy is recognized as a beneficial and positive practice; however, individuals living with PD are listed in the literature as having limited access to effective psychotherapy,

which contributes to poor prognosis and continued functionality impairment. Mental health professionals and psychotherapists can gain valuable insights from this study by learning about the lived experiences of individuals with PD, which can help eliminate the maladaptive misconceptions associated with being a trauma-informed psychotherapist.

Chapter Two: Literature Review

Overview

This literature review explores the lived experiences of psychotherapists and their endeavors to provide treatment competently for individuals living with PD symptoms. This review examined the prevalence of PD and its psychological impact on individuals. Emphasis on psychotherapists operating in traumatology colligation and training toward competent treatment for individuals living with dissociative symptoms will be detailed. Dissociative disorders and their pathological presentation are detailed in this literature review. Lastly, the focal core of this literature review is the revealing of historical proceedings, anteceded traumatic relevance, barriers, research, and individualized experiences of psychotherapists working with individuals living with PD symptoms.

Introduction

Pathological dissociative symptomologies have been a phenomenon of interest since the 1890s (Loewenstein, 2018); however, intense research and treatment practices were initiated in the 1900s (Loewenstein, 2018). Pierre Janet and Sigmund Freud were notable figures who made significant contributions to understanding dissociative symptoms, particularly in the areas of development, research, and initial course of treatment (Serina, 2019). While esteemed minds have conducted groundbreaking research in initiating treatment for dissociative symptoms, the actual treatment process remains underdeveloped in contemporary practice, as evidenced by Bailey and Brand (2017). There is a lack of research on dissociative treatment approaches, with Schiavone et al. (2018) noting that minimal research has been conducted on the examination of dissociative treatment approaches. Pierorazio et al. (2023) report that no research has addressed treatment barriers identified and recorded by individuals living with dissociative symptoms.

Research indicates a significant standing of individuals living with dissociative symptoms; Kate et al. (2019) shared that approximately 11.4% of college students live with a dissociative presentation; Fung et al. (2022) stated, "prevalence rates of dissociative amnesia (DA) and depersonalization/derealization disorder (DDD) in the general population varying across studies from 0.2 % to 7.3 % and 0.8–2.8 %, respectively, whereas the prevalence of dissociative identity disorder (DID) is consistently noted at an approximate 1 %" (p.1). However, mental health professionals report not being adequately trained or not having any education regarding the provision of treatment to individuals living with dissociative symptoms (Brand et al., 2018; Loewenstein, 2018). The need for competent treatment for dissociative symptoms continues to grow worldwide (Lynn et al., 2019). However, positive outcomes regarding treatment are not highly reported (Brand & Stadnik, 2013), and individuals living with dissociative symptoms often engage in non-suicidal self-harming injuries (NSSI) or utilize NSSI to induce dissociation as a primary means of coping (Pierorazio et al., 2023).

Providing effective treatment for individuals with dissociative symptoms is considered challenging (Ford & Gómez, 2015) because many individuals living with dissociative symptoms may show little to no change in the appearance and experience of dissociative symptoms (Hoeboer et al., 2020). Therefore, while individuals may not be able to control the manner and frequency of their experiences with dissociative symptoms, some intentionally induce dissociative symptoms as a coping practice (Kecala et al., 2022; Morgan & Taylor, 2013). Dissociation is classified as a peritraumatic response and is considered a passive or avoidant coping mechanism, which can lead to difficulty in achieving a favorable prognosis (Kecala et al., 2022).

Many mental health professionals and psychotherapists report little to no training (Brand, 2016), with fewer training programs providing education on treating individuals with dissociative symptoms (Loewenstein, 2018; Myrick et al., 2015). However, competent training and psychotherapy practices are considered ethical standards (ACA 2014). According to research, students in mental health programs who go on to provide trauma therapy often lack adequate training, utilize non-evidence-based skills, and have limited access to accurate knowledge and training for individuals with trauma and dissociative presentations (Brand, 2016). The prevalence of dissociative manifestations in individuals who meet the criteria for post-traumatic stress disorder (PTSD) or who live within the criterion traits is significant, with a range of 12-30% (Hill et al., 2020; Nicholson et al., 2015). This bears concern because it may indicate the presence of complex post-traumatic stress disorder (C-PTSD), which is a diagnosis that may be given to individuals who have experienced prolonged trauma. Mental health professionals and psychotherapists often refer individuals with dissociative symptoms to other providers or facilities due to a lack of training in dissociative symptoms, which can disrupt therapeutic rapport and cause a pause in treatment if access to a competently trained mental health professional is limited (Howell, 2011). Further research is needed concerning the recognized lack of training for mental health professionals regarding the prevalence of trauma and dissociative symptoms.

This literature review will contribute to the research by acknowledging and addressing the limitations and experiences associated with treating individuals with PD symptoms. While research concerning the awareness of dissociative presentation has grown, research on the incidence, successful treatment, and recognition of lowered dissociative symptoms is limited (Brand & Stadnik, 2013). Due to the lack of research, it has not been established whether treating

comorbid disorders effectively leads to the remission of dissociative symptoms (Weiner & McKay, 2013). This study aims to gain insight into psychotherapists who actively provide therapy for individuals living with dissociative symptoms, the challenges they report, and the difficulties in providing psychotherapy for individuals living with PD.

Theoretical Framework

An intention to adhere to ethical principles when working with individuals exhibiting dissociative symptoms leads to a reduction in misdiagnosis, unethical practices, and improved outcomes for those with PD presentations (Cook et al., 2019). Mental health professionals and psychotherapists are encouraged to practice psychotherapy through empirical and research-based modalities, with dissociative symptoms often addressed and treated through trauma or socio-cognitive theoretical frameworks (Polizzi et al., 2022). Although competent care is deemed necessary, annunciated within the mental health graduate school curriculum, and stated within the ethical standards suggested by the American Counseling Association (ACA, 2014; Overholser, 2017), few mental health professionals know the structures offered through trauma or socio-cognitive models that target dissociative symptoms. Dissociation has been researched and explored in various theories, but primarily within trauma and socio-cognitive models (Kate et al., 2019; Lynn et al., 2019; Polizzi et al., 2022). An in-depth analysis of the socio-cognitive model is presented as a point of comparison for the author's selection of the trauma model framework.

Socio-cognitive Model

The socio-cognitive model (SCM) targets social, cultural, and cognitive influences on the appearance and triggering of dissociative symptoms (Dalenberg et al., 2014; Lynn et al., 2022). SCM challenges the belief that a traumatic event is necessary for the development of dissociative

symptoms and suggests that individuals with a history of psychological symptoms or other concerns may be at a higher risk for developing dissociative features because of suggestive procedures (Lynn et al., 2022). This is supported by research that suggests that coexisting concerns may contribute to the clinical presentation of dissociation (Dalenberg et al., 2014). SCM highlights the impact of environmental factors and their potential to trigger dissociative behaviors, which may be related to fantasy thinking (Lynn et al., 2019). This can lead to a concern with therapy engagement due to fear of suggestibility, which is a critical indicator of pseudo-memories and false traumatic experiences, resulting in an increase in dissociative production rather than a decrease in concentration (Lynn et al., 2019).

SCM disputes trauma as the primary cause of dissociative symptoms, instead focusing on acknowledging mild cognitive impairment or personality traits as a predisposition to fantasy proneness (Kluemper & Dalenberg, 2014). Dissociative symptoms, as defined by SCM, stem from predisposing dissociation that leads to the formation of trauma fantasies. This is concerning because childhood fantasy proneness may harm the storage of autobiographical memory, as suggested by SCM (Brand et al., 2018; Kluemper & Dalenberg, 2014). SCM recognizes the phenomenon of interrogatory suggestibility, which is the impact of social pressure and the revision of an individual's account due to misinformation that has been intentionally or unintentionally altered (Kluemper & Dalenberg, 2014).

Bailey and Brand (2017) provided education on the research study completed by Dalenberg et al. (2014), which involved a review of approximately 1,500 studies to assess the validity of the trauma model against the SCM. The study results indicated that the trauma model had increased validity because the SCM hypothesis was not supported by the yield of 1 to 3% variance, which suggested suggestibility. Brand et al. (2018) emphasized the lack of evidence

supporting the connection between suggestibility and dissociation. They pointed out that the theoretical model needs to be more reliable in diagnosing these phenomena.

Trauma Model

The trauma model (TM) and dissociative presentation derived from Pierre Janet's theory recognize dissociation as an internal coping mechanism of protection from intense traumatic stress and psychological pain (Lynn et al., 2022). While dissociation presentations were discovered in the 1890s (Fitzgerald, 2017), as stated in Janet's psychological analysis theory, they were overshadowed by Sigmund Freud's psychoanalysis theory (Fitzgerald, 2017; Lynn et al., 2022). Janet emphasized the presence of experienced trauma(s) as a prerequisite to dissociation presentation, whereas Sigmund Freud pointed toward neurosis of sexual origin (Fitzgerald, 2017). Janet accentuated the underlying impact of repressed/suppressed trauma and its relevance in the unconscious versus conscious realms (Fitzgerald, 2017).

The trauma factor in this model refers to a distressing event or experience that has not consistently been integrated into consciousness (Moskowitz & van der Hart, 2019). This is significant, as trauma is psychologically defined as a wound, but in TM, it is the source of division (Fitzgerald, 2017). TM postulates that early trauma is the cause of dissociative symptoms (Lynn et al., 2014). Dissociation symptoms resulting from trauma have been identified and documented in research studies conducted in various countries, including China, Spain, Australia, and Turkey (Kluemper & Dalenberg, 2014), where trauma is the origin of fragmentation or PD (Moskowitz & van der Hart, 2019; Van der Hart, 2021).

As a result of a traumatic encounter, personality is divided into two separate entities: an apparently normal part (ANP) and an emotional part (EP) (Moskowitz & van der Hart, 2019). TM recognizes that ANP and EP correlate with the avoidance and re-experiencing criteria

defined in the PTSD disorder of the DSM-5-TR. TM recognizes that a traumatic event can be present in early childhood and can be complex, allowing for multiple ANPs and EPs (Moskowitz & van der Hart, 2019). The trauma model is considered the dominant and critical benchmark model against which other theories, such as SCM, are compared and assessed (Buchnik-Daniely et al., 2021; Fitzgerald, 2017; Lynn et al., 2014; Moskowitz & van der Hart, 2019). Trauma is identified as a prominent antecedent of dissociative symptoms, whether through trauma or a socio-cognitive framework. Understanding trauma is critical in treating PD.

Trauma/Complex Trauma

According to Jowett et al. (2022), traumatic events are prevalent worldwide, ranging from 81% to 90% in terms of frequency and urgency. Individuals worldwide often begin their lives in situations that heavily influence their psychological, physical, and future internal belief structures, as Briere and Scott (2015) and Garami et al. (2019) noted. Studies recognize trauma as a significant public health risk (de Munter et al., 2020). It has been reported as the third leading cause of death in the United States, particularly among individuals aged 1-44 years (McQuillan, 2021; Rhee et al., 2014). The term 'trauma' etymology can be traced back to the Greek word 'wound' (Schimmenti, 2017). According to notable researchers, trauma refers to direct or indirect exposure to a distressing event or situation that can make an individual feel helpless and fearful and negatively impact their psychological state (Saillot, 2018; Schimmenti, 2017; Schimmenti & Caretti, 2016). Experiencing traumatic situations can leave individuals incapacitated, leading to disruptions in their lifestyle and way of thinking (Fugate-Whitlock, 2018). According to Schimmenti's 2017 findings, people who experience a traumatic event might exhibit symptoms that can harm their cognitive abilities and lead to negative self-image, dysfunctional relationships, and distorted beliefs.

The symptoms of trauma and complex trauma can vary and depend on the individual. The Diagnostic and Statistical Manual of Mental Health Disorders Fifth Edition Text Revision (DSM-5- TR) can provide more information on these symptoms (American Psychiatric Association, 2022; Saillot, 2018; Schimmenti, 2017). The effects of a traumatic event can alter an individual's ability to function in their daily lives (Friedman, 2015; May & Wisco, 2016; Sanderson, 2013) while also having an impact on their physical health, mental health, and ability to self-regulate safely (Rizeq & McCann, 2023). Individuals who have experienced repetitive and prolonged traumatic experiences are also prone to experiencing post-traumatic stress, conflicting relationships, sleep disruptions, and medical health concerns (Rizeq & McCann, 2023).

Trauma is significant in its ability to increase psychopathology, emphasizing its frequency, intensity, and duration (Schimmenti, 2017). Trauma can be caused by direct or indirect exposure to violence, assault, severe injury, natural disasters, or learning about a loved one's difficult situation. Complex trauma is mainly due to traumatic interpersonal experiences and adverse childhood experiences (ACE) (APA, 2022; Sanderson, 2013; Mertens & Daniels, 2021). ACEs are demonstrations of maltreatment, family and household dysfunction, violence, death, socioeconomic deficits, attachment disruptions/deficits, and mental illness. Experiencing ACEs can lead to recurring difficulty in regulating emotions, engaging in substance use or avoidance coping mechanisms, legal issues, and limited educational growth (Malvaso et al., 2022).

As mental health professionals who prioritize trauma-informed care, it is common practice to inform clients about the possible psychological and physical responses that can arise from traumatic experiences without suggesting that they are somehow flawed or damaged

(Sanderson, 2013). Benfer et al. (2018) indicate that the collection of symptoms displayed by individuals who have experienced trauma can provide valuable information that can be used to identify and understand the trauma they have encountered. These symptoms should be carefully considered without judgment or assumptions about the individual's character or mental state. The internal physiological system of the body often elicits the presenting symptoms of trauma. The frequency, duration, and intensity of a traumatic event can lead to increased levels of stress hormones. Cortisol and adrenaline are stress hormones that trigger flight, fight, or freeze responses (Van der Kolk, 2015). An overproduction of stress hormones can create confusion between the hippocampus and amygdala, according to Sanderson (2013). This can result in an excessive reaction from the automatic nervous system when reminded of a traumatic event.

Individuals displaying symptoms of trauma or complex trauma typically meet one or more of the four primary criteria outlined in the DSM-5-TR (APA, 2022; Friedman, 2015; Lynn et al., 2012). These criteria consist of intrusive presentations, avoidant behaviors, cognitive and mood alterations, and alterations in arousal and reactivity regarding an individual's response (APA, 2022; May & Wisco, 2016; Sanderson, 2013). Concerning distressing intrusive presentations, individuals may encounter disturbing memories, dreams, and thoughts that disrupt their sense of self and overall functionality (Horowitz, 2015). Intrusive presentations can cause disruptions that affect an individual's awareness of their current environment, producing dissociative responses that impair their ability to remain aware of their surroundings (APA, 2022; May & Wisco, 2016; Sanderson, 2013). Individuals may develop anxiety, depressive symptoms, fractured insight toward the self, and altered abilities to trust others (Briere & Scott, 2015; Horowitz, 2015; Sanderson, 2013).

Trauma and the Brain

The brain is vital in safeguarding the body from harm (Van der Kolk, 2015). Traumatic experiences can disrupt the communication between the brain, mind, and body, leading to increased activity in the amygdala, which sends a signal to the hypothalamus and brainstem, activating the autonomic nervous system. Trauma can cause significant damage to the brain, particularly in the amygdala, which regulates emotions. This heightened activity in the amygdala can lead to long-lasting emotional imprints and a heightened response to stressors. Furthermore, it diminishes the ability of the frontal lobes to analyze and process language and thought communication (Nicholson et al., 2015; Van der Kolk, 2015). The amygdala is responsible for emotional processing and is part of the limbic system, which acts as an alarm system that monitors and processes environmental stimuli (Uhernik, 2016; Van der Kolk, 2015). The prefrontal cortex, responsible for executive function, becomes inactive, allowing the amygdala to take over. This leads to a lack of impulse control, difficulties in emotional regulation, and the release of hormones that trigger aggressive or defensive behaviors (Sanderson, 2013; Uhernik, 2016). As a result, the body will respond to the stimulus, and an individual living in this heightened state may display symptoms of post-traumatic stress. Following a traumatic experience, the limbic system may become and continue to be hypervigilant and distorted (Sanderson, 2013; Uhernik, 2016; Van der Kolk, 2015).

Van der Kolk (2015) detailed the consequences of trauma to the brain, emphasizing the left hemisphere of the brain halting and the right hemisphere overcompensating. The left hemisphere is deemed the ‘rational’ brain; however, it fails to organize experiences, significantly impacting the brain's language area following a traumatic event. The brain's right hemisphere is known as the 'emotional' brain. In the aftermath of a traumatic event, an excessive production of

stress hormones may occur, leading to difficulties in regulating emotions and behavior. This happens because of miscommunication between the hemispheres. Van der Kolk asserts that traumatic events can impair the thalamus's capacity to adequately integrate, categorize, and interpret sensory inputs. This, in turn, can result in debilitating flashbacks, nightmares, and dissociative behaviors. Trauma is a common trigger for dissociative symptoms. Studies conducted by Krause-Utz et al. (2017) highlight the link between disruptive attachment, psychological trauma, severe childhood abuse, and neglect in developing these symptoms.

Dissociation and the Brain

With trauma affecting cognitive processing and brain function, dissociative behaviors are recognized as a coping practice of disengagement from traumatic stressors and their emotional consequences (Kecala et al., 2022; Tseng et al., 2021). Atchley and Bedford (2021) reported that dissociative symptoms result from an overt emphasis on limbic reactivity by the medial prefrontal cortex, leading to disconnection noted within the characteristic dissociative state. Differential neural patterns that communicate a dissociative appearance have been documented as taking place in the amygdala, prefrontal cortex, anterior cingulate cortex, precuneus, and parietal lobe of individuals living with post-traumatic stress presentation and reports of experiencing dissociation (Nicholson et al., 2015). Understanding the processing network that causes dissociative appearances can help identify communication issues between the left and right hemispheres.

Duncan et al. (2015) examined the application of resting-state functional magnetic resonance imaging (rs-fMRI), functional magnetic resonance imaging (fMRI), magnetic resonance spectroscopy (MRS), and diffusion magnetic resonance imaging (dMRI) to understand changes in brain communication related to task orientation and overall brain activity during

dissociative episodes. In their 2021 publication, Mucci and Scalabrini discussed the confirmation from neuroscience research that dissociative symptoms are present in individuals with post-traumatic stress disorder and derealization/depersonalization subtype (PTSD + DS). The study found reduced activation in the medial prefrontal cortex and rostral anterior cingulate cortex (ACC), as well as increased amygdala reactivity for individuals diagnosed with PTSD - DS. The research confirmed how blockage in the frontal lobe activation led to increased activity in the limbic system. Individuals with PTSD + DS exhibit heightened activity in the rostral ACC and medial prefrontal cortex, coupled with decreased activity in the amygdala. This can result in the manifestation of dissociative symptoms (Mucci & Scalabrini, 2021).

Neuroscience has employed the defense cascade theoretical model, which supports the discovery that hyper-activation of the fight, flight, or freeze nervous system leads to increased amygdala engagement via the periaqueductal gray. The amygdala cultivates emotional processing and salience detection, emphasizing the stress and fear responses (Krause-Utz et al., 2017). When the amygdala's ability to receive information from the thalamus is compromised, it can lead to dissociative features. This is because the amygdala continuously detects and analyzes stimuli. Recent studies suggest that detachment and decreased reactivity during dissociative states may be linked to decreased regulatory capabilities in the amygdala (Mucci & Scalabrini, 2021; Van der Kolk, 2015). Research using neuroimaging techniques has found a connection between patients presenting with dissociative symptoms and higher scores on tests designed to measure such symptoms (Krause-Utz et al., 2017). Despite our growing understanding of dissociation and its effects on the brain, more research is required to fully grasp its expressions, outcomes, and underlying processes (Nicholson et al., 2015).

History of Pathological Dissociation Theory

Pierre Janet, a French psychiatrist, philosopher, psychologist, esteemed pioneer, and founder of dissociative traumatology studies (Saillot, 2018; Tarquinio & Van der Hart, 2021; Van der Hart, 2016), has been recognized for his advancements in pathological dissociative presentation (Van der Hart, 2016). Sigmund Freud is also recognized as a contributor to the theory of unconsciousness and hysteria, initially validating Janet's approach regarding hysteria, dissociation, and the subconscious, which he termed the unconscious (Fitzgerald, 2017; Van der Hart, 2016). Freud criticized Janet's theory due to his belief that too much emphasis was placed on the 'splitting of the consciousness' as a primary cause of hysteria and dissociative disorders (Van der Hart, 2016). After initially accepting and incorporating Janet's findings into psychoanalytic theory, Freud later began to discredit Janet and his work on dissociation and hysteria (Fitzgerald, 2017; Van der Hart, 2016). Both Freud and Janet were keen on utilizing hypnosis to treat patients exhibiting symptoms of dissociation and hysteria. Still, Freud later discontinued his involvement with the study of hypnosis while Janet continued to do so (Van der Hart, 2016).

Janet researched the therapeutic use of hypnosis as part of his doctoral dissertation, which inspired him to work with individuals who exhibited traits from two main subtypes: "1) the reduction of the number of psychological phenomena that could simultaneously be perceived; and 2) the doubling of the personality" (Van der Hart, 2016, p.45). Janet determined that the subtypes mentioned above enabled specific personality traits to be present or absent within one 'existence' rather than another, highlighting specific mental and physical attributes noted within each identified 'existence' (Van der Hart, 2016). Janet gained a comprehensive knowledge of dissociative identity disorder and the presence of multiple personalities through his collaboration

with 19-year-old Lucie. Lucie herself acknowledged the presence of these distinct personality types. Through his work with Lucy, Janet hypothesized various ways the mind engages with an individual who has endured a traumatic encounter (Van der Hart, 2016).

Janet studied how the mind works to preserve and reproduce past encounters and how the mind works to utilize integration and creation (Van der Hart, 2016). By studying these concepts, Janet coined the term ‘subconsciouses’ to delineate how the mind processes information within an automatic gesture (Van der Hart, 2016). It is understood that the subconscious mind can contain a secondary existence with its sense of self. This means that what we know today as a person's personality or sense of self is present in a basic form within the subconscious or dissociative state rather than in a state of crisis or hysteria (Van der Hart, 2016). Janet reported awareness of multiple existences, demonstrating decision-making skills, presenting a healthier personality, and being aware of other personalities (Van der Hart, 2016).

Janet suggested that fixed ideas or dissociative experiences, which involve presenting mental images, memories, emotions, thoughts, and familiar behaviors, may influence the conscious mind from a subconscious state and cause maladaptive behaviors (Overholser, 2017; Van der Hart, 2016). Fixed ideas are characterized by persistent emotional states that affect the individual's ability to reason, causing a form of dissociation and leading to physical and emotional exhaustion due to repeated traumatic experiences associated with these ideas (Overholser, 2017; Van der Hart, 2016). Fixed ideas tend to focus on past traumatic encounters that are unresolved and unprocessed (Overholser, 2017). Janet discovered two types of fixed ideas - primary and secondary. The primary fixed idea deals with the intricate interplay of images, emotions, and behaviors that characterize a traumatic experience.

On the other hand, secondary fixed ideas build on the primary fixed idea to further emphasize its significance (Van der Hart, 2016). Van der Hart asserts that Janet was instrumental in identifying and illuminating the dissociation phenomenon, which refers to the disintegration of the mind's meticulously crafted syntheses and the subsequent emergence of various personality divisions. Janet posited that psychological unity, identity, and initiative are not inherent characteristics of human psychology but rather are incomplete outcomes that require a great deal of exertion and are susceptible to vulnerability.

Understanding Pathological Dissociation

Dissociation presentations are more common than previously reported and discussed within research (Brand et al., 2017). Dissociation is considered a transdiagnostic feature in mental health and psychiatry because it is present in disorders other than dissociative disorders, such as borderline personality disorder, schizophrenia, and anorexia nervosa (Longo et al., 2021). According to Brand and Stadnik (2013), dissociation is a disturbance to an individual's identity, perception, consciousness, or memory. Lloyd (2015) further underscores that PD is an unconscious defense mechanism that alters conscious awareness, often as a response to severe psychological distress, particularly after experiencing trauma. Dissociation is recognized as a regular aspect of mental and psychological functioning and is viewed on a spectrum (Becker-Blease, 2013; Kluft, 2022). The extent of suggestibility, fantasy proneness, and hypnotic state all play a role in the variation of dissociation. However, when dissociation becomes pathological, it can lead to difficulty managing emotions, motor control, and sensory connections (Van der Kruijs et al., 2014).

PD is discussed within the context of two subtypes: psychoform and somatoform (Kienle et al., 2017; Longo et al., 2021; Romeo et al., 2022). Psychoform comprises dissociative

experiences involving the mind and its mental processes, resulting in an overall understanding and definition of "dissociation" (Kienle et al., 2017; Longo et al., 2021; Romeo et al., 2022). Psychoform has been identified as a subtype by more research studies than somatoform (Longo et al., 2021). Somatoforms include dissociative experiences that negatively impact the body, sensory perception, and motor control, causing physiological deficits that are not medically conceptualized or linked to substance usage. Somatoform dissociative presentations have been identified as bearing semblance to the 19th-century hysteria symptomology (Romeo et al., 2022). Somatoform disorders are characterized by both negative and positive symptoms that reflect the individual's experience of traumatic events and unresolved memories. These symptoms include anesthesia, analgesia, motor inhibitions, localized pain, and altered sensory presentations such as changes in the perception of smell, taste, and receptors (Longo et al., 2021; Romeo et al., 2022).

PD can lead to the separation of a person's trauma-related thoughts, memories, and emotions, making it possible for them to share with a therapist that they do not feel whole, have a sense of emptiness, or feel numb (Courtois & Ford, 2016; Ford & Gómez, 2015; Kluft, 2022). PD impairs the functionality of an individual's psychological capacity, emphasizing identity, consciousness, motor control, and memory (Atchley & Bedford, 2021; Parlar et al., 2016). The mind employs PD as a means of shielding the individual from anxiety, stress, exhaustion, or traumatic circumstances, whether they originate internally or externally (Brand et al., 2017; Büetiger et al., 2020; Friedman, 2015; Lynn et al., 2012; Sanderson, 2013). Courtois and Ford discussed how the mind uses dissociation to distance, disclaim, disown, and disempower traumatic memories. Mucci and Scalabrini addressed the importance of dissociation as a defense mechanism in response to interpersonal violations, as opposed to dissociation arising from

experiencing a natural disaster. Children are often seen as dissociating, usually due to a perceived threat to their well-being or safety (Mucci & Scalabrini, 2021).

PD is recognized as a child-like imaginary practice that evolves into adulthood (Becker-Blease, 2013; Kluft, 2022), where individuals similarly report not being able to recognize themselves in the mirror, having an awareness that they operate within separate personality presentations, and expressing difficulty recalling intimate memories and personal experiences (Becker-Blease, 2013). Research suggests that PD stems primarily from traumatic experiences or volatile attachment disruptions (Becker-Blease, 2013; Parlar et al., 2016). On the other hand, cultural norms acknowledge dissociation as a form of adjustment, religious rituals, sports activities, or imaginative games for kids (de Oliveira Maraldi et al., 2017). Dissociation has been recognized as a possession phenomenon in Eastern cultures as opposed to Western cultures (Pierorazio et al., 2023). To achieve favorable results in therapy, therapists must connect with their clients at their current level and refrain from any conduct that could worsen the situation or prompt the client to disengage. (Brand et al., 2017; Courtois & Ford, 2016).

PD, despite being recognized as an effective psychological protective technique when traumatic stress occurs (Parlar et al., 2016), is concerning due to its spontaneous, severe, and uncontrollable hypnosis-like behaviors that can negatively impact positive outcomes and hinder healthy living (Lyssenko et al., 2018). Within this understanding, severe PD experiences are recognized in the DSM-5-TR. PD is identified in the DSM-5-TR with an emphasis on depersonalization and derealization, dissociative amnesia, and dissociative identity disorder (APA, 2022; Atchley & Bedford, 2021; Friedman, 2015; Lynn et al., 2012; Parlar et al., 2016; Sanderson, 2013). The DSM-5-TR also recognizes dissociative presentations in post-traumatic

stress disorder subtypes, borderline personality disorder, schizophrenia, and other mental health disorders (APA, 2022; Longo et al., 2021; Lyssenko et al., 2018).

Depersonalization/Derealization

Depersonalization refers to a dissociative experience where the mind creates a barrier against triggers related to negative experiences and memories, disrupting the individual's perception of reality (APA, 2022; Sanderson, 2013). Derealization is the alteration of the mind, in which the mind does not decipher what is real and present in real-time; all things may present as foreign, hurried, or slowed to the individual experiencing the dissociative encounter (APA, 2022; Sanderson, 2013). Depersonalization and derealization are considered subtypes of post-traumatic stress disorder due to their inward psychological behaviors that exacerbate the fear and stress patterns outlined in the criteria for PTSD (Weiner & McKay, 2013). Experiencing depersonalization and derealization can impede the healing process of traumatic experiences and memories, which are crucial for successful treatment and a positive outcome (Weiner & McKay, 2013). Both are considered pronounced states of disconnection from reality; while most cases are categorized as transient, others present as chronic bearing weight for depersonalization-derealization disorder (DDD) (APA, 2022; Büetiger et al., 2020; Millman et al., 2021).

According to research, approximately 0.95% to 2.4% of the general population meets the criteria for DDD, with up to 36% of those individuals experiencing psychosis in a hospital setting (Millman et al., 2021; Sedeño et al., 2014; Simeon, 2014). Büetiger et al. (2020) found that around 36% of those with DDD also have a comorbidity of psychosis in hospital settings. Büetiger et al. (2020) state that depersonalization and derealization entail a detachment from oneself, encompassing one's thoughts, emotions, body, and surroundings. It can be like feeling lost in a dreamy or foggy state, emotionally numb, or as if a glass bell separates oneself from the

world. The onset of depersonalization and derealization symptoms is typically reported to occur within the late adolescence/early adult period, between the ages of 25 and 40 (APA, 2022; Büetiger et al., 2020; Millman et al., 2021; Watson, 2022). DDD is recognized as an under-researched phenomenon, in which many mental health professionals are unfamiliar with and unprepared to provide treatment (Gentile et al., 2014; Michal et al., 2016).

DDD is differentiated from other dissociative disorders because individuals report an increase in their ability to concentrate and focus because of anxiety presentation and a reduced impact on memory disturbance (Lyssenko et al., 2018; Sedeño et al., 2014). Triggers toward anxiety presentation have also been described as common antecedents of DDD presentation (Lyssenko et al., 2018; Sedeño et al., 2014). Individuals with DDD do not report the full scale of dissociative symptoms, as identified in correlation with the dissociative experience scale (DES-II) (Lyssenko et al., 2018; Millman et al., 2021). DDD presentation is recognized as a comorbidity with up to 90% of anxiety disorders, mood disorders, personality disorders, obsessive-compulsive, substance abuse disorders, psychotic disorders, and avoidant disorders (Heydrich et al., 2019; Millman et al., 2021; Simeon, 2014).

Dissociative Amnesia

Dissociative amnesia, also known as psychogenic amnesia, is a condition characterized by the inability to recall important personal information that cannot be explained by ordinary forgetfulness, the effects of substances, a neurological or medical condition, and is typically preceded by a traumatic event (APA, 2022; Clouden, 2020; Mangiulli et al., 2021). DA can last from minutes to years, with an estimated 30% of trauma survivors potentially experiencing its effects (APA, 2022; Mangiulli et al., 2021). DA is recognized as an automatic loss of memory concerning the entire traumatic event, details related to the traumatic event, or the result of

memory gaps that lead to clinically defined impairment or distress concerning social interaction, occupational interaction, or affective functioning (Radulovic et al., 2018).

DA was initially identified as memory repression due to its impact on the memory system, allowing the individual to detach from traumatic memory or the past. Research places importance on assessment and ruling out malingering or the DSM-5's factitious disorder (Mangiulli et al., 2021; Pope et al., 202l). Research indicates a 1.8 to 7.3% prevalence rate among the general population, a 7.3 to 13.4% prevalence rate among psychiatric inpatient settings, and a lifetime prevalence rating of 6% (Hafizi & Afolabi, 2021; Mangiulli et al., 2021) regarding individuals living with DA. DA is considered the most common dissociative disorder, with a diagnosable age ranging from 20 to 40 (Clouden, 2020).

DA is a psychological disorder that is controversial due to research suggesting that memories may be well-remembered despite the condition (Mangiulli et al., 2021; Otgaar et al., 2022). Over the past 20 years, it has been argued that most reported DA cases have met differential diagnoses instead of fully meeting the DSM-5-TR's diagnostic criteria (Mangiulli et al., 2021). The term 'dissociative amnesia' refers to the act of forgetting (Patihis et al., 2019) and is considered the simplest form of dissociation (Patrichi et al., 2021). DA was previously named functional or psychogenic amnesia (Simão, 2018).

DA is dependent on repressed memory theory, which originated in the 1990s, suggesting that traumatic occurrence or memory is unconsciously buried for a while with the potential to be resurrected later (Otgaar et al., 2022). The DSM-5-TR classifies repressed memories as 'generalized,' 'localized,' and 'selective,' with only 'localized' and 'selective' memories having the potential to be recovered (APA, 2022; Pope et al., 2022). Repressed memory and DA are often

used interchangeably in clinical settings (Patihis et al., 2019; Pope et al., 2022). DA has a subtype known as dissociative fugue because of the distinction of amnesia (APA, 2022).

Dissociative Fugue

Dissociative fugue (DF), once recognized as a psychogenic fugue, is the temporary loss of personal identity and physical location (APA, 2022; Igwe, 2013; Jha & Sharma, 2015). DF is observed in 0.2% of the general population (Igwe, 2013; Jha & Sharma, 2015). DF differs from other dissociative disorders in that the individual's wander or "flight" is organized, suggesting that relocation correlates with repressed memory (Brand et al., 2018; Mamarde et al., 2013). Individuals who demonstrate sporadic wandering may wander from their current location for thousands of miles, spanning days, weeks, or months (Igwe, 2013). DF is considered a rare presentation with antecedent indications of child abuse or traumatic or stressful experiences that result in a sudden onset. The initial onset of DF occurs in adolescence or early adulthood (Igwe, 2013). Previous dissociative experience does not have to be a predisposing factor (Igwe, 2013). DF is often not diagnosed until the completion of a fugue episode, with the individual not being aware of the incident and expressing a loss of time and disorientation (Jha & Sharma, 2015).

Dissociative Identity Disorder

Dissociative identity disorder (DID) is recognized as a star-dissociative disorder due to its notoriety and mystery, which dates to the late 1890s (Brand et al., 2018). DID was recognized and researched in-depth by Morton Prince, the founder of the Journal of Abnormal Psychology, and Pierre Janet, the founder of dissociative traumatology (Van der Hart, 2016, 2021). It was introduced as a multiple personality disorder in the DSM-III (Reinders & Veltman, 2021) but renamed as dissociative identity disorder in the DSM-IV (Simão, 2018) and popularized in the United States due to fiction works, such as *Sybil and The Three Faces of Eve*. These fictional

productions also added to the controversy and myths associated with speculation and the influence of suggestibility on the validity of DID (Brand et al., 2018; Simão, 2018).

DID is primarily a derivative of the trauma model with an emphasis on traumatic, stressful, and distressing events in childhood, a type of abuse or assault, neglect, disruptive and volatile attachment, and repetitive violations within boundaries being key risk factors (Brand et al., 2018; Şar et al., 2017). Trauma related to DID emphasizes a genetic connection or childhood adversity (Şar et al., 2017). DID impacts the functionality of the cognitive processing system, emphasizing a "disruption of or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior" (APA, 2022, p. 291) DID refers to an individual with two or more different personalities, each with a psychophysiological identity (Şar et al., 2017; Vissia et al., 2016).

DID is more common among psychiatric outpatients and those seeking emergency psychiatric care. Around 5% of inpatients, 2 to 3% of outpatients, and approximately 1% of the general population are affected by DID (Şar et al., 2017). Meeting the diagnostic criteria for DID strongly suggests the presence of a persistent and profoundly distressing experience. This is particularly true when the disorder manifests in early childhood, as the child cannot establish a stable self-identity despite their environment and conduct (APA, 2022; Şar et al., 2017). Trauma can significantly impact a person's identity, leading to changes in their thoughts and behaviors. These changes may include avoidance and intrusive thoughts and cause internal conflict (APA, 2022; Şar et al., 2017).

Most individuals with a DID diagnosis have a history of chronic abuse in their childhood, typically involving an internal attachment figure or family member (Huntjens et al., 2019; Şar et al., 2017). DID clients often have difficulty with their memory capacity, allowing for the

presentation of amnesia, thus causing extreme problems with treatment outcomes and progression (Şar et al., 2017). Clients with DID often experience heightened feelings of guilt and shame. This can further perpetuate the division within oneself and any dissociative identities that may help cope with distressing emotions and memories (Dyer et al., 2017). Shame, humiliation, anger, helplessness, contempt, and hopelessness are regarded as the main catalysts of the psychopathology of DID symptoms (Chefetz, 2017; Dyer et al., 2017).

Individuals diagnosed with DID often report an inability to recognize their reflections in the mirror (Hill et al., 2020). The research proposes that individuals diagnosed with DID have a negative insight toward the self as opposed to those reported with a secure developmental association with the self not living with DID (Hill et al., 2020). Cognitive processing is so averted to re-engagement with the traumatic event that the outer and inner perceptions of self continue to be distorted images (Hill et al., 2020). DID co-occurs with other mental health disorders, such as borderline personality disorder, major depressive disorder, and generalized anxiety disorder, all of which potentially aid in heightening the physiological symptoms associated with DID (APA, 2013; Ross et al., 2013; Şar et al., 2017). Individuals living with DID are reported to have an increased inability to regulate their emotions appropriately, an increased presentation of anger, and an increase in impulsive and self-destructive behaviors (Şar et al., 2017). Many mental health and psychiatric providers attribute treatment for DID to be ineffective, with 5 to 10% of surveyed adults noted by Brand et al. (2018) as having worsening symptoms.

Treatment Presentation for Pathological Dissociation

Accurately diagnosing and assessing dissociative presentations can be challenging, given the variability of symptoms and severity. Conducting an assessment when working with

individuals who may exhibit dissociative symptoms is essential. This is necessary to differentiate between presentations of psychosis and dissociation, aiding in the development of an appropriate treatment plan and ensuring effective implementation (Palic et al., 2015). Assessment of PD often includes utilization of the Structured Clinical Interview for DSM-5 Dissociative Disorders (SCID-D) and the Dissociative Disorders Interview Schedule (DDIS) (Yang et al., 2023). Both assessment tools require administration by a trained practitioner (Yang et al., 2023). To accurately assess symptoms of dissociation, it is crucial for clinicians to use screening tools such as the Cambridge Depersonalization Scale, the Multiscale Dissociation Inventory, and the Dissociative Experience Scale (Jeffirs et al., 2023; Yang et al., 2023). These scales help determine if a patient's symptoms meet the threshold for diagnosis (Jeffirs et al., 2023; Yang et al., 2023). The psychotherapist can then discuss the results with the client while educating the client on the PD treatment structure and practice process.

The treatment of PD dates back to the 1890s, with the evolution from automatic writing as the dissociated individual is in a hypnotic trance to talk therapy and now the implementation of phase-oriented treatment models (Bacopoulos-Viau, 2019; Pierce, 2014). Treatment for PD does not commonly include medication unless the dissociative presentation is comorbid with a depressive, mood, psychotic, or anxiety disorder (Simeon, 2014; Watson, 2022). The phase-oriented outpatient treatment model is gaining popularity as it is seen as more favorable in terms of prognosis for patients with dissociative disorders and those exhibiting PD symptoms. This model is linked to a reduction in the occurrence of self-harm actions and hospitalizations and an improvement in overall functioning (Pierce, 2014). Research indicates that agreeable psychiatric and mental health treatment details the use of multimodal, phasic, trauma-focused psychotherapy

that focuses primarily on dissociation while also integrating direct collaboration with alters (Brand et al., 2018; Ross et al., 2013; Şar et al., 2017).

Phase-Oriented Treatment Models

Phase-oriented treatment models are considered best practices for individuals with PD due to the prioritization of safety and stabilization before the engagement of trauma work (Van Minnen & Tibben, 2021; Willis et al., 2023). By incorporating phase-oriented interventions, individuals can develop the ability to become more independent, enhance their skills, and build resilience in carrying out trauma-focused work. This approach emphasizes teaching and practicing skills for long-lasting success (Willis et al., 2023). Phase-oriented treatment is not linear in execution but interwoven with the client's needs (Van der Hart, 2016). Phase one focused on psychoeducation and skills concerning stabilization and distress tolerance (Willis et al., 2023). Phase two targets confrontation or exposure with the intent to process identified trauma, emotions, thoughts, and bodily sensations (Willis et al., 2023). Phase three targets personality integration through holistic practices that encourage healing and growth instead of a continued reaction and response to trauma triggers (Willis et al., 2023).

Psychodynamic Psychotherapy

Psychodynamic therapy, which is utilized as an interchangeable term with psychoanalysis, has been identified as a collaborative series of theories by Freudism with an emphasis on ego psychology, the Freudian drive approach, object relations and attachment theory, and self-psychology (Luyten et al., 2017). The following four methodologies uphold fundamental principles that are crucial in cultivating a nurturing therapeutic bond, delving into emotions, tackling avoidance and resistance, uncovering recurring patterns, analyzing prior experiences, exploring imaginative realms, and addressing interpersonal concerns (Luyten et al.,

2017; Plakun, 2023). It is also important to note that psychodynamic therapy embraces transference and countertransference, noting them as key identifiers throughout treatment regarding the appearance of resistance and internal exchange concerning internal schemas (Luyten et al., 2017). Psychodynamic practices work to consider and integrate the whole person rather than individualized symptoms, behavior, or personality features, thus primarily operating in a person-centered perspective (Luyten et al., 2017). Psychodynamic psychotherapy is recognized as an effective treatment model for PD and DID because of its ability to operate on a continuum concerning the support of being interpretive for an individual's maladaptive concerns (Leichsenring & Schauenburg, 2014; Luyten et al., 2017; Rinker, 2019).

Psychodynamic psychotherapy with PD is utilized within phase orientation, with the initial phase being safety and symptom stabilization, the second phase being trauma-focused psychotherapy, and the third phase being the integration of the identity population (Van Minnen & Tibben, 2021). Van Minnen and Tibben provided insight into how cognitive behavioral therapy with an emphasis on trauma-focused treatment can aid in individualized phases due to the effectiveness of targeting the behavioral and cognitive distortions commonly noted in trauma clients/patients. Rinker (2019) details how cognitive behavioral therapy (CBT), dialectical behavioral therapy (DBT), and humanistic therapy are other recognized modalities that can be integrated with psychodynamic work to aid in decreasing maladaptive presentations associated with dissociative symptoms (Luyten et al., 2020).

Challenges Associated with Effective Treatment for Pathological Dissociation

A concern is that consistent, ethical, and proper care is not provided to individuals with PD. While research indicates that dissociative presentations can result from social, cultural, cognitive, and traumatic antecedents, no empirical research-based preferred treatment framework

currently encourages an increase in positive outcomes concerning the decreased presentation of dissociative symptoms (Lloyd, 2015; Lynn et al., 2022). With trauma and PD being an ever-growing concern (Schimmenti, 2017), the need for competently trained psychotherapists to provide care to this population continues to grow (Danylchuk, 2015; Rosen et al., 2017). Identifiable concerns that have been recognized in research concerning psychotherapists and their treatment of individuals living with trauma and dissociative symptoms tend to be: (1) proper implementation of interventions that do not lead to an increase in presenting issues (Rosen et al., 2017) and (2) confidence in the conduction of trauma-informed therapy (Danylchuk, 2015; Sansen et al., 2019; Turkus, 2013).

As per the findings of Bruce et al. (2018), the Substance Abuse and Mental Health Services Administration (SAMHSA) has outlined four crucial components of trauma-informed practice (SAMHSA, 2015). These consist of acknowledging the pervasive impact of trauma exposure, comprehending how trauma can influence patients, families, and personnel throughout the system, integrating this knowledge into institutional policies and practices, and preventing any re-traumatization (Bruce et al., 2018). The question considered in this research is how these principles, practices, and expectations are efficiently executed when working with individuals with PD symptoms. Schimmenti's (2017) and Şar et al. (2017) research is crucial to this study as it acknowledges the evidence highlighting the inadequacy of unclear and imprecise solutions to recognized conceptual issues, facilitating further examination and investigation to arrive at a clear solution. The question then arises as to how psychotherapists can gain access to reliable and ethical resources that can aid in the enhancement of competently trained licensed psychotherapists. A common problem is that some mental health professionals are reluctant to use trauma-informed interventions due to negative beliefs about their effectiveness and limited

access to affordable and accessible training options (Danylchuk, 2015; Sansen et al., 2019). Given the increasing focus on the quality of care and limited access to trauma-informed treatment, psychotherapists remain uncertain about participating in trauma-informed training (Turkus, 2013).

Research studies by Danylchuk (2015), Nester et al. (2022), and Sansen et al. (2019) have found that psychotherapists may experience fear due to the risk of a client regressing and being re-traumatized. This fear has the potential to negatively impact the therapeutic alliance, a crucial element in psychotherapy treatment. However, despite its importance, the therapeutic alliance has not received adequate attention in many research studies, as Tschuschke et al. (2020) pointed out. Dissociation has clinical significance concerning comorbidity, higher severity of other mental health symptoms, and non-responsiveness toward treatment; fear and avoidance increase when treating this population (Sansen et al., 2019). Psychotherapists must possess the knowledge and skills required to effectively manage transference, countertransference, and resistance to preserve the therapeutic relationship with their clients living with PD. Failure to do so may lead to unnecessary referrals, ultimately worsening the prognosis (Lacewing, 2014).

Summary

Trauma and dissociative presentations are regularly misdiagnosed due to behavioral presentations and inadequate training among mental health and medical providers, leading to ineffective treatment tools and medication management (Barnes & Andrews, 2019; Sanderson, 2013). Approximately 25% of adult practitioners fail to screen appropriately, therefore failing to provide referrals for specialized mental health treatment due to mainly hyperfocus on pain and non-specific physical symptoms (Barnes & Andrews, 2019). This gap is essential due to the growing need for competency. Nevertheless, the cyclical recognition of incompetent practices,

overworked professionals, and lack of resources continue to be under-researched and unalleviated (Barnes & Andrews, 2019; Sanderson, 2013).

Successful treatment requires intentionality toward the therapeutic relationship and the therapist's ability to be relational, which is considered an essential practice when providing treatment to individuals living with PD (Courtois & Ford, 2016; Lacewing, 2014; Luyten et al., 2017, 2020; Sanderson, 2013). Intentionality toward establishing a safe and secure therapeutic environment is vital for successfully managing reactions to traumatic situations via positive coping mechanisms (Courtois & Ford, 2016; Sanderson, 2013). When psychotherapists lack adequate training and support, it becomes challenging to provide safe and effective therapy. This can compromise the safety and well-being of patients seeking treatment (Kumar et al., 2022). This recognized decline in accessibility to competently trained psychotherapists for individuals living with PD symptoms is a concern that fails to lead to identified solutions. Consideration is also applied to psychotherapists who desire to aid individuals living with dissociative presentations but encounter ongoing limitations, which result in personal trauma (Lueders et al., 2022), therefore helping the cycle of inaccessibility for competently trained psychotherapists for individuals living with PD.

Concerning the need for competent psychotherapists for individuals living with dissociation, this study will work to gain insight and understanding of the lived experiences of psychotherapists and their practices with individuals living with PD. Inadequate and inaccessible training places both the client and psychotherapist at risk, with examples being transference or countertransference being present and premature trauma work without the execution of stabilization and the completion of phase one. Psychotherapists who lack training in dissociation treatment may struggle to differentiate between pathological and non-pathological symptoms

accurately. Psychotherapists who help people with PD need to be able to help them reduce their dissociative practices (Van der Hart, 2016).

Chapter Three: Methods

Overview

Research acknowledges the lack of accessibility of psychotherapists who provide effective treatment for individuals with PD; however, little research has been conducted on effective solutions to this problem (Cronin et al., 2014; Sansen et al., 2019). In 2019, Sansen et al. conducted research on the subjective experiences of psychotherapists and their efforts to receive effective trauma training for treating individuals with PD. This chapter details the purpose of selecting a hermeneutical phenomenological qualitative study approach. Explanations will be provided regarding the processes of procedure, design, and analysis of the construction and completion of this hermeneutical phenomenological qualitative study.

Design

A qualitative methodology study was chosen to investigate the experiences reported by psychotherapists who work with individuals living with PD. The study focuses on the intentional features of these experiences. Qualitative research is a system that allows the exploration and portrayal of subjective perceptions. Using a qualitative methodology enables the incorporation of non-numerical data gathered from focus groups, reports, interviews, narratives, and observations to demonstrate the flexibility of our approach toward enriching literature (Naderifar et al., 2017). Through phenomenological qualitative methodology, researchers can provide an intricate and thorough depiction of a phenomenon, emphasizing key elements that contribute to a comprehensive comprehension of the phenomenon (Heppner et al., 2016). Phenomenology is "a research approach that seeks to describe the essence of a phenomenon by exploring it from the perspective of those who have experienced it" (Neubauer et al., 2019, p. 91). Phenomenology was created in the early 20th century by philosopher Edmund Husserl, who initially identified it

as a philosophical framework and is now recognized and accepted as an empirical research design because of Martin Heidegger, emphasizing the hermeneutical approach (Neubauer et al., 2019; Nigar, 2020; Suddick et al., 2020).

A hermeneutical phenomenological qualitative study approach was selected to add consistency, structure, and development regarding implementing assessment, treatment, and understanding of treatment outcomes related to individuals living with dissociative symptoms (Creswell & Poth, 2018). A hermeneutical phenomenological approach allows the phenomenon to be detailed and explored by the reporting individual, who is identified as the critical source of requested data (Neubauer et al., 2019). Individuals provide personalized data detailing their experiences of the phenomena and the knowledge gained from the phenomenal encounter. The collection of reported experiences was the data required for this qualitative study. A hermeneutical phenomenological qualitative study approach was selected to aid in the understanding and conceptualization of trauma-informed therapeutic practice when working with individuals living with PD.

Research Questions

RQ1: What are the experiences of psychotherapists providing therapy to individuals with pathological dissociation?

RQ2: What experiences do psychotherapists have with implementing interventions for individuals diagnosed with pathological dissociation?

RQ3: What are the psychotherapists' experiences involving supervision/consultation when working with pathological dissociation?

Setting

The present study was executed virtually to ensure optimal convenience for all participating individuals across the United States. Recruitment efforts were focused on psychiatric facilities, private practices, and community mental health agencies that offer services to individuals with PD. The video-conferencing platform, Zoom, served as a versatile tool for conducting interviews, observations, and data collection. The interview process was approximately one hour. The researcher strived to ensure accessibility for the completion of data retrieval, as authenticity and collecting raw experiences were the main focus. To ensure confidentiality, participants and all documents in the study were given pseudonyms.

Participants

Nine participants communicated having a personal history of treating PD, which was a requirement for this phenomenological study. To participate in this phenomenological quantitative study, participants must have had a firsthand experience of the phenomenon being studied and be able to provide detailed information based on their observations. Compliance with these requirements was essential for successfully implementing the study (Heppner et al., 2016). The researcher aimed to enlist six to ten psychotherapists with direct experience working with individuals exhibiting PD. The study employed consecutive sampling, which involved selecting participants who met the criteria until the desired sample size was achieved. This non-probability sampling method is also known as snowball sampling (Naderifar et al., 2017).

Snowball sampling is a method that enables researchers to use referral processes to recruit participants for their study, especially when the desired sampling population is complex to access (Naderifar et al., 2017). The criteria for participant selection are psychotherapists who have provided or had a history of providing treatment for individuals with PD, aligning with the

human experience element of a qualitative study (Creswell & Poth, 2018; Heppner et al., 2016). The psychotherapist must hold a minimum of a master's degree and be a licensed professional at the time of treatment for clients with PD. The psychotherapist has to have treated at least one client with PD for at least 8 to 10 weeks. Individuals who had never treated PD were excluded from the study. Participants were informed that their participation was voluntary and received a small gratuity.

Procedures

Following the approval from Liberty University's Institutional Review Board (IRB), the recruitment process for participants was initiated. The researcher recruited participants by sending emails to potential psychotherapists who have worked with PD and by using social media outlets. The researcher emphasized that participation in the study was voluntary and that participants could withdraw at any time if they felt uncomfortable. During the study, each participant was screened to determine their eligibility. Each participant conveyed to the researcher how they met the criteria. An email was sent to each participant who expressed interest in the study containing a welcome letter, consent form, and contact information for both the researcher and Liberty. A virtual interview schedule was created with specific dates and times allotted for each participant, allowing approximately one hour for engagement. Each participant confirmed their availability and scheduled an interview time with the researcher.

The interviewer meticulously engaged with every participant, ensuring strict adherence to the interview format aligned with each research question. The questions were designed to gather information about the participants' personal experiences working with PD. Each participant expressed their experience and excitement for completing the study. The researcher used the Zoom application to collect data and incorporated Delve software to aid in the analysis and

coding of completed interviews. The interview process took place in November and December of 2023. The researcher reviewed each transcribed interview alongside the corresponding Zoom audio to verify, revise, and finalize the collected data. During the interview, all the data collected from the participants was encrypted and stored securely on a password-protected computer. The data will remain on the computer until the legal timeline for its disposal is reached.

The Researcher's Role

As the researcher, I adopted an approach to engage with participants that facilitated an in-depth exploration of their perceptions and emotions concerning the salience of psychotherapy in addressing PD. Despite my inherent biases, I maintained an unwavering commitment to impartiality, even when it necessitated venturing beyond the confines of my preconceived notions. This approach ensured that my research was accurate and reliable and represented participants' experiences with respect and sensitivity (Sutton & Austin, 2015). Although I have experience with PD, I continuously reflected on my biases and assumptions to avoid contaminating the study. I was aware that I was functioning as a data collection tool (Heppner et al., 2016), which meant I maintained objectivity while collecting data during participant interactions. Throughout the interview process, I worked to employ a semi-structured format and ask open-ended questions to allow participants to share their experiences in treating individuals with PD. I categorized themes reported by participants to describe treating individuals with PD comprehensively.

Data Collection

After obtaining approval from Liberty University's IRB board, the researcher collected data to address the problem statement. Data collection adhered to academic standards and guidelines to ensure validity and reliability (Heppner et al., 2016). The researcher utilized the

Hermeneutical Phenomenological Approach, a human science methodology by Van Manen, to investigate the significance of acquiring knowledge through human experiences of identified phenomena (Paley, 2018; Van Manen, 2016). Emphasis was made on the eloquence noted in human experiences through interviews, observations, and written accounts from identified participants (Paley, 2018). In the context of research interviews conducted via Zoom, it was of utmost importance for the researcher to disclose the data collection and retention details to the participant, including utilizing Zoom storage and documentation. This ensured ethical and transparent research practices and promoted trust and credibility between the researcher and participant (Creswell & Poth, 2018). Interviews were conducted with open-ended questions to understand the participant's experience treating individuals with dissociative presentations (Heppner et al., 2016). The psychotherapists asked open-ended questions about their trauma-informed training, assessment processes, session structure, treatment of PD, and outcomes. The researcher listened to the psychotherapist's information to identify areas needing clarification or further exploration (Galletta & Cross, 2013).

Interviews

A standard protocol is necessary because interviewing is the primary data collection method (Heppner et al., 2016). Zoom's secure practices were employed for data collection to protect confidentiality. Participants were asked open-ended questions about their professional therapy background, opinions, beliefs, feelings, knowledge, and experiences. All participants provided informed consent for the recording of their interviews. Examples of open-ended questions are as follows:

1. Describe experiences/training that assist in treating trauma and understanding dissociative pathological populations.

2. Describe your perspective on pathological dissociation and its role within psychotherapy.
3. Describe what led you to work with the pathological dissociative/disordered populations.
4. Describe a notable experience regarding initially working with pathological dissociation.
5. How have you been able to implement self-care practices while working with a pathological dissociative population?
6. What steps do you take to screen, assess, and choose treatments for people with pathological dissociation?
7. What interventions or strategies can be used to recognize dissociative symptoms?
8. What protocols or documentation practices are utilized to monitor progress while working with pathological dissociation?
9. What treatment modality(s) do you utilize while working with pathological dissociation?
10. Which interventions have contributed to the reported decrease in pathological dissociation?
11. Which interventions have contributed to the reported increase in pathological dissociation?
12. What resources have enabled access to support in treating pathological dissociation for both you and the client?
13. What methods do you use for supervision or consultation when working with a population experiencing pathological dissociation?
14. Describe the process of selecting your supervisor/consultant.
15. How has supervision/consultation affected the conceptualization of treating individuals with pathological dissociation?

16. Is there any additional information that would be important to this study and relevant for individuals considering working with pathological dissociation?

Question one allowed the researcher to be educated on the participants' professional experiences related to trauma-focused psychotherapy. Question two aimed to illuminate the participants' perspectives and comprehension of the strategy for working with PD and its effect on psychotherapy methods. Questions three and four describe the participants' pathways to work with PD. Question five evaluated how well the participant prioritizes self-care and adheres to treatment practices when addressing PD. Questions six and seven targeted the participants' professional protocol, emphasizing the steps to screen and identify PD.

Question eight was created to gain insight into any documentation and progress-tracking requirements. Question nine elicited an understanding of the participants' treatment approach to PD. Questions ten and eleven were designed to acquire the participants' perspectives concerning the intervention application and its reported outcome. Question twelve was intended to generate awareness concerning available resources and support for clients and psychotherapists alike concerning PD. Questions thirteen and fourteen aim to promote greater understanding and comprehension of the utilization of consultation and supervision methods when working with individuals with PD. Question fifteen targeted the protocol and therapeutic conceptualization regarding the interaction and treatment of dissociative symptoms. Question sixteen allowed the participants to express further information that may aid the current study.

Data Analysis

The proposed methodology involved a qualitative analysis utilizing Van Manen's framework, which aims to derive meaning from the data collected through a hermeneutical

phenomenological approach. The utilization of this approach is extensively acknowledged and esteemed in scholarly inquiry as it offers a meticulous and methodical means to scrutinize intricate phenomena. Adopting this methodology ensures dependable and credible conclusions, contributing to knowledge progression in our domain (Sutton & Austin, 2015; Van Manen, 2016). To thoroughly analyze the data collected, adherence to four criteria outlined by Heppner et al. (2016) was modeled. These criteria involve grouping themes into meaningful units, removing irrelevant information, and combining these units into a coherent structure. The intention was to clarify and fully understand the data throughout this process.

Data analysis was performed manually by the researcher in collaboration with Delve Software. To ensure the security of retrieved data, the researcher stored, categorized and filed it according to established protocols using Delve to organize and manage while manually analyzing the transcribed data (Creswell & Poth, 2018). The researcher transcribed the collected data into discernible themes and similarities in experiences. To achieve this, the researcher employed note-taking while perusing and re-reading the transcribed data. Subsequently, the researcher classified the identified themes, allowing for an interpretation to be formulated. The categorized themes were labeled according to their similarities with the patterns of experiences. Ultimately, the researcher crafted a narrative by consolidating the categorized themes and eliminating those that require further data.

Trustworthiness

Researchers engaged in qualitative research must be aware of the complexities that arise in establishing the credibility of their findings. The credibility of qualitative research is a multifaceted issue that requires careful consideration of various factors, including the researcher's reflexivity, the rigor of the research design, the credibility of data sources, and the

coherence of the findings. The researcher considered the principles of trustworthiness, rigor, and credibility as a paradigm variation (Heppner et al., 2016). The researcher incorporated triangulation, structural corroboration, and rhizomatic validation.

Triangulation

Triangulation allows the compiled findings to be transferable between the researcher and those being studied (Creswell & Poth, 2018). Triangulation compiles several databases, processes, and theoretical schemes to establish credibility (Creswell & Poth, 2018).

Credibility

To ensure the study's validity, it was imperative to thoughtfully choose suitable participants (de Lacey et al., 2016). The researcher carefully examined each participant's professional background and license according to their state board's regulations. This involved cross-checking the licensure specifics with the participant's designated licensure board, providing credibility to the study. Furthermore, rigorous measures were implemented to strengthen confidentiality for every participant. These measures included the utilization of pseudonyms, keeping the participants unaware of any collected data and interview questions, and minimizing prior exposure to the study to uphold an impartial approach (de Lacey et al., 2016).

Structural Corroboration

Structural corroboration allows researchers to utilize several data types to support or refute the analysis. Structural corroboration involves gathering evidence to establish a strong foundation for interpreting data analysis that contributes to literature (Creswell & Poth, 2018).

Rhizomatic Validation

Rhizomatic Validation involves examining excesses and overlaps without underlying structures or deeply rooted connections (Creswell & Poth, 2018). The correct use of this technique allows the reader to transition from judgment to understanding (Creswell & Poth, 2018). The use of rhizomatic validation in this study will enable the researcher to gain valuable insights and understanding through the experiences shared by psychotherapists when working with PD clients.

Ethical Considerations

One of the most important ethical considerations for researchers is to protect all participants from potential harm. The researcher used pseudonyms and a password-protected computer (Creswell & Poth, 2018). The researcher utilized locked cabinets to secure completed documentation. To uphold ethical standards and protect participants' privacy, the researcher obtained informed consent that outlined the rights, limitations, and confidential processing procedures utilized throughout the study. Committing to ensuring participants' safety and protection is fundamental to ethical research practices. Researchers must uphold ethical principles by prioritizing the safety and well-being of participants throughout the research process. This principle is essential in studies that involve vulnerable populations, such as children, elderly individuals, and those with cognitive or physical impairments (Creswell & Poth, 2018). Adherence to this ethical standard is a moral obligation and a legal requirement in most research institutions and organizations.

Summary

The present utilized a hermeneutical phenomenological qualitative approach to shed light on the lived experiences of psychotherapists who provide treatment to individuals with PD. The

researcher was the instrument for data collection by conducting semi-structured interviews and gathering data on the identified phenomena. Participants were selected based on their identification as a psychotherapist who works with individuals with PD. Confidentiality was prioritized using secure virtual platforms: Zoom for interviews and Delve for transcription and coding. Data analysis involved thoroughly examining the transcribed interviews, ensuring credibility through triangulation, structural corroboration, and rhizomatic validation.

Chapter Four: Findings

Overview

This phenomenological study explored the experiences of psychotherapists who provided psychotherapy to individuals with pathological dissociation (PD). This chapter will provide a descriptive overview of the participants' understanding of working with PD, their training toward PD, their recognized support while working with PD, and their preferred treatment modalities in working with PD. It will provide insight into the selection of participants, the interview process, and the development of the themes correlated with the analyzed detailed accounts from the participants' perspectives. A summary will be provided at the end of this chapter.

Participants

The results of this study are based on first-hand accounts from nine self-reported psychotherapists. The participants were recruited via Facebook, a social media platform, and snowball sampling (Naderifar et al., 2017). Pseudonyms were assigned to each participant to enforce anonymity. The participants were provided with the following aliases:

1. Minnie H.
2. K. Bates.
3. K. Merrymas.
4. Bonny C.
5. Shai W.
6. Fin S.

7. K. Clarkson.

8. Stormi M.

9. Green B.

Minnie

Minnie is a licensed psychotherapist and the owner of a private practice. She is also a licensed supervisor and consultant. Minnie has been working in the field of psychotherapy for more than ten years and is a certified trauma therapist and EMDR therapist.

K. Bates

K. Bates is a licensed psychotherapist, private practice owner, and supervisor at a multi-systemic facility specializing in community care mental health services. K. Bates shared her experience of ten years of working with individuals who have severe and persistent psychiatric disorders, including children, adolescents, and adults.

K. Merrymas

K. Merrymas is a licensed psychotherapist and supervisor who specializes in trauma therapy. She has been working in the field for five years and stated that most of her training was from working with combat veterans.

Bonny C.

Bonny is a licensed psychotherapist, supervisor, and certified EMDR therapist. Her primary specialty is working with dissociative disorders and trauma. Bonny also disclosed actively working to be an EMDR consultant. Bonny shared working as a psychotherapist for over ten years.

Shai W.

Shai is a licensed psychotherapist who has reported working in psychotherapy for five years. Shai disclosed that her work with trauma is her primary specialty.

Fin S.

Fin is a licensed psychotherapist who disclosed working primarily with trauma clients for 5 years.

K. Clarkson

K. Clarkson is a licensed psychotherapist, supervisor, and dissociative disorder consultant of ten years. K. shared her work with a non-profit that specialized in working with PD and her operating as a board member for the non-profit organization.

Stormi M.

Stormi is a licensed supervisor and certified EMDR psychotherapist. Stormi shared working primarily with dissociative disorders and individuals working through trauma for seven years.

Green B.

Green is a licensed psychotherapist and supervisor pursuing her doctorate in trauma and counseling studies. Green shared working with individuals who have a trauma history and combat veterans for 3 years.

All participants met the requirement for this study through their self-report of:

1. Being a master's level, a licensed psychotherapist with lived experience in providing psychotherapy for individuals living with PD.

2. They are currently or have a history of providing psychotherapy to a client living with PD for at least eight weeks.

Participants' interviews were completed between November and December 2023. The researcher explained their role as an information gatherer before the initiation of each interview. Each participant gave the researcher written and verbal consent regarding the recorded Zoom engagement. Each participant was emailed an individualized Zoom meeting invitation link to engage in the interview process. Each participant voluntarily engaged with the researcher in the recorded interview, with the researcher informing the participants of the start of the recording and the end of the recording. Interactions between the researcher and each participant were limited to the approved questions, discussion around the questions, and observations received from the researcher throughout the video interview.

Interviews

Each semi-structured interview was completed and transcribed through Zoom, a video-conferencing application, while themes were categorized and created via Delve software. The researcher manually completed the data analysis. Each transcript was imported to a Word document, allotting for additional assessment of the accuracy of each interview. Each transcript was cross-referenced with the oral recording. Following the hermeneutical phenomenological approach, each interview provided insight for exploring and gathering experiential data to understand better the psychotherapists' perspective in treating PD (Van Manen, 2016). The questions in the study were limited to the participants' perspectives. The collected data examined participants' intrapersonal knowledge and how their experiences shaped their personalized perspectives.

Results

Hermeneutical Phenomenological Approach

Results from this study were yielded via a hermeneutical phenomenological approach (HPA). The HPA analysis approach consisted of grouping themes into meaningful units, removing irrelevant information, and combining the resulting units into a coherent structure. HPA's phenomenological reflection helped capture the essential meaning of participants' lived experiences related to treating PD (Van Manen, 2016). The researcher employed the HPA for manual analysis by transcribing, reviewing, and cross-checking interviews to match recordings. Secondly, the transcripts were read repeatedly to allow for the recognition of trends and commonalities. Thirdly, the researcher connected recurring concepts, practices, and connections. Fourthly, themes were identified through commonly used jargon, experiences, and concepts. The primary areas toward central theme development were 1) Introduction to PD, 2) Training experiences in working with PD, 3) The function of PD, 4) Interventions applied while working with PD, and 5) Supports experienced while working with PD. Lastly, the researcher evaluated, eliminated, and combined words, expressions, and experiences from identified themes, allowing complete analysis and generating a study narrative.

Table 1

Thematic Alignment with Research Questions

RQ	Themes	Participants' Response
What are the experiences of psychotherapists providing therapy to individuals with pathological dissociation?	Theme 1: Introduction to Pathological Dissociation	6 participants encountered PD by chance, and 3 sought it out working with PD intentionally.
	Theme 2: Training Experiences in	0 participants reported completion of a PD-specific

	Working with Pathological Dissociation	certification program. 1 reported active engagement in a PD-specific certification program.
	Theme 3: The Function of Pathological Dissociation	All participants identified PD as a coping practice, protection mechanism, and result of a traumatic encounter.
What experiences do psychotherapists have with implementing interventions for individuals diagnosed with pathological dissociation?	Theme 4: Interventions Applied While Working with Pathological Dissociation	All participants identified the therapeutic rapport as the key intervention for working with PD. All participants identified the usage of more than one modality as best practice for working with PD.
What are the psychotherapists' experiences involving supervision/consultation when working with pathological dissociation?	Theme 5: Supports Experienced while Working with Pathological Dissociation	Supports were identified as self-care practices, academic resourcing, audio engagement, and participation in a type of consultation. 8 out of 9 participants detailed a history or current engagement with a consultant source. Support for working with PD was described as sparse and limited in accessibility.

Theme One: Introduction to Pathological Dissociation

All participants detailed their introduction to working with PD symptoms. Six out of the nine participants reported initial engagement with PD as happenstance, while the other three participants had a more personalized intentionality. Each participant reported that working with trauma clients was the primary precursor to working with PD. Minnie shared her initial PD

encounter as an overt happenstance that led to her researching the phenomenon to assist her client better.

Minnie stated:

> I ended up having a client that I figured out was dissociative, and so, like, it was very overt. You know, it was, like, very overt. And I so had an experience with that client. At some point, they discontinued treatment with me. I was really early in knowing what to do with this, and I think I maybe didn't handle them the way they needed me to. But then another client came, and it was like, okay, this isn't going to be a one-off thing. And I was already working with trauma. I didn't realize early on how dissociation and trauma are connected there and how PD is a coping strategy for trauma and neglect. So, I was in the trauma world, and then it was like, okay, I started then the more I started learning, I just started getting more and more complex clients that required more training that I would get more. So, it became kind of a feedback loop at that point.

K. Bates shared her initial engagement with PD due to the continued incongruent appearances of her client.

K. Bates stated:

> So, that was when, for the first client I worked with, I first thought, wow, I am not looking at the same person I saw last week. And they hadn't had any significant treatment that should have no medication that should have altered that. So, I think that's really something that I've seen. I've also seen kids who had some pretty significant behaviors and honestly didn't seem to believe that they had done those behaviors. And that was another. At first, that might appear very manipulative, but after getting to know some of

> these kids, I really could see that they truly were not aware of what they had done or if they were aware. They were putting it off on another character altogether because they would give that character a name and say, Jake, did that know at first that came across as looking manipulative? But the more that I understood about dissociative disorder, the more I understood that that really could be a whole different part of them.

K. Merrymas disclosed how her practicum site, a trauma center, led her to be exposed to an increased appearance of individuals living with PD in the primary form of DID.

K. Merrymas stated:

> It was not a choice. It was God. I had my sight set on something else, and he put me in a place with combat veterans, and a lot of these guys have dissociative just symptoms, reactions, all of that, without treating childhood trauma. They take this into combat, and now they have all this complex stuff. So, it was not until I did my practicum for my master's program that I found this place, but it was not my intention. It was far from it, and it was all very overwhelming whenever I realized what was happening because those are things that were taught, like, oh, like, 0.3% of the population. In my time there, I had three clients who did. Yeah, but it was a trauma center. People with complex trauma from their childhood coming up and finding out in the military that they were switching and didn't even know it, and then learning as they started counseling, like, hey, let's work with this, and let's see what's happening.

Bonny C. shared that she was aware that she needed to be trained and was prepared to refer her initial client to a trained therapist.

Bonny stated:

> Well, I kind of fell into this work because one thing that I found is that you may think you're treating something simple like anxiety or depression. Still, they are often driven because of something that's happened in the past that causes different levels of dissociation. Yeah, PD is a different term. But I think that it's safe to say that when we talk about structural dissociation, when we talk about parts work, we're really talking about what used to be called multiple personality disorder, typically driven by childhood trauma.

Shai W. and Stormi M. reinforced their work with PD via the treatment of clients living with trauma.

Shai stated,

> I believe it was just a byproduct of me working with trauma. It wasn't sought out that I wanted to work specifically with individuals with PD. It was more so, hey, I want to work with trauma individuals, and it's one of their responses.

Whereas Stormi M. shared:

> So, when I started, I worked with trauma, working with a grant through an organization…So, after EMDR, the EMDR world is well known for saying there is dissociation. Almost every population of someone who has trauma has some sort of dissociation, and there's healthy dissociation as well. So, getting in there, I started to notice a lot of my clients do have dissociation. I worked with a huge population of complex post-traumatic stress.

Fin S. and Green B. detailed personal reflections regarding traumatic occurrences that led them to work with clients living with trauma, ultimately leading them to be introduced to PD.

Fin S. shared:

> Well, it's just kind of a personal conviction. And the father actually grew up with someone that was actually traumatized from birth, so there's more of a conviction from early on that actually pushed me to actually go through the training and everything—just more of a personal experience for me.

Green B. stated:

> Seeing my own family struggle with areas of trauma and even my personal own trauma experiences, I just knew there's so much, and there's so much help out there available. And so, as I began to become available to those populations, then naturally, those with the more dissociative symptoms landed in my office. And because I treat them like human beings, that makes a difference.

K. Clarkson shared her reflection on where to focus her specialty for her internship, which led her to create an intern program at a facility catering to dissociative individuals.

K. Clarkson stated:

> I remember my very first catch, the first time I caught it in someone. And to this day, I'm a little mad about it, but it was my third year of my master's internship. I was working at the Caps on campus. Hence, the college counseling and I ended up with a client who had obvious complex trauma and was dealing with disordered eating and was really spacey and presented glassy and executive dysfunction, was shut down, and just a lot of things that I wouldn't have had necessary language for at that point. Looking at this client, I'm like, wow, there's something off here.

The participants detailed their introduction similarly, with the constructs being accidental and intentional. Participants described abnormalities recognized in PD and feeling uncomfortable with working with PD symptoms. Participants described a desire to learn more about PD in a manner that was beneficial for ethical practice and competency, along with the increased potential for effective treatment to aid with the trauma responses.

Theme Two: Training Experiences in Working with Pathological Dissociation

None of the participants reported completing a program specifically designed for treating PD alone. However, one of the participants reported active engagement in the International Society for the Study of Trauma and Dissociation (ISSTD) certification program on treating PD and is working toward completion. Three of the nine participants reported completing eye movement desensitization reprocessing (EMDR) training and being made aware of its application with individuals living with PD. However, awareness was not attributed to specialized training for treating PD. Three other participants reported engagement in research, supervision, or consultation after their initial exposure to PD instead of attending a type of training. One participant detailed learning at her place of internship, which specialized in treating PD. Two other participants detailed the completion of multiple trainings, allowing insight into the treatment of PD.

K. Bates shared her meeting a psychiatrist who worked with PD through her EMDR training and following up with him as she received more clients living with PD.

K. Bates stated:

> So, during my EMDR training, I did meet a psychiatrist who specialized in dissociative identity disorder. And so, I took a one-week course with him, which was he did it as, like,

> a group of us therapists who were working with somebody who actually had DID, and we could come in and get that really focused training on how to help our clients.

Bonny C. and Stormi M. shared the completion of an EMDR training program, detailing EMDR as their primary means of treating PD. Both also reported being certified EMDR consultants.

Bonny C. shared, “In my work with EMDR, I use it with every client. I am a certified EMDR therapist and a consultant in training. I specialize in dissociation and structural dissociation.”

Stormi M. stated:

> My first training was EMDR, so eye movement desensitization reprocessing therapy was a huge part of what I feel is one of the best treatments for dealing with trauma and dissociation. So, that is my training, as well as working with advanced training in complex post-traumatic stress disorder as well as dissociative disorders.

K. Clarkson shared her meeting with a therapist who treated PD with a DID diagnosis, resulting in her working with the therapist to create an internship program specializing in treating PD.

K. Clarkson stated:

> When I was in my second year in my master's program, which was about a little over a decade ago, we had a guest speaker that came in, and that speaker was living with DID. And so, through the years, she caught me, and then the more that I learned and the more I was around the population, the more I was engrossed with it, the more I knew it was it. That was what I was meant to be doing. And I have had such an incredible career with it so far.

Minnie H. and K. Merrymas., both described engaging in research catered to assisting clients living with PD.

Minnie H. stated:

> So early on, I had a client that was very overtly switching. So, I found out about the International Society for the Study of Trauma and Dissociation and quickly went to them and tried to get them to have adult guidelines that I poured over trying to figure out what kind of treatments are beneficial and ethical with this population—a ton of reading. Also, I forget what it's called, but I think it's a professional training program. Maybe that's it, the ISSD, and I'm in my third year of doing an advanced certification with them around treating complex trauma and dissociative disorders.

K. Merrymas stated:

> Training, no training. I think that even in my master's program, they focused a lot on PTSD and never really stressed that there was possible dissociative. Like, oh, yeah, dissociation. But it’s not really an explanation of it. It wasn't until I was with a client that switched that I did, and I was like, I don't know what to do, so I had to go to supervision. But I think the only training I took on my own would have been training. Like, the MID is an assessment.

Fin S**.** shared having an awareness of advanced training yet did not report completion of any.

Shai W. and Green B. detailed the completion of training that allowed for trauma processing and allotting for the treatment of PD.

Shai W. stated:

Most of my training outside of schooling is trauma-focused. So, a lot of the training that I have completed regarding trauma and or dissociative disorders has been EMDR, internal family systems, brain spotting, and somatic experiencing as well.

Green B. shared:

> One of the things, like, early on, I did a TF-CBT training in working with trauma, but I saw quickly in working with trauma populations and being married to a military combat veteran that I didn't know enough about trauma. But I have also done the cognitive processing therapy training. I've done some workshops and various others, like EMDR.

Participants detailed that training toward the treatment of PD was developed through phase-oriented modalities such as EMDR, psychodynamic, and parts work or ego states theory. Participants shared all training held a trauma-focused lens.

Theme Three: The Function of Pathological Dissociation

All participants reported validity in the appearance of PD, with it being a trauma response, protection mechanism, or coping mechanism for individuals who have experienced a traumatic event. Participants reported their clients detailing PD through the definition of depersonalization, derealization, and part appearance that engaged in switching. Participants emphasized the importance of the appearance of PD within the client-psychotherapist relationship.

Minnie H. and K. Clarkson described the role of PD as a healing component resulting from traumatic exposure.

Minnie H. stated:

> Oh, wow. That's a big question. My views on it? Well, I am a follower of Jesus, and so I believe in the dissociative processes, as in derealization and depersonalization toward barrier identities with DID. I view this as a common grace that God gave to survive un-survivable experiences.

K. Clarkson stated:

> But dissociation itself isn't our enemy. It's not a bad thing. We don't need to eliminate it. We don't need to wait for a client to be in their body completely to be able to do work with them. They can do work and be dissociated. We just have to understand how their particular brand of dissociation works. And then again, like I said earlier, it's like a dance. We have to dance with it. And sometimes we're going to trip. Sometimes, we're going to step on its foot, and sometimes, it's going to step on us. But as long as we're able to work with that, that's what helps move the client forward, right?

Shai W. and Green B. shared the function of PD as a survival response to trauma.

Shai cited her view of it as:

> So, my understanding of PD is it is a trauma response, more so a survival response to trauma. When it happens to an individual, it's too much for their body to handle; it's too much for their nervous system. They can't engage. So, they'll dissociate and detach from the traumatic situation that is happening at the moment so that the capacity is basically outside of their window of tolerance at that point and so that they can just tolerate it that way. Whatever experience they are going through in that moment and therapy, the role in therapy that I've seen it play is that we're watching for it, we make sure we're careful around it in regard to noticing it and how it may come in or out of sessions. Of course, as

> a therapist, I'm calling it out when I see it so that they can notice it and increase awareness around their own dissociation when it is happening as well.

Green B. commented, “So, I think a lot of the PD is a trauma response, and so, really, kind of understanding where it came from, why is it there, you know? Five other participants described the function of PD as a safety practice or protection mechanism.

Stormi stated:

> Yeah. Okay. Yeah. So typically, when I have clients who are dissociative, I feel like it presents really to there are parts which I find dissociation parts of self that just don't feel yet safe to go there, to go work on trauma that is a protective part of the self. So, I think people dissociate in sessions when we're working on some hard topics that they're not yet ready to work through. Sometimes, it's because they are depressed. So, our depressive system and the hypo arousal in the body at times when they're coming in may not be due to therapy but due to what's kind of going on in their nervous system. So, yeah, I think a lot of times it's presented sometimes as a defense, as a protective part, just not ready to go and work through something, whether it's homework or whether it's stuff in the session. But other times, I feel like it can be either. Flashbacks we have that happen in therapy, too. So sometimes, the dissociation is flashback-related when we are working through hard things, which also presents itself that way.

Bonny C. stated:

> So, in their mind, they escape. They go somewhere else. Right. And then when mom and dad come home, they come back, and they're normal. So, this is a dissociative state where they escape with repeated or ongoing trauma.

Fin S. detailed, “Well, dissociation is a way of the mind to protect itself from painful or distressing memories and emotions.” K. Bates demonstrated agreement through her comment, “We can work together on helping them to stay present and to get to know all these parts of themselves.”

K. Merrymas stated:

> So, okay, so do you mean, like, grounding to the present? Okay. And I feel like that's going to be different for everybody, obviously, but establishing safety is going to be really important because if they've dissociated in a session, something went awry, they didn't feel safe. If they have DID, their protector came out, or if they're just dissociating because that has been a learned thing, then they're feeling unsafe. So, my role then is to ensure they're grounded in the present and feel safe in that environment.

Participants worked to normalize the appearance of PD due to its function being that of a protection and coping practice for individuals exposed to a traumatic event. All participants acknowledged trauma as a key antecedent to PD.

Theme Four: Interventions Applied While Working with Pathological Dissociation

A variety of interventions were noted for treating PD. All participants agreed that establishing a therapeutic rapport was crucial when working with PD. This intervention helped the client feel safe, learn self-soothing skills, and understand the presentation of PD. Bonny stated, “I think the most integral part is the therapeutic alliance, the relationship.” K. Merrymas reported agreement, stating, “So, I don't even know if this is really an intervention, but a therapeutic alliance, having them trust that the person they're with is someone on their side, will help them.”

Rapport, mindfulness practices, and body awareness were frequently identified interventions. Mild self-disclosure from the psychotherapist was identified as a method of enhancement to the therapeutic alliance.

K. Bates stated:

> It's hard for them [the client] to connect with therapists. They still haven't been through anything [with the psychotherapist], and of course, they don't know you. Don't know what somebody's been through just by talking to them if they're not sharing any of that. But they could connect with me because I would be willing to share a little bit of my past so that they know that I kind of get it.

The therapeutic relationship enhances the ability of the therapist and the client to grow in recognition of dissociative symptoms while incorporating skills to decrease their appearance. Minne stated:

> I think learning to ground, learning to orient, be present, and engage with internal conflicts so that there's more internal collaboration and cooperation. So, parts aren't like hijacking things and not mindful of what the others are valuing or the importance of other parts' needs. I think the relationship with me is a significant intervention learning that I'm very attuned and I found that's necessary with this population. So, having someone track with them and help externally regulate if they're open to that, surrendering power in the room so that they get to decide what we're doing or if they're open to something. Trying to think about what other interventions I think are just over being stable and consistent. The therapy frame really is an intervention or interventions that provide stability because this population tends to have not had boundaries have been violated. It's really confusing.

> And so I think having a very clear frame that if I'm deviating from it, I have a good clinical reason for and validating. I mean, some of these might seem kind of elementary, but they've been pretty huge.

The participants also noted the matriculation of grounding skills as a mindfulness practice for the client. Participants attributed grounding to reorientation and stabilization. Two participants emphasized the usage of ground for reorientation.

Shai W. stated:

> So, of course, I encourage clients to do in everyday life that won't add another thing to their to-do list: doing the 5-4-3-2-1 method of just using their senses to connect with their environment.

Fin S. stated:

> Well, it's kind of very simple for therapists. Well, I normally employ different kinds of techniques when dealing with patients with trauma, such as grounding techniques focusing on sensory experience or using positive affirmation mindfulness exercises such as meditating or progressive muscle relaxation. So, there are a few to choose from.

K. Clarkson commented on grounding being an introduction to body awareness and a calming practice. She stated, “I find the more that the client can find some grounding and presence by themselves, the more that the body starts just to calm naturally.”

Body awareness was addressed via mindfulness, somatic experience, and polyvagal-informed practices. Both modalities are utilized to stabilize the nervous system, again reinforcing stabilization and orientation.

Shai shared:

> Somatic experience would probably be my top one. Polyvagal-rooted ones as well. So, I am very nervous system-based before we touch any content, and I try to let them know that the content is, of course, important; the story is important. But before we get to that, let's see if we can implement more regulation into their nervous system.

K. Clarkson shared:

> I've also integrated a lot of somatic experiencing just because so much of it is body stuff, and being able even just to be next to the body sometimes is powerful enough for them.

The therapist's role regarding increased body awareness for the client was addressed in that it was continual and slow practice.

Green shared:

> So, we do a lot of very slow. That's one thing that I take things very slow with those clients. And so, I'm always assessing as we go, even like sessions. I'm monitoring their body language, watching for those intensities, is their breathing changing? Am I picking up on any of their habits? So, lots and lots of observation, but also getting them to talk about it and normalize.

Stormi shared:

> So, we kind of do a body scan and relax tight, tense muscles. And we help just kind of reduce that. That can be helpful using cold like the temperature. So extreme temperatures try to do like ice or cold water on the face to help reduce some of that dissociation if it feels more like a panic or flashback.

The rapport between the client and psychotherapist demonstrated an increased ability to introduce and encourage the usage of mindfulness skills, therefore increasing body awareness.

EMDR was the leading trauma intervention voiced by the participants. EMDR was celebrated for its success with PD but was also identified as an avenue into PD. Participants detailed being trained and elaborated on whether they pursued EMDR certification, along with its effect in treating PD.

Table 2

Participants Response to the Effectiveness of EMDR for PD

Participant	EMDR Trained	EMDR Certified	Response to PD
Minne H.	X	X	There are different kind of modifications to EMDR that I'm using lots of inner ways parts work, obviously. I'm just thinking of particularly with EMDR, that's my primary mode of trauma processing for sure.
K. Merrymas	X		Oh, EMDR. Yeah. I have found that EMDR is not for everybody. And the place where I was working once I became EMDR trained, they wanted everybody to have EMDR and it was not right for everybody. Especially clients that have multiple parts that don't always realize where they are. But I've had clients with complex trauma just say, this is too much for me. This is something that I have obviously been trying to avoid. I pull myself out of it for a reason. And feeling safe or not, this is making me feel worse. EMDR, it's great, but obviously not

			everything is perfect. And I think that that has triggered individuals before.
Bonny C.	X	X	I'm titrating their treatment with the EMDR. It's an eight-phase approach. Right. So, the first phase is history-taking. I typically start with phase two, which is preparation and stabilization, because I want my clients to know how to hold dual attention. They can be in the memory, and they can be in the room. Right. So we do a lot of preparation stabilization. Every client is unique, so every phase two is different. So I use ego state therapy, EMDR combined
Shai W.	X		I know with EMDR we are encouraged to utilize things like peaceful place or safe space to help them meditate, but I'm very careful with that. When it comes to that. Close your eyes and visualize things because they can dissociate into that world. And then, when it's time to pull them back to the room, they may have a hard time returning.
Fin S.	X		The most common for me is trauma-focused psychotherapy. This includes approaches like EMDR as well as cognitive processing therapy. Well, this actually helps individuals to process and resolve trauma-related memories, emotions, and beliefs. So that's basically it for me.
K. Clarkson	X		I do utilize EMDR with some while I lean heavier into brain spotting. EMDR is much more clinician-driven, but brain spotting is much more client-driven. And I find anything that gives a client more power in that space, especially if there's very complex dissociation and did

			and so forth, tends to be more well received and more engaging for them. Plus, we can step out of brain spotting if we need to if things get really intense, whereas EMDR, you're supposed to finish the phasing.
K. Bates	X		I have used some EMDR to help with the trauma. I have seen EMDR be very helpful with it [pathological dissociation], especially when we can take some notes on it or even take some pictures to look back at some of the things we've done.
Stormi M.	X	X	Sometimes, what we do in EMDR is called a safe, calm place. And so, we'll do that. And sometimes, especially if we add bilateral stimulation, sometimes it can make them feel a little floaty. Sometimes, I notice because it is a form of dissociation, a safe, calm place. So, it can be something that can bring on some dissociation. EMDR can bring on some dissociation, whether it's old past stuff or current stuff we've noticed that can bring it on.
Green B.	X		I've done some workshops and various other, like EMDR. And I think that there's a lot that I've liked and there's a lot that I haven't liked, but I think there should be more discussions of how the brain processes trauma and how it encodes the trauma.

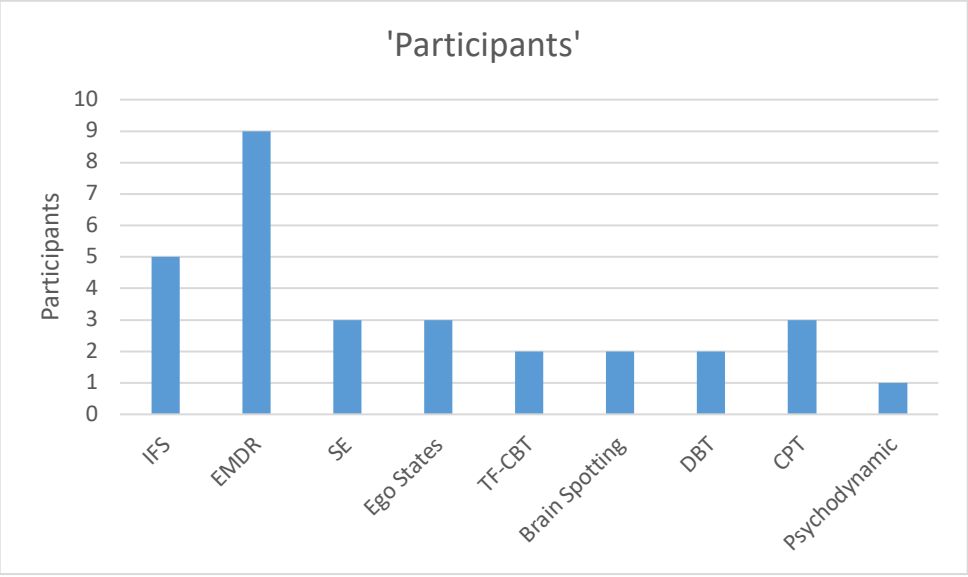
While EMDR was recognized as a leading trauma intervention, it was also recognized as an inductor for PD. This led participants to remain observant and titrate other modalities to assist

with PD. Some participants detailed their preference for other trauma interventions as opposed to utilizing EMDR. Other modalities reported were:

1. Internal Family Systems (IFS)
2. Somatic Experiencing (SE)
3. Ego States
4. Trauma-Focused Cognitive Behavior Therapy (TF-CBT)
5. Brain spotting
6. Dialectical Behavior Therapy (DBT)
7. Cognitive Processing Therapy (CPT)
8. Psychodynamic
9. EMDR

Figure 1

Modalities used by the Participants



Interventions used for the treatment of PD were described as eclectic and integrative. Participants reported being self-motivated to engage in advanced treatment to assist clients. IFS, or what was often described as “parts work,” was also reported as an effective intervention for PD. Five out of the nine participants reported incorporating parts interventions into their treatment. Shai W shared being trained in IFS and integrated within her PD treatment.

K Bates stated:

> Well, as I told you, I'm learning a lot more about internal family systems because I feel like this is going to be such a great tool to use with people, I think. So, I'm using more of that now. And I think that's why I'm turning more and more to the internal family systems because more and more information shows that as people write their stories about what happened and try to go through that desensitization process, that can sometimes trigger that dissociation and have more issues.

K. Merrymas stated:

> I didn't understand internal family systems then, but I think that that might have helped if I could put them in perspective of, you know, we all have parts. And right now, I feel like you're feeling that part of you needs to be protected and and kind of work around that to where they didn't feel like it was. When they hear the word pathological, there's such stigma with mental health as it is, and you put those words like schizophrenic or did or borderlines, and people panic, and they don't want help. I think that's the scariest part. We scare them away.

Green B stated:

> Oh, definitely the IFS, the internal family systems, that has helped a lot, but also like the, you know, the distress tolerance, it doesn't really, like, create a reintegration as much as often the beginning stage of that is maybe gentle transitioning between one identity to the other, but then really kind of moving into creating ways that those parts can work together. So, again, lots of parts work.

Stormi M. stated:

> I don't have certification in internal family systems, but I have read books, and I've had a lot of doing work with parts work, taking advanced training in kind of the EMDR field, as well as parts work in understanding complex PTSD and Dissociative disorders.

Participants understood the importance of interventions that increase self-awareness, centeredness, and safety. The ongoing evaluation of the client and a strong therapeutic alliance were key components for implementing any other interventions. Participants emphasized the importance of allowing the client to participate at a comfortable pace that promotes safety instead of triggering PD.

Theme Five: Supports Experienced while Working with Pathological Dissociation

Participants identified a variety of supports in working with PD, such as self-care practices, academic resourcing, audio engagement, and participation in a type of consultation. Participants shared that access to consultation while working with PD was scarce and limited. The lack of support caused some participants to feel overwhelmed and concerned about potential negative effects on the client. Other participants found it challenging to identify knowledgeable or accessible supports, leading them to focus more on self-care, time management, and intentionality in their acceptance of clients. Fin S. denied engagement in outside supports, citing,

“I don't really go; I'm more of a self-taught.” K. Merrymas detailed receiving scant support from her clinical superiors, which led her to be intentional in her self-care practices.

K. Merrymas stated:

> They just said, this is a client with DID, and we just want you to work on it. It's probably pretty unethical. They shoved me in this spot, but we want to work on integrating parts. And I'm like, okay, I don't know what that means. I feel like just, I guess, the cliche answer of taking that time out and engaging in intentional self-care. On the days that I had a group of veterans that did deal with PD, I had to take my 50 minutes. I couldn't go over because I needed those ten minutes. I needed those ten minutes to stretch because I could feel it at the end of the day that I just held everything. I think probably, too; then I was scared, so I held in a lot, not wanting to say the wrong thing. I practiced alternate nostril breathing, re-grounding, or recentering. So, I would just do that for a few minutes, stretch, go to the bathroom, and put some lotion on between clients. I think that was really important. I don't think we do well with ourselves with [practicing healthy] boundaries.

K. Clarkson stated:

> And because there is such a lack [of psychotherapists working with PD], there are so few of us who work with such heavy, complex dissociation. Self-care is very necessary. This is intense work. And I'll be honest, it hasn't always been a strong suit. I'm very rigid about my sleep. I make sure I get enough sleep at night. I have movement in my day. I try to journal. I used to journal a lot more. I could be better at that. I make sure that there's peace in my house. I make sure that my weekends are my weekends. I try to set and hold

> pretty solid boundaries as best I can. I do have one or two clients right now who are a bit more on the severe side, and so I let them communicate with me a little bit more than any other client would. It's like a small world. It was almost hard to find a good consultation for me initially. Now, I've got a great pool, and it does come up. And so, I'll set up a meeting and say, hey, I need to talk this thing through, or can you help me conceptualize? And I'll tell you what, the most learning has come from my clients. Resources, resources. Huge amount of resources on the website for the nonprofit that I work with, podcasts. There are a couple of great podcasts out there. Braving the way by Dr. Fletcher. System speaks, which is really great.

Shai W. stated:

> So, just having other therapists that I could call up as support, I've been in consultation groups in the past for my clients. As far as outside support, that's a tough one because I haven't found a lot of support. There might be groups here and there, but I haven't found anything that's like a consistent resource besides maybe books. So, with my own self-care practices in session, I'll have things that help me stay grounded. So, I do have things like fidget toys, or I'll always check in and just notice where my feet are on the ground. So, it's a balancing act of, yes, I'm paying attention to my client, but I'm also doing my best to notice where I'm at at the moment so that I'm not getting too pulled into their world. So, I'm still aware of my clients; I'm still focused on them, but I'm also noticing my own sensations. And then, outside of therapy, I try to limit how many clients I see per week so that I'm not too overloaded. I also engage in regular exercise about three to four times a week, eat nutritious meals, and get proper sleep. So, those are some of the main ways, and of course, I have fun when I'm off.

Green B stated:

> So, when I want to consult with somebody, I'm going to want to know this isn't just a one-off. And so now they think they're the expert. I want to know who this person is. Do they know what they're talking about? Have they been trained in something or anything? Are they even independently licensed? What level of experience have they had? And I may look to see what kind of networks they're a member of because, again, if they're not working with the community and involved in the community, like I'm probably going to look for someplace else. If I need some assistance with a client, I would probably want to know how long ago they were trained. I think it's because some of those consultations [increased] my understanding of how much hope there is because I did not understand [when working with PD] early on. If I must stay an extra hour to debrief from my day, I will wait until I can leave it [residuals of working with PD] there because my family doesn't need to see it. They don't need to see the burden.

Stormi M. stated:

> Yeah. I have fellow consultants and EMDR consultants with whom I work. We talk together. We try to do monthly, where we meet for an hour and just kind of go over what's going on with the consultees we see, but also our cases that we go through. Typically, what I do is reach out to the EMDR consultant community that I'm familiar with to be able to go and talk about a case. Yeah, because it is true that it can be intense work. So, working with this population is intense work. And I have noticed I can get that vicarious trauma because a lot of times, huge trauma comes with a lot of when someone has a lot of association. So, my kind of self-care is, first of all, getting in the word since I am Christian. Also, I'm a huge crafter, so just being able to work with my hands and

> make time for myself to get in my craft room and just make things have been helpful. Making sure that I'm working with colleagues and just being able to debrief has been helpful, as has giving myself time off.

Bonny C stated:

> So, there's a couple of things. First of all, I love the Lord, and he is my primary method of self-care. I am always praying before I see my clients and after I see them. But there is a wonderful, wonderful contributor to the world of substantive disorders. Her name is Robert Shapiro. Don't know if you know her. Robert Shapiro, I met with her, and she's taught me some things about how to get my system back into a regulated state after I work with these clients. Okay, interestingly enough, when I went through my [EMDR] basic training, I had a consultant, and she was an expert in structural dissociation [PD]. Then, after my basic training, my new consultant, who was in my basic training, was a big advocate for me to learn. She pushed and pushed me, and she's like, you'll be amazing a consultant. So, I chose her because we connected, and she's still my consultant.

Kathy B. stated:

> Well, I work for a clinic that has a multi-professional team. So, we have nurse practitioners, we have a health coach, and then we have a recreational therapist. So, it is kind of nice to work on those. And we also have a psychiatrist. So, it is kind of nice to have that on my team, too, to be able to check in with people and just kind of brainstorm some ideas if we're having trouble. And then, I can reach out to other people who do this kind of work to ask if I can get a consult on it. It's very hard to do this work all on your own because every patient is so different. After doing this work, I see that I need so much

> more self-care than that. So, I do so many things for myself now to really help myself have the energy it takes to be present all the time when you're with your clients and then still have to be present for your family, too. That's the thing we could really empty ourselves out at work, really being present for the clients, really listening to their stories, and really trying to help them. And then you go home, and you still have people that need you and want to talk to you and stuff like that. My self-care is a whole. It's an everyday thing that begins in the morning with meditation and ends at night with prayer, exercise, and fun books. Now, I give myself books that are not none of them are trauma-related. They're the good, uplifting, wholesome stories that I can really detach.

Minnie stated:

> So, in order for clients to work with me, they have to be stable enough. Part of my kind of screening process when I am taking new clients is that they need to have some resources or other coping so that they don't need me necessarily. Consistent crisis. So I'm not available. I have client hours, and then I don't really engage with most clients outside of those hours. So, I'm pretty boundaried with my time. I see fewer clients because of the complexity and emotional load that I carry as I'm leaving work. I do like guided imagery, where I am kind of releasing whatever I've experienced or whatever my clients have brought to me for the day so that I'm leaving it, and I see myself doing that before I leave the parking lot. I think I do prioritize time for myself, too, like quiet, or for me, reading fiction is pleasurable. Every day on my lunch break, I get out of the office, I move, I listen to music. I also receive monthly consultations and am a part of a peer supervision group where we of did or Dissociative therapists, therapists that treat Dissociation. We meet like once a month. So, supporting the ISSTD has been a huge resource for me. I

> think Infinite Mind put on an annual conference geared towards folks who are dissociative, and that's been really great. I have individual consultations once a month with someone who's very well-versed in Dissociative disorders and EMDR.

Research Question Responses

The designated research questions for this study were:

RQ1: What are the experiences of psychotherapists providing therapy to individuals with pathological dissociation?

The research question was addressed throughout the data collection process, with each participant providing lived experiences in alignment with the themes – their introduction to PD, training experiences in working with PD, their perception regarding the function of PD, interventions applied while working with PD, and supports experienced while working with pathological. Participants disclosed an awareness concerning the perception of working with PD among other untrained therapists and how fear of working with PD was unwarranted. Participants worked to normalize working with an unfamiliar trauma response while also encouraging untrained psychotherapists to explore the work of PD.

Stormi M stated:

> I think the main information that I've learned that I would like to share is. Initially, a lot of people were kind of scared, and that's where I was, too. We're scared to work with this population because you're afraid that you're going to retraumatize them or how to work with them, how to help them. And the more and more studying I've done and the more and more I've worked with them, it's actually to be more curious and to step in it and to not be afraid and to just know you need training. You can't just work with this population

> and think the same CBT is going to work with them or whatever standard type of therapy that you do need extensive training in just understanding and knowing, but also to feel comfortable working with them and that it's not scary. It's actually, for me, I love it. It's intriguing. It's challenging.

Shai W stated:

> I think the main point here for individuals who may be questioning or working with individuals with dissociation is to make sure that you get the training and help that you need. I'll say it's a different type of trauma symptom. There are all types of trauma symptoms, of course, but dissociation, in my opinion, is very delicate and something that you really want to understand and work with in a way where you're not retraumatizing the client or sending them further into a spiral. So, I would definitely encourage individuals who are questioning it to get the help experience or consultation or training, whatever that may look like, so they are not afraid to do the work either. Because I know some individuals may be afraid to work with individuals with dissociation, but I see it as any other mental health disorder, depression, anxiety, and things like that. Like, this is something that this person is experiencing, and we're here to help without judgment. And I know that we don't want to harm our clients. Of course, as therapists, we really want to be helpful to them and help them improve. But a lot of times, we also had to examine our own fears first before jumping into this work so that we could feel like we were able to support and have the capacity for our clients as well.

K. Clarkson stated:

> Just show up one day and be there. That right. There is 50% of the healing. Don't be scared of it. Don't feel like it's something that's going to be harmful. Have an open mind. Okay. And then, yeah, seek out others that are in the field doing the work. Every clinician I've met who's doing this work wants to educate others. We want to bring others into doing this. I can't tell you how often I give free consultation. Please, let's just talk. Let me tell you how to do this. Let me give you my tools so that you can go out and start doing this work because we need good therapists who know what they're doing with this. And that doesn't run away. Imagine being a client who keeps getting passed off because therapists are afraid of it.

Green stated:

> I would say one of the things that I would encourage people if they're thinking about it, is to get some training, get legitimate training that is evidence-based, but also not to be afraid to work with humans that have a pathological illness and remember that they're just humans that have been through something that they never ask for and really kind of inject that hope and humanity back in the process.

Bonny stated:

> Yes, so much. A lot of people think when they hear dissociation when they hear when they hear dissociative disorders, they get scared away because it sounds scary because the media has made it so scary.

Fin stated:

> Well, it's actually important for a client to actually build this alliance and trust and deal with the evidence-based intervention and for therapists to be willing to understand the

> intricacies of dissociative behavior and be able to play a crucial role in making the clients more adaptive to the treatment, like making the clients believe that there's nothing actually wrong. So, it's more of an empathy-based experience. That's what I have to say. So many clients actually struggle just to clear the experience of feeling the charge from their own emotions and memories.

RQ2: What experiences do psychotherapists have with implementing interventions for individuals diagnosed with pathological dissociation?

Participants detailed the importance of proper assessment, screening, and applying interventions that allowed the client to grow in safety, rapport building, and body awareness. Participants detailed prioritization of interventions that validated the client's ability to feel safe. The initial clinical intake interview, Dissociative Experience Scale – II (DES-II), and The Multidimensional Inventory of Dissociation (MID) assessment and screening tools were described as recurring interventions that allowed for psychoeducation of PD symptoms to be identified, discussed, and processed throughout treatment.

Green stated:

> I'm always assessing as we go, even during sessions. I'm monitoring their body language, watching for the intensities of their breathing changes. Am I picking up on any of their habits? So, lots and lots of observation, but also getting them to talk about it and normalize.

Minnie stated:

> Yeah, so, the DES-II, I run through that with anybody I will be doing EMDR with. Also, as I'm doing an intake assessment, I have questions that I'm asking around derealization,

depersonalization, and amnesia questions that I've incorporated into my assessment. And then also, if I have strong suspicion or want clarification about someone's system, I have them do the MID. I think those are the primary ones that I use. And depending on someone's responses and assessment, that could open up a lot more questions and gathering examples and that kind of thing.

Shai stated:

But particularly, it is the DES II, I will say, for right now, and or asking them questions about their ability to have sensations in their body. And then, of course, from there, if I notice that there is a high amount of dissociation, then I usually do my best to let them know that we're going to do what's called more somatic experiencing.

Fin stated:

Well, the Dissociative Experience Scale is a self-report measure that can be used to assess the extent of disassociation. Well, the second DES version, the DES II, is the most widely used and validated version. This can also be used to monitor the progress and symptoms of PD.

K. Clarkson stated:

For those that are a little less or have had less assessment, it's a lot of leaning into self-report and environmental reports. I have family members who'll sometimes be a part of this, leaning into reports from the medical team. So, a lot of times, there are a lot of other things present: physical somatic ailments, psychiatry, et cetera, and comparing notes of what they're seeing and what's happening, utilization of the MID.

K. Bates stated:

> Well, one of the steps is giving them that assessment that I told you about [DES-II], which I'm not at the office, so I don't have that in front of me, but if it's something you want to see, I could send it to you. And then, of course, I do the trauma assessments and the ACES; I'll do that sometimes, too.

Bonny stated:

> In my screening, I use the Multidimensional Inventory of Dissociation, MID, on every single client because, as I said, they can present with something that seems very benign, but you have a whole system of parts that are hiding beneath. And the mid, what I love about the mid is that it's able to discern deception. If they try to lie on the mid, it's not going to go very far.

K. Merrymas stated:

> So, the DES-II was probably the first one. And I think if they scored, I can't remember the score, but if they scored higher than a certain amount, we kind of go over it and make sure that they were understanding the questions because sometimes the questions seem very to the point, but they're kind of confusing. And if it was high, then I would talk to them about, like, look, I'm not saying that you have DID. I'm saying that you dissociate. I'm saying that you've got things that you have forgotten. Why is that? Let's explore that. So, I would administer the MID if they were interested in that, just to see. I think that for sure was like, yeah, this is PTSD, but look, there's some dissociation here. So, kind of give them some education on that.

Stormi stated:

> Yeah. So, I do the DES-II, and if I do know they're coming in with a good amount of symptoms that warrant that this is a possible dissociative disorder higher on the spectrum, I will do a MID 6.0, and I usually do the extensive one. I know they have the mini-mid at 60 questions. That one's newer, and I am just a fan of the larger one if this person is warranting that. But typically, I'll do the DES-II and see where they are. And if they are below, I would say 30%, like a 30 on the score, then I just kind of go with that. But if they do score higher, I might ask them to let's go into the MID.

RQ3: What are the psychotherapists' experiences involving supervision/consultation when working with pathological dissociation?

Eight of the nine participants detailed whether they engaged in supervision or consultation, with most participants sharing their value within peer interaction and its ability to expand their conceptualization and treatment of PD. Participants detailed some difficulty with acquiring and consistently engaging in consultation or consultation groups due to the limited experience of psychotherapists known for working with PD.

Shai stated:

> But I have, of course, been in my consultation groups where somebody else is leading the consultation group, but that's where I guess my experience is. It's nice to hear other individuals' perspectives because they'll have different viewpoints I may not have considered or thought about. So, it's nice to have the input of other individuals where they can help me understand, oh, do this, or maybe you can try this, or have you tried this? And I can take that feedback and incorporate it with my clients in the next session. So, I

> have found that to be very supportive and tremendously helpful in supporting my clients with dissociation.

Bonny stated:

> [My consultant] had no training in PD, but she was a big advocate for me to learn. She pushed and pushed me, and she's like, you'll be amazing a consultant. So, I chose her because we connected, and she's still my consultant.

Green stated:

> So, when I want to consult with somebody, I want to know this isn't just a one-off that they've worked with one client somewhere. And so now they think they're the expert. I want to know if this person knows what they're talking about. Have they been trained in something or anything? Are they even independently licensed? What level of experience have they had? And I may look to see what kind of networks they're a member of because, again, if they're not working with the community and involved in the community, I'm probably going to look for someplace else. If I need some assistance with a client, I would probably want to know how long ago they were trained. That might be something. Have they kept up with their training?

K. Merrymas stated:

> For consulting supervisor, I went with a supervisor that was free to me, so I knew that I wasn't going to get a lot of trauma stuff, but that straight up was a financial motivation. I will go to consultations if I have a client who scores high on dissociation because she is what I would call an absolute expert, Jennifer Madeira.

K. Clarkson stated:

> The consultation itself can be informative. Don't get me wrong. I think consultation itself is very important. I find, and maybe this is why I lean into the community aspect of things so hard, or, like, the normalization. I actually find the more valuable information that I've received has been in the friendlier dialogues. Not necessarily like actual consultation, but dialogues with people with lived experience that are in the field, or dialogues with people with lived experience that have had 20 therapists that didn't know what they were doing or they couldn't get their needs met.

Minnie stated:

> So, I have individual consultations once a month with someone who's very well-versed in Dissociative disorders and EMDR. So, marrying the two of those, although I do a lot less EMDR consultation with her, the peer supervision group I participate in.

Stormi stated:

> Okay, so I think, gosh, it [consultation] has helped me. I guess I tend to have a view on it, and it gives me a different perspective. So, it does tend to help me have a broader view of my client and give me other ideas. So, the case conceptualization kind of helps me pinpoint where this might be coming from. Is that what you are looking for? Yeah, I was going to say that, typically, it just helps expand my horizons, gives me ideas I might have missed, or helps confirm I'm on the right track. So, sometimes it's just, oh, yeah, okay, I'm on the right track. I just have to keep plugging along.

K. Bates reported:

> Well, it is good to step outside of it because getting that fresh perspective on it. I think it is good. When you're with somebody for a while, you may have already had some notions in your mind about where things should go or how things should go. So, I think stepping outside of it and getting that fresh perspective is good.

Summary of Findings

This chapter detailed a synopsis of the lived experiences of psychotherapists who work with individuals living with PD. The participants shared their perceptions on working with PD while also expounding on the challenges they experienced in providing treatment for PD. The thematic analysis was completed through a hermeneutical phenomenological approach (HPA), resulting in five central themes: Introduction to PD, Training experiences in working with PD, the function of PD, Interventions applied while working with PD, and Supports experienced while working with PD. The research questions were answered from the participants' perspectives and lived experiences as described through the central themes and responses to the research questions.

Chapter Five: Conclusion

Overview

This qualitative study's purpose was to gain insight into the lived experience of psychotherapists who provided psychotherapy for individuals living with pathological dissociation (PD). It delivers respected perceptions for psychotherapists who have provided psychotherapy, currently practice, and prospectively will. This chapter will summarize this study's findings, a discussion, and the study's implications. The delimitations, limitations, and recommendations for future research will also be addressed. The focus of this study was on three research questions:

RQ1: What are the experiences of psychotherapists providing therapy to individuals with pathological dissociation?

RQ2: What experiences do psychotherapists have with implementing interventions for individuals diagnosed with pathological dissociation?

RQ3: What are the psychotherapists' experiences involving supervision/consultation when working with pathological dissociation?

Summary of Findings

This qualitative study delved into the lived experiences of psychotherapists who worked with individuals living with PD. Five central themes were developed using the hermeneutical phenomenological approach (HPA). The five themes responded to each research question. Themes 1-3 address the first research question: Introduction to PD, Training on working with PD, and the function of PD. Theme 4 addresses interventions used during PD work, answering

research question 2. Theme five addressed research question three by exploring the support experienced working with PD.

Participants shared their initial exposure to PD, with six describing it as incidental and three as intentional due to personal reasons. The consensus among all participants was that PD originated from past traumatic events. All participants shared how they were introduced to PD due to a client's traumatic history. None of the participants had received specialized PD training before their introduction. However, all reported initiation of self-motivated training after exposure to PD. The participants spoke about the methods they adopted to recognize dissociative symptoms, which helped facilitate treatment. Participants emphasized the need for vigilance in client engagement and normalizing dissociative symptoms to build rapport and a sense of safety. The therapeutic alliance was emphasized by all participants as the key intervention to treating PD.

Participants acknowledged PD, describing its function as a safety mechanism and a traumatic response. The function of PD was commonly accepted among the participants as a means of healing and protection for the client. The participants described the characteristics of PD concerning depersonalization, derealization, amnesia, and switching between parts. The participants stressed the significance of educating clients about PD's appearance, role, and functioning. Although participants acknowledged the role of PD, its pathology was validated due to its function of disrupting orientation and stabilization.

Participants emphasized the importance of implementing interventions encouraging safety, somatic awareness, and orientation. All participants shared their understanding and completion of eye movement desensitization reprocessing (EMDR) training. EMDR was discussed as an effective trauma intervention. However, participants highlighted using an

integrated approach of various modalities with or without EMDR. The following treatment modalities were reportedly integrated: internal family systems (IFS), somatic experiencing (SE), Ego States, trauma-focused cognitive behavior therapy (TF-CBT), Brain Spotting, dialectical behavior therapy (DBT), cognitive processing therapy (CPT), Psychodynamic, and EMDR. The therapeutic rapport was identified as the primary intervention to support individuals with PD due to its ability to reinforce orientation and stabilization.

The types of support identified by participants ranged from prioritizing self-care to consistent engagement in a consultation source. The significance of self-care when working with PD was underscored by all study participants, as the mentally strenuous nature of the job necessitates such measures. Eight out of nine participants reported engaging in guided imagery, incorporating movement, PD-specific books/podcasts, and intentionally seeking consultation as a source of support. The participants found consultation to be a positive experience. It provided them with a space to discuss and gain insight into professional development, receive affirmation and encouragement, and obtain academic resources that could be accessed outside of the consultation.

Discussion

Each participant provided significant and insightful perspectives on their experience of working with PD. The study participants displayed high congruence in their narratives concerning their encounters with PD. Specifically, they expressed consistent views on the phenomenon's introduction, manifestation, utility, and attendant support mechanisms. The descriptions of PD provided by each participant validated the theoretical framework underpinning the research. The participants of the study hypothesized that the occurrence of a

traumatic experience plays a pivotal role in the manifestation of PD symptoms, thereby aligning with the TM.

The participants showed high respect towards PD and expressed their interest in spreading awareness about it. Brand's (2016) findings continue to be validated as accidental rather than intentional introduction to PD is reported higher, indicating lowered awareness about PD. The participants expressed a strong inclination towards raising awareness within the mental health community. There is a growing need for increased awareness and educational opportunities regarding the recognition and role of PD. It is important for mental health professionals to be educated on the symptoms and treatment options for PD. This will increase recognition and proper treatment of PD. This would not only improve the quality of life for those affected by PD but also help reduce the stigma associated with it.

Theoretical Literature

PD has been recognized since the 1890s (Loewenstein, 2018). However, the research lacks significant data regarding PD and its treatment (Schiavone et al., 2018). The study participants expressed an absence of prior knowledge or insight regarding the concept of PD until it was presented to them. While this study’s participants validated the research concerning PD and trauma perplexities, early childhood traumas were not the dominant precursors to dissociative symptoms. Participants in this study spoke on generalized traumatic experiences while including early childhood traumatic experiences as antecedents to PD. The treatment of PD has been a subject of fear and uncertainty, as identified in prior research (Brand, 2016). Participants reported experiencing fear and apprehension in engaging with the treatment of PD during their initial exposure. The participants in the study confirmed fear as a significant obstacle to treating PD, which is consistent with prior research findings (Brand, 2016).

The present study employs the trauma model (TM) as a theoretical framework to elucidate the etiology of PD and its clinical implications for psychotherapeutic interventions. TM postulates a traumatic history as the source of dissociative symptoms (Lynn et al., 2022). The present study provides support for the proposed framework, as the participants in the study expounded on the significance of receiving detailed client histories that delineated the complexities of trauma, which in turn led to dissociative origins. It is imperative to acknowledge the prevalence of dissociative symptoms in individuals with PD and the potential influence of trauma-related factors in exacerbating these symptoms. Therefore, psychotherapists and researchers need to be cognizant of the impact of trauma on PD populations to provide effective treatment and support.

Empirical Literature

The participants in the study emphasized the importance of understanding trauma symptoms and responses to facilitate better screening, assessment, and treatment of PD. An essential challenge within PD is the incapacity to engage in functional skills that enable trauma processing, orientation, and daily mental engagement. The occurrence of PD can have a significant impact on the processing of traumatic events. Specifically, research has shown that the presence of PD can result in the inhibition or impediment of trauma processing (Lyssenko et al., 2018; Van der Kruijs et al., 2014). The study participants elaborated on the recognition of PD during the engagement of trauma processing interventions. This recognition enables the psychotherapist to assist the client in reorienting themselves and becoming more aware of the present moment. This allows for continued validation, normalization, and education on PD, thus fostering the therapeutic alliance. Education on the function and appearance of PD is vital for both the psychotherapist and the client. The ability to recognize the appearance of PD without

experiencing fear can promote growth in clients, as it enables them to acknowledge the symptoms and engage with their therapist to develop coping and protective mechanisms.

The study revealed that participants' recognition of PD occurred through two distinct pathways: self-directed learning or by attending trauma training programs. It is essential to conduct a comprehensive assessment or screening for PD, given its various manifestations, such as depersonalization, derealization, amnesia, fugue, and dissociative identity disorder (DID). The failure to do so can result in significant concerns regarding implementing interventions that may not address the presenting issues effectively. Moreover, it can also impact confidence in conducting trauma-informed therapy. The existing literature has identified these research concerns, as highlighted by Rosen et al. (2017), Danylchuk (2015), and Sansen et al. (2019). Therefore, screening and assessing for PD must ensure that appropriate interventions are implemented and the therapy is conducted confidently and effectively. Commonly identified assessment and screening tools were the dissociative experience scale 2 (DES-II) and the multidimensional inventory of dissociation (MID). Participants highlighted the use of these tools to validate clients and their concerns regarding their trauma responses while simultaneously improving therapeutic rapport, which is a crucial aspect of working with PD.

The use of screening and assessment results led to the normalization of PD symptoms, such as switching between parts/alters or detachment from oneself, one's thoughts, emotions, body, and surroundings (Büetiger et al., 2020; Şar et al., 2017; Vissia et al., 2016). The usage of screening and assessment enables the psychotherapist to maintain heightened awareness and discern the subsequent course of action in the treatment process. This may encompass the implementation of safe coping mechanisms or the utilization of advanced trauma processing techniques. Participants emphasized the need for establishing safe practices that encourage

orientation and stabilization interventions inside and outside the therapeutic environment. This approach detailed the integration of somatic awareness with trauma-processing interventions. Participants identified the completion of advanced trauma training, such as EMDR. However, participants emphasized the collaboration of the therapeutic rapport and somatic awareness with an identified trauma intervention for the treatment of PD.

The commitment of the study's participants to an integrated approach confirmed the prioritization of safety, orientation, and stabilization in treating PD through a phase-oriented treatment (Van Minnen & Tibben, 2021; Willis et al., 2023). Phase-oriented treatment is widely recognized as a best practice three-tier framework for addressing trauma-related symptoms in individuals with PD (Van Minnen & Tibben, 2021; Willis et al., 2023). This approach involves regularly evaluating safety measures to ensure the patient's well-being, promoting trauma awareness, and providing processing support to help patients understand and cope with their traumatic experiences, as well as applying trauma interventions to facilitate healing and recovery. The approach has been widely adopted in clinical settings and is effective in reducing the impact of trauma-related symptoms on clients' mental health (Willis et al., 2023). Integrative approaches in the form of phase-oriented treatment provide optimal support for the client and therapist.

Participants discussed support for treating PD. They emphasized the importance of self-care, challenges in accessing consistent support, and engagement in consultation opportunities. Participants disclosed several types of support that were beneficial in managing their professional development. These included engaging in self-care practices, utilizing academic resources, participating in audio-based learning, and attending consultations. The participants provided a detailed account of their self-care practices observed during and outside the

therapeutic interaction. Several significant takeaways emerged from the study, including the importance of intentional time management, an acute awareness of caseloads, and the implementation of mindfulness practices. These findings have important implications for professionals seeking to optimize their productivity and overall well-being. Despite its limitations and occasional inconsistencies, the participants acknowledged the significance of engaging in consultations as a crucial and supportive measure.

Out of the nine participants in this study, eight reported their involvement in a specific form of consultation or their previous participation in it. Consultation can be a conducive environment for clinicians to engage in case discussions and receive insightful feedback from their peers. Consultation can be instrumental in processing complex and challenging cases, thereby enriching the quality of patient care. One of the difficulties associated with consultation engagement was the inability to access peers who specialize in PD or financial limitations. Psychotherapists are strongly inclined toward ethical practice and demonstrate their commitment to enhancing therapeutic interactions by providing adequate support.

Implications

Psychotherapists are reported as frequently reluctant to engage with patients who have PD due to limited awareness, training, and opportunities for consistent support. This hesitancy may stem from a lack of understanding of PD, financial limitations, and the complex and challenging nature of treating PD. Additionally, psychotherapists may feel ill-equipped to manage the spectrum regarding dissociative symptoms exhibited by clients. This concern continues to fuel the debate around the availability of psychotherapists who treat PD, along with ethical considerations when working with PD. Despite the challenges faced in the field of psychotherapy, some psychotherapists are willing and enthusiastic about engaging with

individuals who have a desire to learn but are restricted by fears of harm and concerns about unethical practices. Such collaborative partnerships have the potential to facilitate a more inclusive and supportive learning environment, ultimately benefiting both the individuals seeking to learn and the psychotherapists seeking to extend their knowledge and skills.

Delimitations and Limitations

The study's delimitations noted using a qualitative phenomenology approach to present insight regarding the perspectives of psychotherapists working with individuals living with PD rather than quantitative or mixed methods. Participants must hold a minimum of a master's degree due to national licensing requirements. Participants must have provided consistent therapy to a client with PD for at least eight weeks to complete intake and make clinical impressions for PD treatment. Psychotherapists were asked to confirm their experience in treating PD to aid in verifying the provision of treatment. Limitations were noted in the nonattendance of doctoral psychotherapists; the sole representation was limited to master's level psychotherapists. Another limitation was the sample size of nine participants due to the limited amount of response from psychotherapists, along with a limited amount of individuals that continued to engage after acknowledging themselves as psychotherapists who work with PD. According to Starks and Brown (2016, 2007), increasing the size of a study's sample can lead to a more accurate representation of the population being investigated. This can result in a higher likelihood of achieving significance and can improve the validity of the study's findings. Psychotherapists' gender and length of trauma experience were not considered limitations. The only requirement was to have worked with PD for a minimum of eight weeks. Lastly, another limitation was the recruitment process for this study, which was contingent upon the assistance of both social networks and psychotherapists.

Recommendations for Future Research

Further research with a similar demographic but with a larger sample size is needed to help ensure the validity of the research findings. The current study represented the views and perceptions of psychotherapists at a master's level only. In contrast, additional research could allow for a broader representation of mental health professionals who provide treatment for PD. Psychotherapists who are hesitant to work with PD patients can use the identified themes to address their concerns through continued research. This would benefit student therapists, psychotherapists in training, and those who avoid treating patients with PD. Further research could help reduce discontinuity of care due to a lack of knowledge in working with PD. Further research could facilitate the development of recognized best practices that help psychotherapists utilize interventions leading to increased positive outcomes. Further research should investigate factors that limit accessibility to support for psychotherapists treating PD. Such an investigation could contribute to the development of more effective support systems. Therefore, addressing this study's participants' concerns around accessing reliable support for working with PD. Further research is required to address the shortage of empirical evidence on the treatment of PD by psychotherapists. This research gap has been identified in the current literature.

Summary

The primary objective of this study was to explore and gain a deeper understanding of the lived experiences of psychotherapists who provide treatment to individuals living with PD. The present study undertook a comprehensive literature review to investigate the trauma model, definition, historical representation, and pathology of PD, focusing on theoretical and empirical underpinnings. A phenomenological study was conducted using a qualitative coding design. Interviews were completed and analyzed from nine participants who self-reported being master-

level psychotherapists with experience treating individuals with PD. During the interviews, the participants expounded on their experiences, thereby enabling the development of key themes regarding their introduction to PD, their training experiences in working with PD, the function of PD, the interventions utilized in the management of PD, and the available support systems while working with PD.

The participants engaged in a discourse concerning the correlation between their work involving trauma and their acquaintance with PD. Additionally, they explored the challenges they encountered when attempting to access supportive resources while treating PD. The participants strongly recommended that therapists explore the potential for treating PD. However, they also acknowledged the apprehension and fear that exists among psychotherapists when working with PD patients, which is consistent with the existing literature on this topic. This study aimed to highlight the significance of psychotherapists who provide treatment to individuals living with PD. It is advisable to conduct further research to enhance the identification of prevalent practices, resolutions to identified barriers, and discover additional resources in the field of psychotherapy and treatment of PD. Such research could broaden the understanding of these areas and inform the development of more effective interventions.

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APPENDIX A.

Consent

Title of the Project: A phenomenological study detailing psychotherapeutic perspectives of psychotherapists who treat individuals living with pathological dissociative practices.
Principal Investigator: Ebony M. Martinez, Doctoral Candidate, School of Behavioral Science, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must hold a minimum of a master's degree and be a licensed professional at the time of treatment for clients with pathological dissociation. The participant will have treated at least one client with pathological dissociation for at least eight weeks. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of the study is to explore the experiences of psychotherapists when treating patients with dissociative disorders by examining their subjective viewpoints.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following:

1. Participate in a virtual, audio and video-recorded interview through Zoom that will take no more than 1 hour.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include contributing to the present literature through the reported experiences of psychotherapists who actively offer treatment to individuals living with pathological dissociation.

What risks might you experience from being in this study?

The expected risks from participating in this study are minimal, which means they are equal to the risks you would encounter in everyday life. The risks involved in this study include the possibility of psychological stress from being asked to recall and discuss the treatment of pathological dissociation. To reduce risk, I will monitor participants, discontinue the interview if needed, and provide referral information for counseling services.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential by replacing names with pseudonyms.
- Interviews will be conducted in a location where others will not easily overhear the conversation.
- Data collected from you may be used in future research studies and/or shared with other researchers. If data collected from you is reused or shared, any information that could identify you, if applicable, will be removed beforehand.
- Data will be stored on a password-locked computer and in a locked drawer. Physical data will be stored in a locked drawer. After three years, all electronic records will be deleted, and all hardcopy records will be shredded.
- Recordings will be stored on a password-locked computer for three years and then erased. The researcher will have access to these recordings.

How will you be compensated for being part of the study?

Participants will be compensated for participating in this study. At the conclusion of the interview, participants will receive a $25 Amazon gift card.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Ebony M. Martinez. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [redacted]
You may also contact the researcher's faculty sponsor, [redacted]

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the IRB. Our physical address is Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515; our phone number is 434-592-5530, and our email address is irb@liberty.edu.

Liberty University
IRB-FY23-24-511
Approved on 11-3-2023

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio and video-record me as part of my participation in this study.

_____
Printed Subject Name

_____
Signature & Date

APPENDIX B.

Interview Questions

1. Describe experiences/training that assist in treating trauma and understanding dissociative pathological populations.

2. Describe your perspective on pathological dissociation and its role within psychotherapy.

3. Describe what led you to work with the pathological dissociative/disordered populations.

4. Describe a notable experience regarding initially working with pathological dissociation.

5. How have you been able to implement self-care practices while working with a pathological dissociative population?

6. What steps do you take to screen, assess, and choose treatments for people with pathological dissociation?

7. What protocols or documentation practices are utilized to monitor progress while working with pathological dissociation?

8. What treatment modality(s) do you utilize while working with pathological dissociation?

9. Which interventions have contributed to the reported decrease in pathological dissociation?

10. Which interventions have contributed to the reported increase in pathological dissociation?

11. What interventions or strategies can be used to recognize dissociative symptoms?

12. What resources have enabled access to support in treating pathological dissociation for both you and the client?

13. What methods do you use for supervision or consultation when working with a population experiencing pathological dissociation?

14. Describe the process in the selection of your supervisor/consultant.

15. How has supervision/consultation affected the conceptualization of treating individuals with pathological dissociation?

16. Is any additional information that would be important to this study and viable for individuals questioning working with pathological dissociation?

APPENDIX C.

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

November 6, 2023

Ebony Martinez
Thomas Vail

Re: IRB Exemption - IRB-FY23-24-511 A phenomenological study detailing psychotherapeutic perspectives of psychotherapists who treat individuals living with pathological dissociative practices.

Dear Ebony Martinez, Thomas Vail,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

For a PDF of your exemption letter, click on your study number in the My Studies card on your Cayuse dashboard. Next, click the Submissions bar beside the Study Details bar on the Study details page. Finally, click Initial under Submission Type and choose the Letters tab toward the bottom of the Submission Details page. Your information sheet and final versions of your study documents can also be found on the same page under the Attachments tab.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,
G. Michele Baker, PhD, CIP
Administrative Chair
Research Ethics Office

APPENDIX D.

Email Recruitment Letter

Dear Potential Participant,

As a doctoral candidate in the School of Behavioral Science at Liberty University, I am conducting research to understand a phenomenon better. The purpose of my research is to explore the experiences of psychotherapists when treating patients with dissociative disorders by examining their subjective viewpoints. I am writing to invite you to join my study.

Participants must hold a minimum of a master's degree and be a licensed professional at the time of treatment for clients with pathological dissociation. The participant will have treated at least one client with pathological dissociation for at least eight weeks. Participants will be asked to participate in a one-on-one, audio and video-recorded, virtual interview. It should take approximately one hour to complete the procedure listed. Names and other identifying information will be requested as part of this study, but participant identities will not be disclosed and will remain confidential.

To participate, please contact me at [redacted] to schedule an interview. If you meet my participant criteria, I will work with you to schedule a time for an interview. A consent document will be emailed to you if you meet the study criteria one week before the interview. The consent document contains additional information about my research. If you choose to participate, you will need to sign the consent document and return it to me at the time of the interview.

Participants will receive a $25 Amazon gift card digital gift card.

Sincerely,

Ebony M. Martinez, MA, LCMHC, NCC
[redacted]