

THE USE OF THE
DES IN STUDYING
TREATMENT OUTCOME
WITH DISSOCIATIVE
IDENTITY DISORDER;
A PILOT STUDY

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INTRODUCTION

Dissociative identity disorder (DID), formerly known as multiple personality disorder (MPD), has been diagnosed and treated with increasing frequency in recent years. Despite many advances in psychiatry's understanding of dissociation and the dissociative disorders, and significant progress in the understanding, recognition, and treatment of DID, treatment outcome research on DID and dissociative phenomenology in general has remained minimal. Putnam underlined the urgent necessity for undertaking such studies and proposed a number of potential projects as early as 1986, but his recommendations have been largely unheeded.

The compelling need for such investigations has been emphasized by studies in several nations that demonstrate that DID is a very common form of psychopathology and that dissociation is an extremely frequent aspect of the trauma response. Clinical investigators in the United States (Saxe et al., 1993), Canada (Ross, 1991; Ross, Anderson, Fleisher, & Norton, 1991), the Netherlands (Boon & Draijer, 1993), and Norway (Knudsen, Haslerud, Roe, Draijer, & Boon, 1995) have demonstrated that DID patients constitute 3-8% of the psychiatric inpatient population of studied acute psychiatric units, and studies from Turkey (Tutkun, Yargic, & Sar, 1995) and Germany (Hofman & Rost, 1995) demonstrate that DID patients are not uncommon in these nations when systematic efforts are made to recognize their presence. Furthermore, high rates of dissociative symptoms have been found in post-

traumatic stress disorder and sexual abuse victim populations (e.g., Branscomb, 1991; Bremner et al., 1992; Carson & Rosser-Hogan, 1991; Strick & Wilcoxon, 1991). Dissociative symptoms may play a considerable role in many psychiatric psychopathologies (Choe, Kluft, Park, Hahn, & Jo, 1994). Furthermore, numerous studies by Spiegel and his colleagues (e.g., Spiegel, 1991; Koopman, Classen, & Spiegel, 1994) have demonstrated that normal populations exposed to extraordinary stress will demonstrate a high incidence of dissociative symptoms, and that the presence of dissociative symptoms is a predictor for the subsequent development of post traumatic stress disorder.

All these findings suggest that means for the systematic assessment of the fate of dissociative symptoms in treatment must be developed in order to facilitate both research and clinical management. Although a review of the literature discloses virtually no studies of the fate of general dissociative symptoms in therapy, a small number of communications have attempted to study the impact of treatment on DID. Kluft (1982, 1984, 1986, 1993) has reported on the results of patients in treatment with himself, and Coons (1986) has followed twenty patients in therapy with twenty clinicians. However, neither study used objective measures, and both studies are vulnerable to the criticism that confirmatory bias may have clouded or colored the clinician reports that were the source of the data. Kluft (1994a, 1994b) has developed an instrument for following the treatment progress of DID patients (the Dimensions of Therapeutic Movement Instrument, or DTMI), but this was designed primarily for use by the treating clinician. Although the DTMI is amenable to research use by objective observers, and has been used in pilot studies by its author, as of yet no publication addresses this application. Furthermore, neither the reliability nor validity of the DTMI has been established.

Therefore the senior author (BMC) undertook a pilot study to explore the use of the well-established, reliable, and valid Dissociative Experiences Scale (DES) of Bernstein and Putnam (1986) as a potential indicator of response to treatment. An additional goal of the study was to explore whether the inpatient treatment of DID would result in the reduction of the frequency and intensity of DID patients' dissociative experiences.

METHODS

Instruments

The Dissociative Experiences Scale or DES (Bernstein & Putnam, 1986) is a 28-item brief self-report instrument that measures the frequency of dissociative experiences. The response scale allows subjects to quantify their experiences. It was designed as a screening rather than a diagnostic instrument. Designed as a trait measure, it allows subjective description of the frequency of dissociative events in the subjects' daily lives (Carlson & Putnam, 1993). Its reliability and validity are established. It has been used quite widely in dissociative disorders research and in characterizing the dissociative aspects of other psychopathologies.

The Dissociative Disorders Interview Schedule or DDIS (Ross, 1989; Ross, Heber, Norton, Anderson, D., Anderson, G., & Barchet, 1989) is a highly structured interview with 131 questions in 16 sections. The interview is read to the interviewee, who endorses one of several possible multiple choice alternatives for each inquiry. It is designed to elicit information about several *DSM-III-R* diagnoses, certain childhood experiences, features commonly associated with dissociative disorders, and a number of other areas of inquiry. Its reliability and validity are established. It has been widely used in dissociative disorders research.

The Study Site

The Dissociative Disorders Unit at The Institute of Pennsylvania is a 25-bed closed psychiatric unit dedicated to the treatment and evaluation of the dissociative disorders and post-traumatic stress disorder. It has functioned both as a referral center and as a resource to Delaware Valley mental health providers since July, 1989. Its occupancy rate is high and the average length of stay during the period of this study was approximately 23 days. Patients receive individual psychodynamic psychotherapy, usually facilitated with hypnosis, five days a week. They attend approximately a dozen specialized groups per week, including art, cognitive, movement, and verbal group therapies. The milieu is strong and aggressively managed to maximize safety.

Subjects

The subjects were inpatients with DID treated in the Dissociative Disorders Unit (DDU) of The Institute of Pennsylvania discharged between March 1993 and February 1994. Inclusion criteria were: 1) female gender; 2) age 18 or older; 3) a diagnosis of DID (then MPD) by *DSM-III-R* criteria (American Psychiatric Association, 1987) by both the structured DDIS interview (Ross, 1989) and the unanimous clinical consensus of three experienced psychiatric clinicians including the junior author (RPK); 4) an admission DES score of 30 or more; 5) four weeks of treatment between the admission and discharge DESs.

The authors adopted these criteria for the following rea-

sons. The vast majority of patients admitted to the DDU are female. Without certainty that male and female patients would respond comparably to the treatment protocol, the inclusion of a small number of male patients might have been problematic. The DES was designed for and has been validated for populations 18 years of age and older. While many dissociative disorder investigators believe that all DID research should use populations characterized with standardized instruments, still others entertain severe doubts as to whether the endorsement of crucial items on a structured instrument is a sufficient basis for making the DID diagnosis. It seemed best to avoid such problems by using both an instrument and a clinician-derived diagnostic consensus. DES scores of 30 or more are recommended as a cut-off point in recent research (Carlson & Putnam, 1992). In addition, for the purposes of this study a reasonable degree of overt dissociative features was deemed necessary in order to study change in a small population. Furthermore, the authors were concerned that DID patients with low DES scores might have been hospitalized in connection with comorbid psychopathology that itself became the major focus of the hospital treatment, so that the hospital treatment would not have addressed dissociative psychopathology primarily. Finally, four weeks was established arbitrarily as a minimum period for the assessment of meaningful change because many shorter admissions clearly had been interrupted prior to the achievement of change-oriented goals, or were specifically for the purpose of stabilization or assessment, so that aggressive attempts to alter DID symptomatology had not been undertaken.

Of the 66 patients discharged from the DDU with a DID diagnosis over the study period, 21 patients (32%) qualified for inclusion in this study. They averaged 33.2 years of age (S.D.=9.0). They had had an average of 1.8 (S.D. = 1.1) total DDU admissions.

The Study Protocol

The patients received their admission DES within 48 hours of admission and their DDIS was completed within 72 hours of admission by trained nurse interviewers. Standard instructions were given prior to their administration. All patients were interviewed several times by one or more of the DDU's three administrative psychiatrists in the presence of the other two, the senior author, and the remainder of the treatment team. Within the last two days of the anticipated duration of their hospital stay, patients were approached by the senior author, who administered the DES, but introduced the test with different instructions that requested the patients to complete the DES considering only their current experiences. The wording of these instructions is included as Appendix 1. The authors assumed on the basis of their experience with the DES that a second administration with identical instructions would not demonstrate significant change, an assumption recently confirmed by the work of Dubester and Braun (1995), who tested a series of dissociative disorder inpatients

twice during their admissions and found the baseline DES scores remained stable.

Neither the patients nor those involved in their care were told their initial DES scores or DDIS findings; nor were they informed of the implication of their DES scores or of the DDIS findings for their diagnoses. The DES subscales (amnesia, absorption or absorption/changeability, and depersonalization/derealization) were drawn from Carlson and Putnam's manual (1992).

RESULTS

The results (see Table 1) demonstrate that the total DES scores decreased significantly over the course of inpatient treatment, as did the scores for absorption and changeability, and depersonalization/derealization. However, the amnesiafactor increased significantly.

DISCUSSION

Attempts to study the fate of dissociative symptoms in treatment have been hindered by the absence of a reliable and valid measure of the state of patients' dissociative experiences. This study begins the exploration of the use of the DES, designed to measure trait aspects of dissociation, as an instrument for the assessment of dissociation from a state perspective. It employed the standard form of the DES, but used alternative instructions in its second administration. Several DES items inquire after circumstances unlikely to be experienced during hospitalization, but were filled out without hesitation by the subjects.

A further caution is that because the baseline DESs were obtained using instructions designed to measure trait variables, and the new instructions were designed to elicit state information, it is certainly possible that this study actually failed in its efforts to measure changes in state phenomena with regard to the intensity or frequency of dissociative symptomatology because it elicited inappropriate baseline information. We assumed that the stable psychometric properties of the standard DES would give us a reliable baseline, but remained aware that newly admitted inpatients might be in a state of agitation that might yield discordant findings. For the above reasons and many others, this should be understood as a very preliminary study. Further studies will be necessary to conclude whether the DES has an enduring role in clinical and basic research as a state measure, and

TABLE I
Comparison of Dissociative Experiences Scale Scores (DES) Between On Admission and On Discharge in the Admitted Patients with Dissociative Identity Disorder (N=21)

DES Scores	On Admission		On Discharge		P
	mean	S.D.	mean	S.D.	
Total Score	59.54	12.75	37.04	22.58	0.011
Amnesia Factor	43.99	21.55	59.62	15.25	0.017
Absorption Factor	66.07	15.22	53.44	19.20	0.029
Depersonalization/ Derealization Factor	64.72	21.15	58.39	17.91	0.002

p: Wilcoxon Matched-pairs Signed-ranks Test, two-tailed; *ns*: Not significant, *p* > 0.05

whether the instruction modifications employed in this study are useful, but these initial findings demonstrate the worthwhileness of continuing these lines of exploration.

The reduction of the total DES scores and the scores on two of the three subscales suggests that the treatment program on the DDU is effective in reducing dissociative symptomatology as measured by these DES scores (with the qualifications noted above). This is consistent with the patients' clinical improvement as assessed impressionistically by both the patients and their treating psychiatrists. In this context, the increased amnesia scores might be understood to reflect a diminished denial of dissociative difficulties and/or enhanced self-observation and/or increased reporting frequency due to sensitization to this phenomenon. It is possible that the reduced scores might reflect denial and wishful thinking, dissociation of unwanted ego-dystonic evidence of psychopathology, or negative malingering designed to encourage being discharged. However, the elevation of the amnesia factor, which includes items quite ego-dystonic to DID patients, is inconsistent with this as an overall hypothesis. Amnesia for amnesia or the wish to deny or misrepresent one's degree of amnesia at initial presentation (and at times, thereafter) are well-known DID phenomena (Kluft, 1987; American Psychiatric Association, 1994). Many can acknowledge their amnesia only after a period of treatment or evaluation. It is of interest that seven DID patients qualified for the study except for their admission DES scores. They were characterized by considerable degrees of denial about their conditions, amnesia for amnesia, and dissimulation of their difficulties in the attempt to evade problems in their lives associated with their dissociative psychopathology. By the end of their admissions they universally were more open

about their dissociative difficulties. Whether they then would have scored higher on the DES due to their increased openness, or the same or lower due to their clinical improvement, is a subject for future study.

It is also possible, in the absence of pre-admission DES scores, that the overall distress that occasioned the admission led to overendorsement at the initial assessment, and that rather than reflecting improvement of the dissociative symptoms, the reduced DES scores may reflect a return to a prior baseline. That is, general distress may have inflated the endorsement frequency. If increased general distress were accompanied with increased denial of amnesic experiences, one could conceive of these results also representing a return to a baseline. This might speak to stabilization without change in the underlying DID. Although stabilization in and of itself is a worthwhile objective in many inpatient treatments of DID, the documentation of stabilization is a different pursuit from the documentation of change in the patient's ongoing symptomatology.

The authors anticipate the development of new tools that can measure the state of dissociative symptomatology more accurately and will be more readily applicable to the study of these phenomena in both clinical and research settings. In the interim, it is useful to study potential novel applications of the established instruments already in hand. ■

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APPENDIX I

Instructions for the Discharge DES

We would like to get information about recent dissociative experiences in your daily life.

So, we want to see if there are any changes in your experiences since admission.

The degree of some phenomena maybe increased because you are able to be aware of them. Others may be decreased or stationary as a result of your work here.