

**The Role of Clinical Experience, Diagnosis and Theoretical Orientation in the
Treatment of Posttraumatic and Dissociative Disorders: A Vignette and Survey
Investigation**

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RUNNING HEAD: Treatment preferences in posttraumatic and dissociative disorders

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Abstract

Controversy exists regarding the merits of exposure-based treatments of posttraumatic stress disorder (PTSD) versus a phased approach when prominent dissociative symptoms are present. The first aim of this study was to examine the degree to which diagnosing dissociation in two traumatized patients' vignettes influenced clinicians' preference for phase-oriented treatment, and whether clinicians' treatment experience contributed to their treatment preference. The second aim was to assess the extent to which participants had observed traumatized patients worsen when treated with exposure therapy or phase-oriented therapy, and whether the theoretical orientation and treatment experience of the clinician were related to the observed deterioration. In the tradition of expert and practitioner surveys, 263 clinicians completed a survey of their diagnoses and treatment preference for two vignettes, and their treatment experience, theoretical orientation, and observations of patients' deterioration. When a marked degree of dissociation was noted in the PTSD vignette, respondents favored phased approaches regardless of the diagnosis given. Reports of having observed patient deterioration during both exposure and phased therapy were predicted by years of experience. Psychodynamic therapists reported more observations of worsening during exposure therapy than CBT therapists. Clinical experience treating PTSD may heighten awareness of negative therapeutic effects, potentially because experienced clinicians have a lower threshold for detecting such effects and because they are referred more challenging cases.

KEYWORDS: Diagnosis, dissociative disorders, posttraumatic stress disorder, treatment

Research on the most effective and efficient therapies for trauma-related disorders like posttraumatic stress disorder (PTSD) must balance the desire to move people to recover as quickly as possible and the principle of first ‘doing no harm’. Moving a patient too quickly can lead to decompensation and worsening outcomes. Moving them too slowly prolongs their suffering and reduces their quality of life.

Treatment guidelines generally support exposure therapy as one of the most efficacious treatments for PTSD, with cognitive-behavioral therapy (CBT) and eye movement desensitization and reprocessing (EMDR) exposure interventions being particularly helpful (e.g., Australian Centre for Posttraumatic Mental Health (ACPMH), 2007; Kulkarni, Barrad & Cloitre, 2014; NICE, 2005; VA/DoD, 2010). However, research on these therapies is hampered by limitations that impede generalization (e.g., Yehuda & Hoge, 2016). Concerns have also been raised about the effectiveness of exposure therapies with patients who show more complex and severe symptoms than are typically addressed in research (Bradley, Greene, Russ, Dutra & Westen, 2005; Brand, 2012; Westen, Novotny, & Thompson-Brenner, 2004).

Treatment guidelines and clinical experience have suggested that as patients’ presentations become more complicated, exposure therapies are best withheld until a period of stabilization has been achieved, enabling patients to acquire internal and external resources before facing the magnitude of their trauma (e.g., ACPMH, 2007; ASCA, 2012; Cloitre, Courtois et al., 2012; ISSTD, 2011). This therapeutic framework, called *phase-oriented* treatment, prioritizes stabilization before exposure, in contrast to exposure therapy, which does not focus on prior stabilization based on the belief that stabilization occurs as the exposure therapy progresses (De Jongh et al., 2016). Thus the difference between ‘exposure’ and ‘phase-oriented’ therapy is that while both methods include exposure, the latter engages in a period of stabilization

before exploring traumatic experiences, which may extend from weeks to months or even years depending on the complexity of the condition.

Dissociative symptoms are thought to increase the complexity of a trauma presentation and take the form of *amnesia, flashbacks, identity alterations, depersonalization* and *derealization*, among others. The DSM-5 distinguished a dissociative subtype of PTSD characterized by the core symptoms of PTSD along with depersonalization and/or derealization symptoms. Individuals with the dissociative subtype of PTSD typically have *more severe and earlier-onset trauma, greater comorbid symptoms and personality pathology, more suicidality* and *increased functional impairment* (e.g., Stein et al., 2012; Steuwe, Lanius, & Frewen, 2012; Wolf et al., 2012). Many experts support the use of phased treatment approaches when dissociation is present in PTSD (e.g., ASCA, 2012; Cloitre et al., 2011; Jepsen, Langeland, & Heir, 2013; Lanius et al., 2012; Price, Kearns, Houry, & Rothbaum, 2014). In addition, therapists often perceive dissociative symptoms as a contraindication for exposure therapy (Becker, Zayfert, & Anderson, 2004). Moreover, some research shows that exposure therapies have limited impact when trait dissociation is relatively high, and that stabilization prior to exposure offers the best outcome in such cases (e.g., Cloitre, Petkova, Wang, & Lassell, 2012; D'Andrea & Pole, 2012). Patients who dissociated during treatment sessions, that is, who experienced *state* dissociation, were less likely to have a good response to trauma-adapted dialectical behavior therapy, although trait dissociation did not moderate outcome (Kleindienst et al., 2016).

However, other studies have shown that regardless of the presence of dissociative symptoms, exposure therapy is an effective treatment for PTSD (e.g., Hagens, Minnen & Hoogduin, 2010; Halvorsen, Stenmark, Neuner, and Nordahl,

2014; Resick, Suvak, Johnides, Mitchell, & Iverson, 2012; Wolf, Lunney & Schnurr, 2016). The view that dissociation is not an impediment to exposure therapy is expressed in a recent review recommending exposure therapy in cases where dissociative and complex PTSD presentations are evident (De Jongh et al., 2016). Nevertheless, there is continuing controversy about the generalizability of exposure therapies for complex clinical cases (Steenkamp, 2016; Yehuda & Hoge, 2016).

Findings from well-controlled studies employing numerous exclusion criteria is one way of accruing knowledge based on groups of patients with PTSD. However, clinicians also accrue experiential knowledge through the ‘school of hard knocks’ from the time they see their first traumatized individual. Consequently, decision-making in clinical situations is likely to be guided both by the empirical literature and experience working with traumatized patients, which yields invaluable practice-based evidence in treating complex trauma patients (Barkham & Mellor-Clark, 2003).

In the tradition of expert and practitioner surveys in the area of trauma treatment (e.g., Brand et al., 2012; Cloitre et al., 2011; Van Minnen, Hendriks & Olf, 2010), the current study sought to assess therapists’ practice-based evidence and had two broad goals. The first was to examine the degree to which diagnosing dissociation was associated with clinicians’ preference to utilize a phase-oriented framework in the treatment of two patients with varying degrees of dissociation as described in two vignettes, and whether treatment experience contributed to treatment preference. The second goal was to determine whether clinicians had observed traumatized patients worsen when treated with exposure therapy and/or phase-oriented therapy, and whether the theoretical orientation and treatment experience of the clinician was related to their observations of patients’ deterioration.

Given that dissociation is generally seen as a marker for a more cautious

approach to treatment, we expected that if clinicians identified dissociation as a prominent feature of the patients in the vignettes, they would likely advocate using a phase-oriented approach when given the choice between it, exposure therapy, or symptom management. Symptom management is often utilized for traumatized patients who have not benefited from other therapies (NICE, 2005). We also expected that clinicians with greater experience treating traumatized patients would recommend a more conservative, phase-oriented treatment approach, due the potential danger of decompensation with more rapid exposure therapies. To determine whether exposure-based and/or phase-oriented treatment were associated with patient deterioration, we examined whether therapists' theoretical orientation (i.e., primarily CBT vs. psychodynamic) and their treatment experience were related to their observations of patient deterioration in one or both types of therapy. We hypothesized that therapists whose primary orientation was CBT would report fewer detrimental effects from exposure therapy than would psychodynamic therapists. We also anticipated that years of treatment experience would predict reports of negative therapeutic outcomes with both treatments, as experience likely increases the ability to detect negative effects and also increases contact with complex clinical presentations and comorbid symptomatology.

Method

Participants

To survey practitioners worldwide with a wide range of experiences, we approached various professional organizations. The following agreed to distribute the survey to their members: New Zealand College of Clinical Psychologists, New Zealand Association of Psychotherapists, Australian Psychological Society, International Society for the Study of Trauma and Dissociation, Division 56 of the

American Psychological Association (i.e., Trauma Division), European Society for Traumatic Stress Studies, The Society for the Study of Psychiatry and Culture, the European Society for Trauma and Dissociation, The South African Society of Psychiatrists, the Psychological Society of South Africa, the Australian and New Zealand Association of Psychotherapists, the American Society of Hispanic Psychiatry, and an independent listserv of Turkish psychiatrists.

It was impossible to calculate how many people received the survey invitation. However, 368 clinicians began the survey, and 242 completed it. An additional 21 completed the diagnostic and treatment sections for the two case vignettes and the demographic questions, but not the section on experiences of patient deterioration in therapy. These participants were included in the vignette analyses, bringing the total sample to 263 (71.47% of those initiating the survey).

Participants had a mean age of 46.21 years ($SD=12.83$) and 76% ($n=200$) were female. Most were psychologists (56.3%; $n=148$), but there were also psychiatrists (17.9%; $n=47$), social workers (9.5%; $n=25$), psychotherapists (8%; $n=21$), counselors (3.8%; $n=10$), nurse practitioners (1.5%; $n=4$), and 'other' providers (3.1%; $n=8$).

The most prominent theoretical orientations were CBT (30.8%; $n=80$), psychodynamic/analytic therapy (28.5%; $n=75$), EMDR/energy therapies (13.3%; $n=35$) and humanistic therapy (8%; $n=21$). Participants were located around the world (e.g., Argentina, Canada, Denmark, Peru, Turkey, South Africa, Sweden, Venezuela), with sizable subsamples from the USA (41%; $n=108$), Australia (20%; $n=53$) and New Zealand (18%; $n=47$). Participants often worked in multiple settings. Most were in private practice (60.5%; $n=159$), while 35% ($n=92$) were in clinic or hospital outpatient settings, 12.5% ($n=33$) in hospital inpatient programs, and 14.4% ($n=38$) in university or tertiary settings.

Materials and Procedure

Participants were informed about the study via email or website advertisement from their professional organization. Surveys were completed online via the Qualtrics software platform. After reading study information and consenting by continuing, participants were presented with two case vignettes. The instructions stated that both patients had experienced traumatic stress, but that the presentations differed.

The first vignette described 38-year old “Ms. Y” (see supplementary material), who experienced the following symptoms of PTSD: dissociative flashbacks (i.e., “*She describes experiencing distressing memories of childhood trauma coming back to her ‘out of the blue’ and in a way she can’t control*”); dissociative amnesia; dissociative numbing; physiological arousal when experiencing reminders of the trauma; avoidance of thoughts and feelings associated with the trauma; sleep difficulties associated with ‘bad dreams’; concentration problems; irritability; and hypervigilance. The vignette explicitly stated that the patient “*reports no other symptoms or difficulties*”.

This first vignette was developed and edited until the authors agreed it presented a case of PTSD with explicit dissociative symptoms (e.g., flashbacks, amnesia, numbing). No mention was made of the symptoms that are crucial in discriminating PTSD from dissociative PTSD (depersonalization/derealization). Thus, Ms. Y’s presentation was specifically designed to feature dissociative symptoms, but not of the type, or so pronounced or frequent, to make it likely she met criteria for either the dissociative subtype of PTSD or a dissociative disorder in addition to PTSD.

The second vignette (see supplementary material) described 39-year old “Ms. F” who struggled with emotional lability, self-harm, and dissociative symptoms (e.g., “*She uses behaviors such as cutting to assist herself when she feels detached from her*

body or when she cannot control her thoughts or actions”). Ms. F was depicted as ‘losing time’ and ‘coming to’ in unfamiliar places, with amnesia for interactions with relatives and childhood abuse experiences. Ms. F was noted to have ego-dystonic voices that commented on her behavior, psychosomatic pain symptoms, anesthesia (i.e., occasional absence of sensation in her body), identity confusion, and severe derealization and depersonalization.

The second vignette further described Ms. F’s intense shame about her abuse and avoidance of interpersonal relationships. This vignette was edited until the authors agreed it captured sufficient psychological and somatoform dissociative symptoms to portray a patient with a dissociative disorder. The vignette purposely did not include dissociative identities (the most dramatic and severe dissociative symptom). Rather, the intent was to assess how well clinicians could identify a dissociative disorder in the absence of overt evidence of dissociative identities. The core symptoms of PTSD were not included, so the case gave no indication that either PTSD or dissociative PTSD was the most appropriate diagnosis.

After reading each vignette, participants were asked to choose a diagnosis among five options: PTSD without dissociative symptoms, PTSD with some dissociative symptoms, PTSD with prominent dissociative symptoms, Other Specified Dissociative Disorder (OSDD, labeled Dissociative Disorder Not Otherwise Specified [DDNOS] in DSM-IV) or Dissociative Identity Disorder (DID). The first option was included to determine the presence of therapists who were unaware that dissociative symptoms exist in PTSD.

Participants were then asked to choose the best treatment approach for each case from the following options:

1) Move quickly to discussing in detail, focusing on, and/or exposing the patient to her traumatic experiences to reduce or ameliorate her symptoms. Dissociative symptoms do NOT need to be dealt with separately and before trauma-focused work commences.

2) Delay more direct and detailed focus on the patient's traumatic experiences in favor of assisting her to learn symptom management. Exploring her trauma history in detail at this point OR in the future would likely be unhelpful and unproductive.

3) Delay more direct and detailed focus on the patient's traumatic experiences until development of inner resources and coping skills, and management of her dissociation, for more successful discussion of her traumatic experiences. Discussion of her traumatic experiences in therapy will be important, but only after stabilization and work on her dissociative and other symptoms.

Participants completed demographic questions, including their age, gender, and the country in which they practice. They indicated their profession (e.g., psychiatrist, psychologist), main/primary theoretical orientation (e.g., cognitive-behavioral, psychodynamic), work setting (e.g., private practice, clinic/hospital outpatient), primary clinical population (i.e., adults or children/adolescents), and years practicing as a therapist. To further assess therapeutic experience, participants were asked how many patients they had treated during their career with 1) PTSD and 2) DID, using a categorical scale of 0 patients, 1-5 patients, 6-10 patients, 11-20 patients, or >20 patients. Using the same scale, participants reported how many patients with PTSD they had treated or directly observed others treating who worsened with 1) exposure therapy or 2) phase-oriented therapy. Finally, participants described whether they had received specialized training in treating complex trauma or dissociative disorders. All

procedures were approved by the Human Ethics Committee at the University of Canterbury in New Zealand.

Analysis

In light of sample size considerations, to reduce the discrete categories for analysis and to capture a single dissociative disorder group, we collapsed DID and OSDD diagnoses (for the vignettes) into one DD category.

Logistic regression was used to determine the degree to which a therapist's diagnosis and experience in treating PTSD (Ms. Y) or DID (Ms. F) predicted therapist preference for phase-oriented therapy separately for the two vignettes. Due to the study focus on phase-oriented therapy, the treatment preference outcome variable was dichotomous, with exposure and symptom management collapsed together (due in part to their relatively small number of respondents) and compared with phase-oriented therapy. The diagnosis variable was also treated as dichotomous (Ms Y: PTSD with some vs. prominent dissociative symptoms; Ms F: PTSD with prominent dissociative symptoms vs. DD). The treatment experience variable was categorical (Table 2).

Logistic regression was also used to examine the relationship between theoretical orientation, PTSD treatment experience, and therapists' observation of negative therapeutic effects during exposure therapy or phase-oriented therapy. This outcome (observation of worsening) was regarded as dichotomous (i.e., no vs. yes). The predictor variable of theoretical orientation was also dichotomized (CBT vs. psychodynamic/analytic) because these two orientations were affirmed most frequently (other orientations were only minimally represented and therefore excluded). The second predictor variable, PTSD treatment experience, was categorical.

To test the impact of excluding respondent endorsement of therapeutic orientations other than CBT and psychoanalytic psychotherapy, we conducted a sensitivity analysis in which we collapsed orientations on the basis of their reliance on exposure approaches (CBT, EMDR, Energy therapies) vs. other forms of treatment that do not rely as much on exposure (psychodynamic/analytic, narrative, family systems and humanistic). We then examined the association of this alternative dichotomization of the orientation data with endorsement of observed negative effects from exposure and phase-oriented therapy.

Results

Participating clinicians worked largely with adults (84.8%; $n=223$); only 7.6% ($n=20$) primarily saw children and adolescents. Thus the majority were well positioned to evaluate the two adult case vignettes. The sample was clinically experienced; 80% had >5 years of clinical practice. Additionally, the sample was experienced in treating trauma-related and dissociative disorders; >80% had treated ≥ 1 case of DID (Table 1). Only six respondents (2.3%) lacked experience treating PTSD and 6.5% ($n=17$) lacked training in the treatment of complex trauma or dissociative disorders.

Table 1: Number of PTSD and DID cases treated per participating clinician (N = 243)

| Number of cases treated | PTSD n (%) | DID n (%) |
|-------------------------|-------------|-------------|
| 0 | 6 (2.5%) | 49 (20.2%) |
| 1-5 | 15 (6.2%) | 104 (42.8%) |
| 6-10 | 31 (12.8%) | 39 (16.0%) |
| 11-20 | 25 (10.3%) | 25 (10.3%) |
| > 20 | 166 (68.2%) | 26 (10.7%) |
| Total | 243 (100%) | 243 (100%) |

Preferred treatment of Patient Vignettes

Ms. Y: A case of PTSD with evident dissociative symptoms.

Most clinicians chose a diagnosis of ‘PTSD with some dissociative symptoms’ ($n=175$, 66.54%). A substantial minority suggested Ms. Y had ‘PTSD with prominent dissociative symptoms’ ($n=59$, 22.43%), while six chose a DD (2.28%). Twenty-three participants (8.75%) misdiagnosed Ms. Y as having ‘PTSD with no dissociative symptoms’; indicating failure to recognize dissociative symptoms in the presenting problem *even though these were explicitly described*. As a small number suggested a DD, and ‘PTSD without dissociation’ was an inaccurate diagnosis, the logistic regression used PTSD with some or with prominent dissociative symptoms as a predictor. As shown in Table 1, there was a range of experience treating PTSD, with most participants having considerable experience. Regarding the preferred treatment for Ms. Y, 20 (7.61%) participants advocated exposure, 16 (6.08%) chose non-trauma-focused symptom management, and 227 (86.31%) preferred phase-oriented treatment.

Diagnosis and PTSD treatment experience were entered as predictors of clinicians’ suggested treatment for Ms. Y. Controlling for PTSD treatment experience, diagnosis significantly predicted treatment preference. A diagnosis of PTSD with prominent dissociative symptoms increased by 7.75 the odds of favoring phase-oriented therapy for Ms. Y (Table 2). PTSD treatment experience did not make a unique contribution to clinicians’ recommended treatment.

Ms. F: A Case of Dissociative Disorder.

This case describes the characteristic presentation of a DD without explicitly mentioning dissociative identities. Clinicians typically diagnosed PTSD with

prominent dissociative symptoms ($n=102$; 38.78%) or dissociative disorder ($n=155$; 58.94%). Very few participants suggested Ms. F had PTSD with no dissociative symptoms ($n=2$; .76%) or some dissociative symptoms ($n=4$; 1.52%); these were excluded from further analysis. A dichotomous diagnosis variable (PTSD with prominent dissociative symptoms vs. DD) was entered as a predictor of treatment preference for Ms. F. Clinicians' treatment experience with DID (Table 2) was also examined as a predictor.

The large majority of participants advocated phase-oriented treatment ($n=237$; 90.11%), with the remainder preferring exposure ($n=3$; 1.14%) and symptom management ($n=23$; 8.75%). After controlling for diagnosis, DID treatment experience fell marginally short of predicting treatment preference for Ms. F ($p=.09$; Table 2). Diagnosis made no unique contribution to treatment choice.

Table 2: Diagnosis and treatment experience as predictor variables for the treatment preference of phase-oriented therapy for Ms. Y ($n = 216$) and Ms. F ($n = 238$)

| | B | S.E | Wald χ^2 | p | Exp(B) | 95% CI Exp(B) |
|---|------|------|---------------|------|--------|---------------|
| Ms. Y | | | | | | |
| Diagnosis of PTSD with some vs. prominent dissociative symptoms | 2.05 | 1.04 | 3.89 | .04* | 7.75 | [1.01, 59.28] |
| PTSD treatment experience | .21 | .20 | 1.17 | .28 | 1.23 | [.84, 1.81] |
| Ms. F | | | | | | |
| Diagnosis of PTSD with prominent dissociative symptoms vs. DD | .19 | .22 | .78 | .38 | 1.21 | [.79, 1.86] |
| DID treatment experience | .37 | .22 | 2.84 | .09 | 1.44 | [.94, 2.20] |

* $p < .05$

Negative Treatment Outcomes

Treating PTSD with Exposure Therapy.

Fifty-eight participants (23.87%) reported not observing negative effects during exposure therapy of PTSD and 100 (41.15%) observed at least one case where exposure therapy had a negative effect. Eighty-five participants (34.98%) did not answer the question and were excluded from the analysis. Logistic regression was used to determine the degree to which participants' theoretical orientation (CBT vs. psychodynamic) and experience treating PTSD predicted observed negative effects of exposure therapy.

Controlling for PTSD treatment experience, therapeutic orientation (CBT: $n=68$, 62.39% vs. psychodynamic: $n=41$, 37.61%) significantly predicted observed negative reactions to exposure therapy for PTSD (Table 3). Compared to CBT orientation, therapists with a psychodynamic orientation had 3.63 higher odds of observing negative reactions to exposure therapy. CBT therapists were evenly divided between those who had ($n=33$; 48.50%) and had not ($n=35$; 51.50%) observed negative effects from exposure, while psychodynamic therapists largely reported observing negative effects ($n = 32$, 78.00%), with only 9 (22.00%) describing no negative outcomes during exposure therapy. After controlling for the impact of theoretical orientation, experience in treating PTSD also predicted observed negative outcomes to exposure therapy. Therapists with greater PTSD treatment experience had nearly twice the odds (1.83) of reporting observed negative outcomes from exposure therapy for PTSD.

Treating PTSD with Phase-Oriented Therapy. About half of participants ($n=122$; 50.21%) reported they did not observe a worsening of PTSD with phase-oriented treatment. Fifty-five (22.63%) observed negative effects for this treatment,

and 66 (27.16%) were excluded because they did not answer the question. Controlling for theoretical orientation, experience in treating PTSD significantly predicted observing negative reactions during phase-oriented treatment (Table 3). Participants experienced in treating PTSD had 1.67 higher odds of observing negative reactions from phase-oriented therapy. Theoretical orientation made no unique contribution to this analysis.

In the sensitivity analysis (data available upon request), the same pattern of results was found for exposure and phase-oriented therapy when therapeutic orientation was dichotomized into modalities that favor exposure as a primary intervention for PTSD (CBT, EMDR, energy therapies) vs. those that put less emphasis on (though do not necessarily ignore) exposure (i.e., psychodynamic/analytic, narrative, family systems, and humanistic). An orientation that places less emphasis on exposure ($Wald(1)=8.34, p=.004$) and greater PTSD treatment experience ($Wald(1)=7.87, p=.005$) predicted observed negative effects from exposure therapy. For phase-oriented therapy, PTSD treatment experience, but not orientation, predicted observation of negative outcomes. Respondents with more PTSD treatment experience were significantly more likely to report negative therapeutic reactions during phase-oriented treatment ($Wald(1)=4.21, p=.04$).

There was a significant positive correlation between observation of negative effects during exposure and phase-oriented therapy, $r(142)=.33; p<.001$. Given that greater PTSD treatment experience predicted observed negative outcomes in both forms of therapy, chi-square analysis was conducted to determine whether treatment experience [dichotomized into those who had treated fewer ($n=28$) or more ($n=130$) than 10 PTSD patients] was related to observed negative reactions to exposure and phase-oriented therapy.

Table 3: Theoretical orientation and PTSD treatment experience as predictors of observed negative outcomes from exposure ($n=109$) and phase-oriented ($n=112$) therapy

| | B | SE | Wald χ^2 | p | Exp(B) | 95% CI Exp(B) |
|--|-------|-----|---------------|--------|--------|---------------|
| Negative effects from exposure therapy | | | | | | |
| Theoretical orientation (CBT vs. Dynamic) | -1.29 | .46 | 7.76 | .005** | 3.63 | [1.47, 8.97] |
| PTSD treatment experience | .60 | .24 | 6.31 | .012* | 1.83 | [1.14, 2.92] |
| Negative effects from phase-oriented therapy | | | | | | |
| Theoretical orientation (CBT vs. Dynamic) | -.08 | .42 | .04 | .85 | .92 | [.41, 2.10] |
| PTSD treatment experience | .51 | .25 | 4.22 | .04* | 1.67 | [1.02, 2.72] |

* $p < .05$; ** $p < .01$

For exposure therapy, experienced therapists were proportionally more likely to report observed negative reactions ($n=90$; 69%) than not ($n=40$; 31%). Less-experienced therapists showed the opposite pattern, with more reporting no ill effects of exposure ($n=18$; 64%) than negative effects ($n=10$; 36%), $\chi^2(1, n=158)=11.14$; $p=.001$. The effect was less dramatic for phase-oriented therapy, but a higher proportion of more-experienced therapists observed negative effects during phased

interventions (yes=49, 35%; no=93, 65%) than did less-experienced therapists (yes=6, 17%; no=29, 83%), $\chi^2(1, n=177)=3.95, p=.047$.

Discussion

Participants who diagnosed the PTSD case of Ms. Y as having more dissociative symptoms were more likely to recommend phase-oriented treatment, regardless of their experience treating PTSD. Degree of experience may have mattered less for this sample of clinicians because they were generally experienced in treating PTSD and dissociative disorders. Their practice-based experience seems to have sensitized them to the importance of a broad range of dissociative symptoms, and appears to have been an indicator for phased treatment. Although all participants diagnosed Ms. F as having marked dissociative symptoms, they disagreed on the exact diagnosis (PTSD with prominent dissociative symptoms vs. DD). After adjusting for level of clinician experience in treating DID, however, this diagnostic distinction was unrelated to the selection of phased treatment. This suggests that once a marked degree of dissociation was noted, respondents favored phased approaches regardless of the diagnosis given.

Although empirically supported treatments exist for PTSD (NICE, 2005; VA/DOD, 2010), the condition remains difficult to treat. While our sample of experienced therapists reported observing more detrimental outcomes for exposure than for phase-oriented treatment, they were more likely to report observed negative effects in both types of therapy compared to less experienced therapists. Moreover, the correlational analyses showed that therapists who reported negative outcomes for one type of intervention were more likely to report negative effects for the other. The finding that more years of experience treating PTSD predicted greater awareness of negative reactions may be due to more experience with complex cases over time (and

thus greater likelihood of unfavorable outcomes regardless of treatment approach or theoretical orientation). This finding may also reflect that experienced therapists are better able to look for and actively assess negative effects, whereas less experienced therapists may be less aware of negative effects, have reduced ability to accurately assess them, or attribute them to something other than therapy. Given that our sample was generally quite experienced in treating PTSD, these findings require replication in a sample of clinicians with a wider *range* of experience with trauma-related disorders.

While CBT therapists reported an equal likelihood of observing or not observing negative effects from exposure, psychodynamic therapists were much more likely to report negative effects from exposure. Exposure therapy in the form practiced in many PTSD outcome studies is a fundamental CBT technique, but less central to psychodynamic therapy. It is possible that psychodynamic therapists may have less comfort and experience with exposure therapy. They may thus be more likely to observe negative effects when applying exposure-type interventions themselves, or observing them in other therapists (e.g., in supervision), or to attribute negative complications to the exposure therapy conducted by another clinician, due to a relative lack of expertise. While any negative attitudes towards exposure may have biased psychodynamic therapists towards seeing more harm in this method (i.e., allegiance effects may have influenced awareness and/or reporting of negative outcomes), it is equally possible that a CBT therapist's preference for exposure reduces the likelihood of acknowledging negative outcomes of this technique. Future work should examine the experiences, motivations, and reasons for observing and reporting negative effects when treating PTSD with exposure therapy among therapists of both theoretical orientations.

Therapist decision making regarding treatment choice for those presenting with trauma disorders rests on a complex set of factors including training, experience, and the identification of particular symptoms that may promote, or raise flags for, specific interventions. Dissociation appeared as one flag in this sample that pointed clinicians towards phase-oriented therapy. Yet some studies, although potentially lacking etiological validity (e.g., see critiques by Cloitre, Petkova et al., 2012; Yehuda & Hoge, 2016), suggest that dissociation may not have a negative impact on the use of exposure therapy in all cases (e.g., Halvorsen et al., 2014; Resick et al., 2012), although dissociation that occurs during treatment sessions is associated with worse outcome for trauma-adapted dialectical behaviour therapy (Kleindienst et al., 2016). Key empirical questions need further exploration. First, what manifestations of dissociation, or variables associated with it, seem to reduce the benefits of exposure (at least in some cases) as a treatment for PTSD? Second, is exposure as effective in treating dissociation as other PTSD symptoms? Studies that compare treatment approaches and associated outcomes for childhood trauma versus adult-onset trauma are also required, as the two cohorts may respond differently to the same treatment. In the current study, both vignettes referred to childhood trauma with differing degrees of dissociative symptoms. Had one of the vignettes depicted adult-onset trauma, greater variation in treatment approach (exposure vs. phased) may have been evident. Given that dissociation is more likely after early-onset than adult-onset trauma (Brand & Loewenstein, 2010), therapists may be more likely to prefer exposure therapy for adult-onset trauma and phased treatment for childhood relational trauma, notwithstanding the presence of dissociative symptoms. Such preferences, and their relationship to clinical outcome studies, require further investigation. Finally, the explanation for why more experienced therapists preferred phase-oriented therapy for

dissociation requires attention. The results suggest the possibility that experience might bring more detection of negative treatment outcomes, which may in turn promote a more measured therapeutic approach. It is also possible that more experienced therapists have been trained to use phase-oriented therapy for dissociation, which has traditionally reflected clinical wisdom for people presenting this problem, especially in more severe forms.

Our findings also raise the critical question of how clinicians can best predict and prevent worsening among individuals with dissociative symptoms during trauma treatment. In the only systematic assessment of deterioration among patients with dissociative disorders, factors predictive of diminished functioning while undergoing treatment included revictimization, patient difficulty in establishing trust with the treatment team, and high levels of stress (Myrick, Brand & Putnam, 2013). In this naturalistic study of predominantly phase-oriented treatment, the percentage of dissociative disorder patients who worsened was lower (9-14%, depending on when the assessment was taken; Myrick et al., 2013) than found in some trials of exposure therapy for chronic PTSD (25%; Tarrrier et al., 1999). Patients who dissociate during treatment sessions are less likely to have a good response to treatment, so state dissociation should be assessed as a moderator of treatment outcome (Kleindienst et al., 2016). A more recent study of exposure therapy with 1,931 veterans revealed that 10% dropped out of treatment because exposure increased their distress (Eftekhari, Ruzek, Crowley, Rosen, Greenbaum & Karlin, 2013). Thus, levels of distress should be monitored closely in treatment regardless of whether exposure or phased therapy is used, particularly when dissociation is evident.

This study is limited in that the sample comprised relatively experienced clinicians, as well as many who did not answer all questions. We were unable to

examine which aspects of phase-oriented therapy were responsible for the reported negative outcomes, and whether this was associated with exposure (i.e., exposure given before sufficient stabilization had been achieved). Similarly, we did not assess which aspects of exposure therapy were involved in the reported negative effects; and whether perceptions of patient deterioration were associated with lack of experience and/or training, a poor working alliance, misdiagnosis of the problem, or other factors external to treatment (such as acute trauma or severe stressors). Nor did we examine whether the observed deterioration was transient with subsequent improvement or more enduring. For example, some clients may cease therapy after worsening while others may persist with the treatment and work through the setback to an eventual positive outcome. Future work should examine therapist, patient, relationship, and technical (e.g., adequate administration of the appropriate technique) factors that may predict negative outcomes in PTSD treatment. In addition, future work should specifically examine what constitutes a negative therapeutic effect for different therapists (e.g., suicidality, self-harm, increased alcohol and drug use, hospitalization). Such work should examine the threshold of deterioration needed before it is noted by therapists, and explore the degree to which therapy, events in the patient's life or a combination of the two contribute to the negative effect.

In summary, our findings suggest that experienced clinicians tend to prefer phase-oriented treatment over exposure therapy or symptom management for dissociative trauma patients. Clinicians' experience treating PTSD appears to heighten awareness of negative effects for both treatment approaches, although they reported more awareness of worsening with exposure treatment if their orientation was psychodynamic. Practice-based evidence derived from the experiences of relatively seasoned therapists provides valuable insights into the treatment of

posttraumatic disorders both with complex dissociative features and more routine dissociative symptoms.

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Supplemental material

Ms Y

Ms Y is 38 years old. She describes experiencing distressing memories of childhood trauma coming back to her 'out of the blue' and in a way she can't control. When this occurs she sometimes feels transported back in time as if she was reliving the event. At other times she finds it hard to remember distressing events from her past, as if they have been taken from her mind. When reminded of these events, she becomes very anxious and her heart starts to pound, her breathing becomes shallow and her muscles tense. Wherever possible she tries not to think about painful events from her past, and tries to push feelings away such that she is often numb and restricted emotionally to feeling quite flat and detached. Due to her disturbing symptoms she has stopped working but has been able to maintain some close emotional connections, which she feels are a support to her. However, she often feels an inability to enjoy herself when with close friends and loved ones. She describes difficulty sleeping, in part because she fears she may have bad dreams associated with her past that cause her to wake in a frightened state. When not numb and detached, she is often overwhelmed with feelings, and experiences a heightened awareness of potential danger in her environment. It is often difficult for her to calm down after being surprised by something that caught her off guard. Concentration problems and irritability have become problematic, such that she feels her behaviour can be unpredictable. Others have also commented that she can be short tempered when stressed. She reports no other major symptoms or difficulties.

Ms F

Ms F is a 39 year old single woman. She describes difficulty keeping her emotions on an even level and often resorts to harming herself or engaging in risky behaviours to help her manage overwhelming feelings. She uses behaviours such as cutting to assist herself when she feels detached from her body or as if she cannot control her thoughts or actions. She reports losing track of time and finding herself in places without recalling how she got there. Although she knows she experienced childhood trauma, memories of traumatic experiences are difficult to access, even when she tries to recall them. At times she hears voices commenting on her actions; these voices seem different from her own thoughts and do not seem to be hers. She often forgets interacting with family members and they have told her she sometimes has dramatic changes in her behaviour, for which she has little awareness. She is plagued by persistent shame, believing she is worthless and at fault for having been traumatized. She often believes life is not worth living. Sometimes she experiences intense pain in her body for which doctors can find no physical cause. At other times she reports being unable to feel sensations in her body, as if anesthetized. In order to keep herself safe from further harm, she tends to avoid interpersonal relationships, and distances herself if relationships begin to deepen. At least once per week, she perceives her environment in a distorted manner which makes it seem unreal or unrecognizable. At these times, she often reports feeling profoundly confused about who she really is and feels detached from her body and the world around her.