Psychological Trauma: Theory, Research, Practice, and Policy

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A Randomized Controlled Trial Assists Individuals With Complex Trauma and Dissociation in *Finding Solid Ground*

Bethany L. Brand[1], Hygge J. Schielke[2, 3], Karen Putnam[4], Nicholas A. Pierorazio[5], M. Shae Nester[6], Jerrica Robertson[1], Amie C. Myrick[7], Richard J. Loewenstein[8], Frank W. Putnam[4], Kathy Steele[9], Suzette Boon[10], and Ruth A. Lanius[3, 11]

[1] Department of Psychology, Towson University
[2] Traumatic Stress Injury and Concurrent Program, Homewood Health, Guelph, Ontario, Canada
[3] Homewood Research Institute, Guelph, Ontario, Canada
[4] Department of Psychiatry, University of North Carolina, Chapel Hill
[5] Department of Psychology, University of Massachusetts Boston
[6] Department of Psychology, University of North Carolina, Greensboro
[7] New Phase Counseling and Consulting, Lutherville, Maryland, United States
[8] Department of Psychiatry, University of Maryland School of Medicine
[9] Metropolitan Psychotherapy Associates, Atlanta, Georgia, United States
[10] Maarssen, The Netherlands
[11] Department of Psychiatry, University of Western Ontario

Objective: Evidence-based treatments are urgently needed for individuals with trauma-related dissociation (TRD), including severe dissociative disorders, the dissociative posttraumatic stress disorder (PTSD) subtype, and complex PTSD (*International Classification of Diseases-10*). TRD is strongly associated with severe trauma, a more refractory treatment course, and high suicidality and nonsuicidal self-injury. We evaluated changes in symptoms and adaptive capacities in individuals with high TRD through participation in an adjunctive online program based on the *Finding Solid Ground* (FSG) psychoeducational program. ***Method:*** We provide an interim report on an ongoing, randomized controlled trial of FSG on an international sample of 291 outpatients with dissociative identity disorder, dissociative PTSD, other specified dissociative disorders, complex PTSD, or dissociative disorder, unspecified (*International Classification of Diseases-10*). Outpatient therapists continued to provide psychotherapy. Participants were randomly assigned to either receive immediate access to FSG or be on a 6-month waitlist before accessing FSG. We did not exclude for suicidality, nonsuicidal self-injury, recent or concurrent hospitalization, or substance abuse. ***Results:*** Although initially comparable on outcome measures, at 6 months into the study, the Immediate FSG group showed significant improvement in emotion regulation, PTSD symptoms, self-compassion, and adaptive capacities in comparison to the Waitlist group. At 12 months, the Immediate group showed large effect size changes in these areas compared to study entry ($|g|$s = 0.95–1.32). The Waitlist group showed comparable improvements after accessing the FSG program for 6 months. ***Conclusions:*** This randomized controlled trial demonstrates that adding FSG to psychotherapy of individuals with TRD results in improvements in emotion regulation, PTSD symptoms, self-compassion, and adaptive functioning.

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Bethany L. Brand https://orcid.org/0000-0003-0377-2770
Frank W. Putnam https://orcid.org/0000-0003-3594-2113

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Bethany L. Brand played a lead role in funding acquisition, writing–original draft, and writing–review and editing, a supporting role in project administration, and an equal role in conceptualization, investigation, methodology, resources, and supervision. Hygge J. Schielke played a lead role in software, a supporting role in writing–review and editing, and an equal role in conceptualization, investigation, methodology, resources, and supervision. Karen Putnam played a lead role in formal analysis and visualization and a supporting role in methodology. Nicholas A. Pierorazio played a lead role in data curation, a supporting role in writing–original draft and writing–review and editing, and an equal role in project administration and visualization. M. Shae Nester played a supporting role in writing–original draft and writing–review and editing and an equal role in data

continued

Clinical Impact Statement

In a randomized controlled trial, we demonstrated that adjunctive symptom stabilization psychoeducation using the *Finding Solid Ground* program is associated with improvements in emotion regulation, posttraumatic stress disorder symptoms, self-compassion, and adaptive capacities in individuals in treatment for trauma-related dissociation. A major strength of this study is inclusion of patients with severe dissociative and posttraumatic stress disorder symptoms, comorbid conditions (e.g., substance use), nonsuicidal self-injury and suicidality, and recent or concurrent hospitalization that result in exclusion from most treatment outcome studies.

Keywords: dissociation, dissociative identity disorder, posttraumatic stress disorder, complex trauma, randomized controlled trial

Supplemental materials: https://doi.org/10.1037/tra0001871.supp

Prospective and retrospective cross-cultural studies in clinical and general population samples of children, adolescents, and adults find that dissociation is a partially genetically mediated, transdiagnostic psychobiological process related to trauma (American Psychiatric Association, 2022; Loewenstein, 2018). Studies demonstrate that high levels of dissociation are linked to multiple types of severe trauma, most commonly childhood maltreatment and/or neglect. Dissociation is associated with earlier age of onset, greater severity, and longer duration of maltreatment and, particularly, maltreatment by primary attachment figures (Dutra et al., 2009; Lyssenko et al., 2018; Vonderlin et al., 2018). The *Diagnostic and Statistical Manual of Mental Disorders, fifth edition, text revision* dissociative disorders (DDs) are strongly linked to antecedent trauma, particularly the most symptomatically severe and complex DDs (CDDs), dissociative identity disorder (DID), and other specified dissociative disorders, Example 1 (OSDD-1; Brand, 2023).[1] Other disorders with high levels of dissociation include the dissociative subtype of posttraumatic stress disorder (PTSD [DPTSD]) and complex PTSD (CPTSD). A meta-analysis of clinical samples of PTSD found DPTSD in 42% of adults and 63% of children (White et al., 2022). A recent scoping review found that dissociation is comorbid among up to 76.9% of individuals in a subgroup of CPTSD (Fung et al., 2023). Severe dissociation is common. In a representative sample of 6,644 adults in the United States National Comorbidity Survey Replication, the 1-month prevalence of a severe DD was 4.1%, with a 1.5% 1-month prevalence of DID (Simeon & Putnam, 2022). In a study of 25,018 individuals from 16 low-, medium-, and high-income countries, the 12-month prevalence of PTSD was 1.9%, with 14.4% of those with PTSD meeting criteria for DPTSD (Stein et al., 2013).

Individuals with severe dissociation commonly experience physical and mental health challenges, extensive comorbidity (e.g., PTSD and major depressive disorder), and high rates of psychiatric hospitalization (Simeon & Putnam, 2022). Dissociative symptoms are linked with functional impairment (Tanner et al., 2019) and role impairment (Stein et al., 2013). Vulnerability to emotional dysregulation in this population also contributes significantly to high rates of nonsuicidal self-injury (NSSI) and multiple suicide attempts (Briere et al., 2010; Nester, Brand, et al., 2022). DDs are associated with high health care costs (Langeland et al., 2020), although costs decrease with dissociation-focused treatment (Myrick et al., 2017). Unfortunately, few clinicians receive systematic training in the assessment and treatment of dissociation and DDs (Kumar et al., 2022). This leaves most severely dissociative patients without accurate diagnosis, adequate case conceptualization, or treatment (Nester, Hawkins, & Brand, 2022).

Prospective, naturalistic studies with inpatients and outpatients show that treatment of CDDs consistent with treatment guidelines (International Society for the Study of Trauma and Dissociation, 2011) is associated with improved functioning, decreased symptoms of dissociation and PTSD, reductions in NSSI, and decreased treatment costs (Brand et al., 2009, 2013, 2019; Jepsen et al., 2014; Myrick et al., 2017). However, the sequence and pacing of interventions are crucial. Individuals with CDDs and their therapists report that carefully paced, responsive treatment and psychoeducation about trauma and dissociation are helpful (Pierorazio et al., 2024). The importance of pacing is also emphasized by the authors of the only randomized controlled trial (RCT) to date for CDD, who speculated that the lack of symptom improvement in their 20-week group psychoeducation study was due to participants requiring more gradual exposure to emotionally laden topics and longer stabilization (Bækkelund et al., 2022).

Given the high degree of clinical, psychosocial, and economic burden associated with CDDs and disorders with high trauma-related

[1] There are four clinical examples in the *Diagnostic and Statistical Manual of Mental Disorders, fifth edition, text revision* OSDD category. Example 1 delineates individuals similar to those who meet criteria for DID, but with less severe subjective discontinuities in sense of self or agency and/or in alterations in sense of self/identity, and/or meet DID diagnostic criteria, except dissociative amnesia is not reported or discerned by the clinician. In the report, "OSDD" will stand for OSDD-1, as the other OSDD examples are unrelated.

curation and project administration. Jerrica Robertson played a supporting role in writing–review and editing and an equal role in data curation, project administration, and visualization. Amie C. Myrick played a supporting role in writing–review and editing. Richard J. Loewenstein played a supporting role in conceptualization, funding acquisition, and writing–review and editing. Frank W. Putnam played a supporting role in conceptualization and writing–review and editing. Kathy Steele played a supporting role in writing–review and editing. Suzette Boon played a supporting role in conceptualization. Ruth A. Lanius played a supporting role in funding acquisition, methodology, and writing–review and editing and an equal role in conceptualization.

Correspondence concerning this article should be addressed to Bethany L. Brand, Department of Psychology, Towson University, 8000 York Road, Towson, MD 21252, United States. Email: bbrand@towson.edu

dissociation, effective treatments are urgently needed. Informed by the research, expert recommendations, and the need to increase awareness of effective approaches to manage trauma-related dysregulation and dissociation, we developed a web-delivered program focused on psychoeducation and skill-building to assist DD patients and their therapists. Developed with input from people living with dissociation, the first version of this program was provided as part of the Treatment of Patients with Dissociative Disorders (TOP DD) Network study (Brand et al., 2019). This study offered CDD patient–therapist dyads 2-year access to online, adjunctive education delivered through 45 short videos with accompanying written and behavioral practice exercises. TOP DD patients showed significant improvements in emotion regulation and other adaptive capacities, as well as decreased PTSD and dissociative symptoms (Brand et al., 2019), and patients and therapists reported multiple benefits from participating in the study (Myrick et al., 2024; Pierorazio et al., 2024).

In response to feedback from study participants and in-person inpatient groups run by the second author, we then refined the TOP DD Network's educational program into the *Finding Solid Ground* (FSG) program (Brand et al., 2022; H. J. Schielke et al., 2022). The online version of this program consisted of 33 videos accompanied by written and behavioral practice exercises to facilitate patients' understanding and application of the material. This study presents an interim report on an RCT of the online FSG program, comparing the outcomes of 291 individuals with DID, DPTSD, OSDD, CPTSD, or dissociative disorder, unspecified (DDU) who participated in the Immediate Access and Waitlist groups at the 1-year mark.

Method

Procedure

Institutional review board approval (Protocol No. 1438) was obtained through Towson University. Therapists were recruited using social media, purposive sampling within professional networks, and snowball sampling between March 2022 and September 2023. Therapists were asked to invite one patient with clinically diagnosed DID, DPTSD, OSDD, CPTSD, or DDU to participate. Eligible patients were required to (a) be at least 18 years of age; (b) be able to read and understand English at the eighth grade level; (c) have a history of trauma exposure and be able to tolerate general references to topics including trauma, dissociation, safety, and "parts of the self";[2] (d) have reliable internet access; (e) have been in individual therapy with their coenrolling therapist for at least 3 months; (f) remain in treatment with the therapist they enrolled with to remain in the study; (g) be willing to review the study's materials and complete the exercises; and (h) be willing to accept being randomly assigned to either immediate access or a 6-month waitlist.

Therapists and patients completed screening surveys to assess inclusion criteria. Before completing a screening survey, therapist and patient participants were asked to review an online informed consent document and complete a quiz with at least eight out of the 10 questions correct to ensure they understood the informed consent and the study's protocol. If found eligible, they were given access to a study entry survey, which included the outcome measures reported here (see the Measures section). After being matched with another dyad with a similar (within seven points) Dissociative Experiences Scale–II (DES-II; Carlson & Putnam, 1993) score, dyads were randomized to either the immediate FSG access or 6-month waitlist followed by FSG access group condition. Members of both groups continued individual psychotherapy.

Participants completed follow-up surveys every 6 months. Participants in the Immediate group completed 6- and 12-month milestone surveys. Waitlist participants completed an Access Baseline milestone survey when they gained access to FSG and additional surveys after 6 and 12 months of FSG access. (*Note:* Waitlist 12-month FSG access data were not yet available at the time of analyses).

Upon gaining access to the program, participants viewed three brief videos with introductory information to watch at their own pace. Next, they were provided access to the first of the program's 30 topics (see Supplemental Table 1, Brand et al., 2022, and H. J. Schielke et al., 2022). Each topic included a 10–15-min video of the first author presenting the specific segment, a transcript of the video, and a handout with writing and practice activities to facilitate learning and implementation (e.g., creating and using a list of grounding skills). To ensure time to make meaningful use of each topic's materials, participants were required to wait at least 7 days prior to accessing the next topic. To decrease the likelihood of participants becoming overwhelmed due to moving too quickly through the program, we encouraged moving through the materials at an individualized pace. Access to program materials expired 1 year following initial access. See Figure 1 for participant flow through the study.

Participants

Participants included 291 patients. Patients ranged in age from 18 to 75 years old ($M = 39.31$, $SD = 11.54$) and predominantly identified as women (80.28%, $n = 232$) and/or White (72.66%, $n = 210$); see Table 1 for full demographics. Dissociative diagnosis composition was 57.39% DID ($n = 167$), 14.78% DPTSD ($n = 43$), 13.06% OSDD ($n = 38$), 11% CPTSD ($n = 32$), and 3.78% DDU ($n = 11$). Participants lived in 27 countries, including the United States (58.76%, $n = 171$), Canada (10.65%, $n = 31$), Australia (7.56%, $n = 22$), and Norway (5.15%, $n = 15$); see Supplemental Table 2 for the full list of countries. We did not exclude patients based on clinicians' reports of comorbid diagnoses (see Supplemental Table 3), suicidality, recent hospitalization, hospitalization during this study, NSSI, or substance use. See Results for descriptions and comparisons of the Immediate and Waitlist groups.

Measures

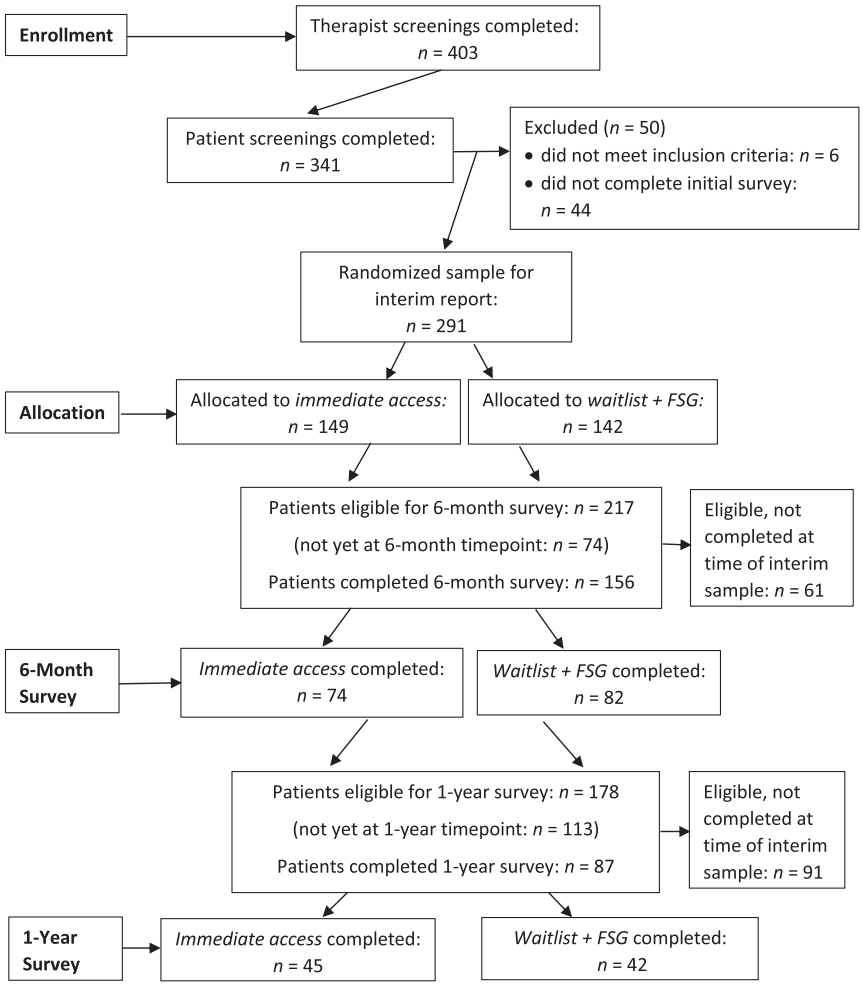
Emotion Dysregulation: Difficulties in Emotion Regulation Scale

The 36 items of the Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) use a 5-point scale ranging from 1

[2] In academic and research writing, we have opined that "self-state" is the most appropriate term to describe the dissociative subjective self-divisions in CDDs (Loewenstein & Brand, 2023). "Parts" is a term of art that many (*but not all*) patients as well as therapists may find to be a helpful shorthand. However, "parts" metaphors for psychological processes tend to reify the self and the mind as physical and mechanical and may too easily reify and concretize self-states as "separate people." The reader should be aware of this issue and avoid the term "parts" in academic and research writing as well as in official patient documents like inpatient/outpatient charts, administrative documents for third parties (e.g., insurance companies), and forensic reports.

Figure 1

Consolidated Standards of Reporting Trials Diagram of Recruitment and Assessments



Note. FSG = *Finding Solid Ground*.

(*almost never/0%–10% of the time*) to 5 (*almost always/91%–100%*) over the last month. Total scores range from 36 to 180; higher scores indicate higher emotion dysregulation. In its development (Gratz & Roemer, 2004), the DERS demonstrated good test–retest reliability, construct validity, and predictive validity. In the present study, internal consistency at initial survey was excellent (Cronbach's $\alpha = .93$).

PTSD Symptoms: PTSD Checklist for Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

The 20 items of the PTSD Checklist for *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (PCL-5; Weathers et al., 2013) use a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*) to assess PTSD symptoms over the last month. Total scores range from 0 to 80, with higher scores indicating greater PTSD symptom severity. In its initial development and validation, the PCL-5 demonstrated strong internal consistency, test–retest reliability, convergent validity, and discriminant validity (Blevins et al., 2015). In the present study, Cronbach's α at initial survey was .89, indicating good internal consistency.

Dissociation: Dissociative Experiences Scale–II

The 28 items of the DES-II (Carlson & Putnam, 1993) use an 11-point scale ranging from 0% (*never*) to 100% (*always*). As in the TOP DD Network study (Brand et al., 2019), the time frame was over the last month. Total average scores range from 0 to 100, with higher scores indicating higher dissociation. Initial development of the DES-II indicated good internal reliability, test–retest reliability, and construct validity (Carlson & Putnam, 1993). In the present study, Cronbach's α for the DES-II at initial survey was excellent (.95). High levels of dissociation are indicated by DES scores of 30 or greater (Carlson & Putnam, 1993).

Self-Compassion: Self-Compassion Scales–Short Form

The 12 items of the Self-Compassion Scales–Short Form (SCS-SF; Raes et al., 2011) use a 5-point scale ranging from 1 (*almost never*) to

Table 1
Patient Demographics and Characteristics at Study Intake

Demographic	Full sample (n = 291)	Immediate access (n = 149)	Waitlist (n = 142)	Difference test
Age				$\chi^2(3) = 0.72$, $p = .868$
18–30 (n, %)	74 (25.43%)	39 (26.17%)	35 (24.65%)	
31–39 (n, %)	83 (29.52%)	43 (28.86%)	40 (28.17%)	
40–48 (n, %)	60 (20.62%)	28 (18.79%)	32 (22.54%)	
49–75 (n, %)	71 (24.40%)	38 (25.50%)	33 (23.24%)	
Gender (n, %)[a]				$\chi^2(4) = 4.83$, $p = .306$
Women	232 (80.28%)	126 (84.56%)	106 (74.65%)	
Men	17 (5.84%)	6 (4.03%)	11 (7.75%)	
Nonbinary[a]	16 (5.50%)	7 (4.70%)	9 (6.34%)	
Binary transgender[b]	7 (2.41%)	4 (2.68%)	3 (2.11%)	
Multiple genders[c]	17 (5.84%)	6 (4.03%)	11 (7.75%)	
Race (n, %)				$\chi^2(4) = 3.71$, $p = .457$[d]
White	210 (72.66%)	105 (70.47%)	105 (73.94%)	
Pacific Islander	18 (6.19%)	10 (6.71)	8 (5.63%)	
Asian	17 (5.84%)	8 (5.37%)	9 (6.34%)	
Latinx	15 (5.15%)	11 (7.38%)	4 (2.82%)	
Black	8 (2.75%)	5 (3.36%)	3 (2.11%)	
Native/Indigenous	6 (2.06%)	3 (2.01%)	3 (2.11%)	
Multiracial	5 (1.72%)	3 (2.01%)	2 (1.41%)	
Other	10 (3.44%)	4 (2.69%)	6 (4.23%)	
Diagnosis (n, %)				$\chi^2(4) = 6.47$ $p = .167$
DID	167 (57.39%)	84 (56.38%)	83 (58.45%)	
OSDD	38 (13.06%)	26 (17.45%)	12 (8.45%)	
Unspecified DD	11 (3.78%)	4 (2.68%)	7 (4.93%)	
DPTSD	43 (14.78%)	21 (14.09%)	22 (15.49%)	
CPTSD	32 (11.00%)	14 (9.40%)	18 (12.68%)	
History of NSSI (n, %)	116 (39.86%)	58 (38.93%)	58 (40.85%)	$\chi^2(1) = 0.09$ $p = .769$
History of hospitalizations (n, %)	37 (12.72%)	18 (12.08%)	19 (13.38%)	$\chi^2(1) = 0.11$ $p = .738$

Note. DID = dissociative identity disorder; OSDD = other specified dissociative disorders; DD = dissociative disorders; DPTSD = posttraumatic stress disorder, dissociative subtype; CPTSD = complex posttraumatic stress disorder; NSSI = nonsuicidal self-injury. [a] Includes individuals who endorsed being nonbinary and/or transgender and nonbinary. [b] Includes individuals who endorsed being transgender and/or transgender and one binary gender of man or woman. [c] Includes individuals who endorsed two or more genders (i.e., man, woman, nonbinary, other). [d] For the sake of the chi-square analysis for the difference test for race, we aggregated Native/Indigenous, Multiracial, and "Other"; this was determined by aggregating groups that had less than five participants in both conditions.

5 (*almost always*). An example item is "I try to be understanding and patient toward those aspects of my personality I don't like." Total average scores are calculated after reverse scoring relevant items; higher scores indicate greater self-compassion. The SCS-SF demonstrated good internal consistency and convergent validity with its long form (Raes et al., 2011). In the present study, internal consistency for the SCS-SF was good at initial survey (Cronbach's $\alpha = .85$).

Adaptive Capacities: Progress in Treatment Questionnaire–Patient Version

The 32 items of the Progress in Treatment Questionnaire–Patient Version (PITQ-p; H. Schielke et al., 2017) measure how often an individual used adaptive capacities in the last week such as healthily managing dissociation-related symptoms; they are scored on an 11-point scale (0%–100% of the time). We averaged Items 1–26 which ranged from 0 to 100; we excluded Items 27–32 because they only apply to individuals with dissociated self-states. Higher scores indicate greater adaptive capacities. The PITQ-p demonstrated good internal consistency, test–retest reliability, and convergent validity (H. Schielke et al., 2017). Cronbach's α at initial survey in this study was .90.

Nonsuicidal Self-Injury

As in the TOP DD Network study (Brand et al., 2019), one item was used to assess recent NSSI frequency: "On how many of the PAST 30 DAYS did you purposefully hurt yourself (e.g., cut yourself)?" Participants typed a number into an open textbox. Two participants indicated a negative value; these responses were excluded from relevant analyses.

Data Analysis Plan

We assessed normality and outliers across the baseline demographic and outcome variables for the full sample (N = 291) and compared Immediate and Waitlist group study entry characteristics using t tests. Combination charts presented in Supplemental Figures 1–5 present box plots and distribution graphs for the DERS, PCL-5, DES-II, SCS-SF, and PITQ-p. Proportions were compared by

chi-square analyses for age, gender, race, diagnosis, NSSI, and the outcome measures (DERS, PCL-5, DES-II, SCS-SF, and PITQ-p). For these interim analyses, program benefits were assessed using a mixed-model approach. Advantages of Statistical Analysis System Proc Mixed are that it allows all the data collected to this point to be utilized in the analyses and different covariance patterns can be applied to select the best fitting model.

Repeated measures (one between groups, one within time) were conducted applying three different covariance structures (compound symmetry, autoregressive, and unstructured) to determine the best model using the fit statistics of Akaike information criterion, Akaike information criterion corrected, and Bayesian information criterion as criteria. Residual (or restricted) maximum likelihood method for estimation of the model parameters was used. The covariance structure of compound symmetry corresponded to the best model fit across the majority of outcome variables. Models that utilize compound symmetry have a common variance and covariance across all the repeated observations for the same subject. Least squared means examined differences using Bonferroni corrections for the significant Group × Time and main level effects for outcome variables. Hedges' g effect sizes were computed to estimate the magnitude of effects. (For additional information, please see the Supplemental Materials).

Results

Table 1 shows the descriptive demographics for the entire sample and the Immediate and Waitlist groups. There were no significant differences between the Immediate (51.20%, $n = 149$) and Waitlist (48.80%, $n = 142$) groups for age, gender, race/ethnicity, primary diagnoses, NSSI history, or hospitalization history; the seven-participant difference in group sizes reflects the result of rolling admission to the study. Notably, 72% of both groups scored over 30 points on the DES-II, indicating high levels of dissociation in both groups. Supplemental Table 4 contains means and standard deviations for the outcome variables for the entire sample and by intervention group and time. Mixed models produced the omnibus F test for each outcome examining the main level effects of group and time, as well as the interaction effects.

Group × Time interaction effects were significant for the DERS, $F(2, 239) = 8.96$, $p < .001$; PCL-5, $F(2, 236) = 7.83$, $p < .001$; SCS-SF, $F(2, 232) = 11.57$, $p < .001$; and PITQ-p, $F(2, 232) = 9.78$, $p < .001$. Figure 2 and Supplemental Figures 6–9 illustrate these improvements over time for both groups, with the Immediate group showing benefit in the first 6 months and the Waitlist group benefitting once exposed to FSG for 6 months.

Significant interactions between Group × Time on the DERS, PCL-5, SCS-SF, and PITQ-p allowed deeper examination into group differences. In this interim sample, although DES-II scores significantly differed across time, $F(2, 181) = 47.6$, $p < .001$, neither group nor interaction effects, $F(2, 181) = 1.53$, $p = .220$, were significant. DES-II main level effects for group had an F statistic less than one, indicating there was more variance within the groups than between the groups, $F(1, 210) = 0.36$, $p = .550$. Similarly, Supplemental Table 4 illustrates the DES-II standard deviations were close to half the DES-II mean values. As a result, the DES-II was not eligible for inclusion in the group comparison analyses.

Table 2 shows Bonferroni post hoc comparisons of progress over time within and between the Immediate and Waitlist groups in the form of means and t tests, as well as effect sizes calculated using Hedges' g. Effect sizes are interpreted following Cohen's (1988) traditional cut points for small (0.20), medium (0.50), and large (0.80) effects.

Within-group comparisons included (a) Immediate at Access Baseline versus after 6 months' access; (b) Immediate at Access Baseline versus after a year's access; (c) Immediate after 6 months' access versus after a year's access; (d) Waitlist at Study Entry versus their Access Baseline (i.e., after 6 months' treatment as usual [TAU]); and (e) Waitlist at Access Baseline versus after 6 months' FSG access.

Between-group comparisons included (a) Immediate at Access Baseline (which, for them, was at study entry) versus Waitlist at Study Entry (to compare the groups at study intake); (b) Immediate at Access Baseline versus Waitlist at Access Baseline (comparing the groups at the point of FSG access); (c) Immediate after 6 months' access to FSG versus Waitlist at their Access Baseline (comparing 6 months' access to FSG vs. 6 months' TAU); (d) Immediate after 6 months' access versus Waitlist after 6 months' access (comparing the groups after each has had 6 months' FSG access); and (e) Immediate after 1 year's access versus Waitlist after 6 months' access (comparing the groups' progress at these timepoints).

Study Intake and Baseline Comparisons Between and Within Groups

As reported in Table 2, there were no significant differences between the Immediate and Waitlist groups' DERS, PCL-5, SCS-SF, or PITQ-p mean scores at study intake. Within the Waitlist group, no significant differences were found in the group's DERS, PCL-5, SCS-SF, or PITQ-p when reassessed after 6 months (at the Waitlist Access Baseline), indicating that these outcomes did not change during 6 months of TAU. In addition, the Waitlist group Access Baseline means did not differ from the Immediate group Access Baseline means for the DERS, PCL-5, SCS-SF, or PITQ-p.

Immediate Group at 6 Months and 1 Year

With 6 months of access to FSG, the Immediate group showed improvements at the medium effect size level for the DERS ($g = 0.72$), PCL-5 ($g = 0.57$), SCS-SF ($g = 0.69$), and PITQ-p ($g = 0.58$) compared to their Access Baseline. The within-group comparison for the Immediate group after 1 year of access to FSG revealed large effect size level improvements for the DERS ($g = 1.32$), PCL-5 ($g = 1.20$), SCS-SF ($g = 0.98$), and PITQ-p ($g = 0.95$) when compared to their Access Baseline.

FSG Versus Waitlist TAU at 6 Months

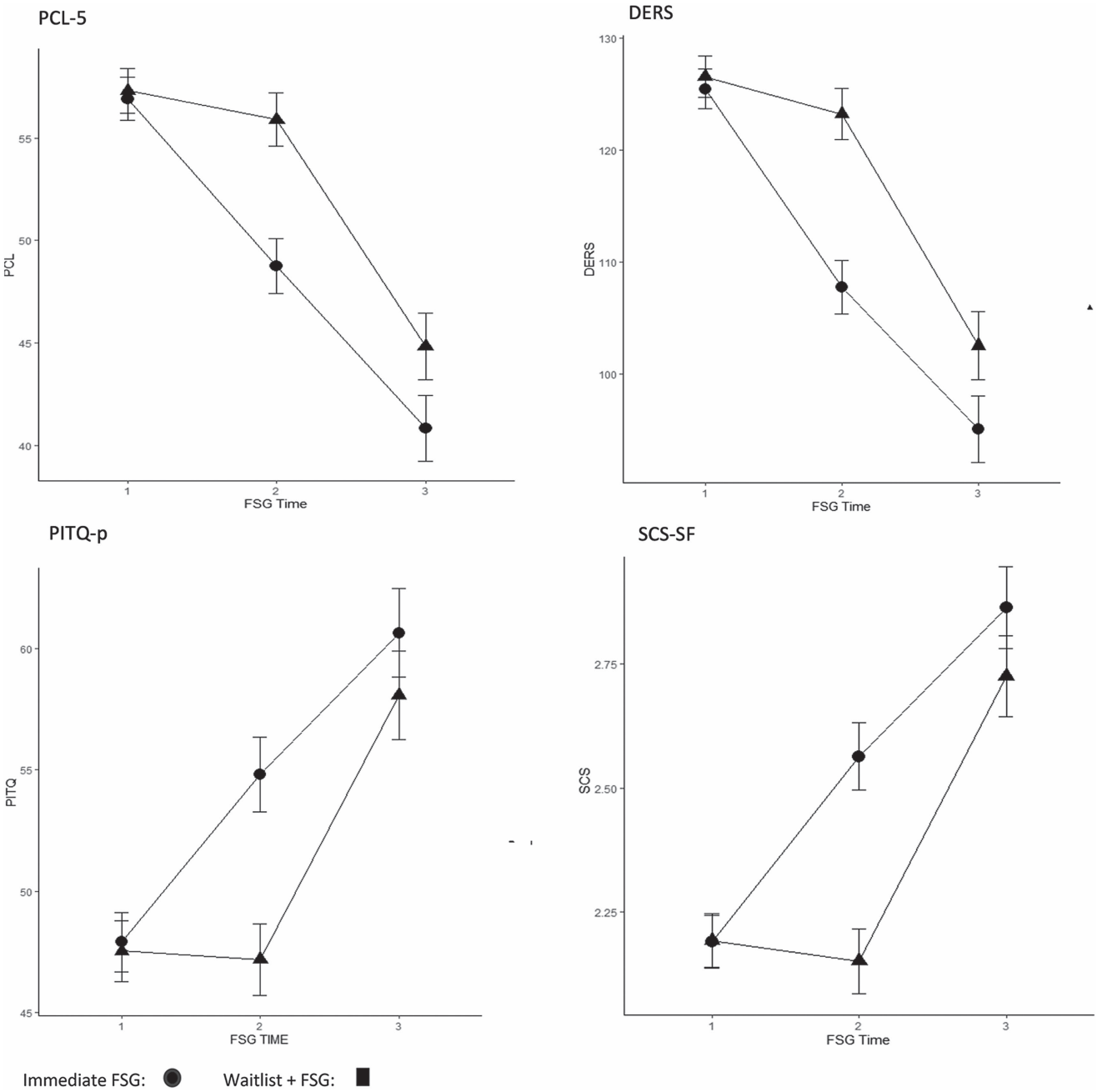
Compared to the Waitlist group at their Access Baseline (i.e., after 6 months of TAU), the Immediate group showed medium level effect size improvements for the DERS ($g = 0.71$), PCL-5 ($g = 0.62$), SCS-SF ($g = 0.63$), and PITQ-p ($g = 0.54$) after 6 months of FSG access.

Waitlist Group After 6 Months' Access to FSG

Comparisons of the Waitlist group's Access Baseline and 6-month access milestones showed medium effect size level

Figure 2

Line Graphs of Outcomes by Group Over Time



Note. Mixed-model LSMeans over time. FSG time for the Immediate group (circles): Time 1 = Access Baseline; Time 2 = 6 months' access; Time 3 = 12 months' access. FSG time for the Waitlist + FSG group (triangles): Time 1 = Study Entry; Time 2 = Access Baseline; Time 3 = 6 months' access. PCL-5 = PTSD Checklist for *DSM-5* (Weathers et al., 2013); DERS = Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004); PITQ-p = Progress in Treatment Questionnaire–Patient Version (H. Schielke et al., 2017); SCS-SF = Self-Compassion Scales–Short Form (Raes et al., 2011); FSG = *Finding Solid Ground*; PTSD = posttraumatic stress disorder; *DSM-5* = *Diagnostic and Statistical Manual of Mental Disorders, fifth edition*; LSMeans = least squares means.

improvements for the DERS ($g = 0.62$) and large effect size level improvements for the PCL-5 ($g = 1.18$), SCS-SF ($g = 0.98$), and PITQ-p ($g = 0.92$), indicating that the Waitlist group also demonstrated significant improvements with 6 months of FSG access.

Immediate at 1 Year Compared to Immediate at 6 Months

Within-group comparisons for the Immediate group at 6 months versus 1 year showed a large effect size level improvement for the

Table 2
Within- and Between-Group Comparisons of Progress Over Time

Measure	Level	Group	FSG T1 to T2	T1 *M* (*SD*)	T2 *M* (*SD*)	*t*	Adjusted *p*	Effect size
DERS	Within	Immediate	AB to 6mo	125.49 (22.20)	107.24 (22.11)	7.23	<.0001	0.72
			AB to 12mo	125.49 (22.20)	94.49 (24.87)	10.16	<.0001	1.32
			6mo to 12mo	107.24 (22.11)	94.49 (24.87)	4.04	.0011	0.80
		Waitlist	SE to AB	126.57 (21.31)	122.18 (22.19)	1.41	NS	0.13
			AB to 6mo	102.31 (23.59)	102.31 (23.59)	6.49	<.0001	0.62
	Between	Imm versus Wait	AB to SE	125.49 (22.20)	126.57 (21.31)	−0.42	NS	0.04
			AB to AB	125.49 (22.20)	122.18 (22.19)	0.76	NS	0.12
			6mo to AB	107.24 (22.11)	122.18 (22.19)	−4.63	<.0001	0.71
			6mo to 6mo	107.24 (22.11)	102.31 (23.59)	1.35	NS	0.21
			12mo to 6mo	94.49 (24.87)	102.31 (23.59)	−1.76	NS	0.32
PCL-5	Within	Immediate	AB to 6mo	56.90 (12.60)	48.36 (14.69)	6.62	<.0001	0.57
			AB to 12mo	56.90 (12.60)	40.50 (17.02)	10.66	<.0001	1.20
			6mo to 12mo	48.36 (14.69)	40.50 (17.02)	5.07	<.0001	0.89
		Waitlist	SE to AB	57.30 (11.47)	56.54 (11.30)	1.21	NS	0.20
			AB to 6mo	56.54 (11.30)	46.71 (14.25)	7.04	<.0001	1.18
	Between	Imm versus Wait	AB to *SE*	56.90 (12.60)	57.30 (11.47)	−0.27	NS	0.03
			AB to AB	56.90 (12.60)	56.54 (11.30)	0.61	NS	0.03
			6mo to AB	48.36 (14.69)	56.54 (11.30)	−3.81	.0026	0.62
			6mo to 6mo	48.36 (14.69)	46.71 (14.25)	1.87	NS	0.11
			12mo to 6mo	40.50 (17.02)	46.71 (14.25)	−1.75	NS	0.18
SCS-SF	Within	Immediate	AB to 6mo	2.19 (0.61)	2.54 (0.62)	−5.93	<.0001	0.69
			AB to 12mo	2.19 (0.61)	2.86 (0.72)	−8.64	<.0001	0.98
			6mo to 12mo	2.54 (0.62)	2.86 (0.72)	−3.72	0.0038	0.66
		Waitlist	SE to AB	2.19 (0.67)	2.16 (0.59)	0.7	NS	0.10
			AB to 6mo	2.16 (0.59)	2.75 (0.76)	−7.22	<.0001	0.98
	Between	Imm versus Wait	AB to SE	2.19 (0.61)	2.19 (0.67)	−0.03	NS	0.00
			AB to AB	2.19 (0.61)	2.16 (0.59)	0.47	NS	0.05
			6mo to AB	2.54 (0.62)	2.16 (0.59)	4.37	.0003	0.63
			6mo to 6mo	2.54 (0.62)	2.75 (0.76)	−1.52	NS	0.30
			12mo to 6mo	2.86 (0.72)	2.75 (0.76)	1.19	NS	0.17
PITQ-p	Within	Immediate	AB to 6mo	47.92 (13.97)	55.18 (15.68)	−5.13	.0149	0.58
			AB to 12mo	47.92 (13.97)	61.10 (18.97)	−7.69	<.0001	0.95
			6mo to 12mo	55.18 (15.68)	61.10 (18.97)	−3.43	.0109	0.66
		Waitlist	SE to AB	47.55 (14.44)	47.04 (14.16)	0.28	NS	0.02
			AB to 6mo	47.04 (14.16)	58.18 (17.64)	−6.46	.0021	0.92
	Between	Imm versus Wait	AB to SE	47.92 (13.97)	47.55 (14.44)	0.21	NS	0.03
			AB to AB	47.92 (13.97)	47.04 (14.16)	0.38	NS	0.06
			6mo to AB	55.18 (15.68)	47.04 (14.16)	3.57	.016	0.54
			6mo to 6mo	55.18 (15.68)	58.18 (17.64)	−1.38	NS	0.18
			12mo to 6mo	61.10 (18.97)	58.18 (17.64)	1.00	NS	0.16

Note. Imm versus Wait = comparison of Immediate versus Waitlist groups. Intervals: AB = Access Baseline; SE = Study Entry; 6mo = 6 months of access to FSG; 12mo = 12 months of access to FSG. FSG = *Finding Solid Ground*; T1 = time 1; T2 = time 2; DERS = Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004); NS = nonsignificant; PCL-5 = PTSD Checklist for *DSM-5* (Weathers et al., 2013); SCS-SF = Self-Compassion Scales–Short Form (Raes et al., 2011); PITQ-p = Progress in Treatment Questionnaire–Patient Version (H. Schielke et al., 2017). DES-II did not have a Group × Time interaction, so was not eligible for inclusion in these analyses. Effect sizes were calculated using Hedges' *g*. PTSD = posttraumatic stress disorder; DSM-5 = *Diagnostic and Statistical Manual of Mental Disorders, fifth edition*; DES-II = Dissociative Experiences Scale–II.

DERS ($g = 0.80$) and PCL-5 ($g = 0.89$) and a medium level effect size for the SCS-SF ($g = 0.66$) and PITQ-p ($g = 0.66$).

Immediate at 1 Year Versus Waitlist After 6 Months of FSG

The between-group comparisons for the Immediate group at 1 year and Waitlist group after 6 months of FSG access were nonsignificant for the DERS, PCL-5, SCS-SF, and PITQ-p measures.

Topics

The Immediate and Waitlist groups each completed an average of 12.8 topics during their first 6 months of FSG access. (See the Supplemental Materials for further discussion related to topics and Supplemental Figure 10 for a graph of the topics completed by each group). At 1 year, the Immediate group had finished another 8.6 topics, for a total of 21.4 topics in 1 year. Six months of participation in FSG yielded significant improvement of scores across the DERS, PCL-5, SCS-SF, and PITQ-p for both groups, and the Immediate group's additional 6 months of FSG participation yielded continual significant improvement in the DERS, PCL-5, SCS-SF, and PITQ-p.

Discussion

We report interim analyses of the first online RCT of the FSG program for patients with DID, DPTSD, OSDD, CPTSD, and DDU. Participants with immediate access to FSG showed significantly greater improvements in emotion regulation, PTSD symptoms, self-

compassion, and adaptive capacities than those in the waitlist condition before they gained access to FSG. After gaining access to FSG for 6 months, the Waitlist group showed improvements in these domains that were equivalent to those of the Immediate access group's 6-month improvements. With 6 months' access to FSG, the two groups' effect sizes for improvements in emotion regulation, PTSD symptoms, self-compassion, and adaptive capacities ranged from $|g|s = 0.57$ to 1.18, and the effect sizes were large ($|g|s = 0.95$–1.32) for the Immediate group after 1 year of FSG. In this interim sample, the greatest gains happened within the first 6 months of FSG; at the end of the study, we will have larger numbers of patients who have completed the program and, hence, greater power to detect changes.

Notably, our RCT findings show that the addition of the FSG program brought about meaningful improvements for individuals with trauma-related dissociation and that these improvements are attributable to the FSG program, not the effects of time or patients' individual psychotherapy. The strength of these findings is magnified since, unlike most treatment outcome studies of psychotherapy and/or psychopharmacotherapy, we did not exclude individuals with multiple comorbidities, high levels of suicidality, NSSI, substance abuse, and recent or concurrent psychiatric hospitalization, etc. (Brand, 2023; Nester, Brand, et al., 2022; Nester et al., 2023). It is very encouraging to have found significant improvements in so many important functioning-related domains in patients with complex dissociative trauma disorders, multiple comorbidities, and a history of NSSI and hospitalizations. Additionally, patients who did not initially receive the FSG program showed no placebo or other nonspecific responses to the study design, even though they anticipated they would have access to FSG in 6 months.

Although we did not have enough participants with active NSSI in this sample to analyze changes in this variable, individuals with CDDs report that activation of PTSD symptoms and intense emotions—particularly shame—are among the most frequent and important determinants for NSSI (Dorahy et al., 2015; Nester, Boi, et al., 2022). The FSG program led to significant reductions in PTSD symptoms and significant increases in capacities for emotional regulation and for self-compassion—critical factors in ameliorating these patients' chronic safety struggles. Interventions that increase self-compassion lower shame and decrease risk for multiple pathologies, including depression (Tirch & Gilbert, 2015).

These findings indicate that FSG offers an evidence-based method to assist dissociative patients and the therapists that work with them. Such materials may also be of particular help to clinicians learning how to better serve these populations (Kumar et al., 2022; Nester, Hawkins, & Brand, 2022). A major strength of FSG is its systematically structured, sequential approach to psychoeducation and skill-building that emphasizes individualized pacing. This program allows for repeated access to educational materials and appears to help both patients and therapists to conceptualize and work systematically on basic goals of trauma treatment: stabilization of severe symptoms and development of safety and recovery-based ways to self-regulate. This is the antithesis of the approach proposed by researchers who advocate rapid, intensive focus on trauma processing (e.g., van Minnen & Tibben, 2021) and who aver that stabilization is unnecessary for trauma treatment. In our model, stabilization is defined as developing recovery-oriented self-regulation that reduces reliance on high-risk behaviors, including NSSI and substance abuse. These behaviors drive treatment at more restrictive levels of care and may disrupt therapy; increase treatment costs; and reinforce a sense of failure, shame, and demoralization.

Stabilization of dissociative symptoms is another defining aspect of stabilization. Dissociation declined over time for participants in both groups. This suggests that, over the first 12 months, this change may not be attributable to FSG participation. We primarily recruited through professional networks focused on the treatment of trauma-related dissociation. Even in the Waitlist group, therapists may already have been working on grounding as well as fostering collaboration and cooperation among self-states which decreases dissociative symptoms (Brand et al., 2019, 2022). Another possible contributing factor may be a "side effect" of participants' increased awareness of dissociative processes. Highly dissociative patients are often unaware of how often they dissociate, or even *that* they dissociate. In therapy and with psychoeducation, they become more aware of dissociation and indicators that they are dissociating (Pierorazio et al., 2024). As a result, they may report awareness of more dissociative symptoms even as they appear less dissociative to clinicians. Given the high variance in dissociation scores among the diagnostic subgroups, we may have had insufficient power at this interim timepoint to detect changes in dissociation. Finally, in prior studies of CDDs, we found that many symptom improvements required 2 years to show significant changes (Brand et al., 2019).

Despite the notable improvements in our sample, and consistent with other studies on the stabilization of CDDs, most patients continue to suffer from substantial symptoms and psychosocial problems requiring further treatment (Brand et al., 2019; Jepsen et al., 2014). This finding is consistent with RCTs for PTSD associated with military trauma: For example, even after excluding patients with severe symptoms and comorbidities, as many as two thirds of these studies' patients still meet criteria for PTSD after treatment (e.g., Steenkamp et al., 2015).

Strengths, Limitations, and Areas for Future Study

This is the first randomly controlled trial of a psychoeducational and skill-building program that demonstrates significant benefit in important domains for people with severe trauma-related dissociation, including CDDs, DPTSD, and CPTSD. Thus, the FSG program has wide applicability to people with trauma-related dissociation. The FSG program offers hope to highly dissociative patients and a systematic, evidence-based program for therapists who treat these individuals.

The strengths of the study include a randomized design with a large international sample and inclusion of highly dissociative patients regardless of symptom severity or comorbidity, self-destructiveness and suicidality, substance abuse, and psychiatric hospitalizations. Also, this standardized program allowed therapist–patient dyads to access the materials on demand and progress through the program at an individualized pace. The FSG program was developed with input from those with lived experience, community clinicians, expert DD clinicians, and researchers.

Study limitations include a sample of predominantly White women from the United States. Therapists may have invited patients viewed as especially motivated for treatment, or conversely, their most difficult dissociative patient. Thus, these results may not generalize to all dissociative patients. Although therapists completed a diagnostic checklist as part of the screening process, structured interviews may have enhanced diagnostic reliability. Finally, the study did not provide

standardized individual therapy (i.e., some therapists may be more effective than others) nor monitor medications across participants. Thus, these factors may have contributed or interfered with the patients' progress. Nonetheless, the randomized design indicates that the effectiveness of the program facilitated improvements beyond possible confounds such as medications or the quality of individual psychotherapy. Further, the study design strongly suggests that patient improvements are not due to time, placebo response, or regression to the mean.

Within-group comparisons examine data across the same subject for multiple points compared to the between or unpaired comparisons, where each subject would be measured once. Paired comparisons are known to have more power and require fewer subjects to detect significant differences than looking at unpaired data or two group comparisons (Hulley et al., 2001). Uneven group patterns were consistent with paired data across all outcome variables. This is an interim report. The FSG sample size continues to grow; future analyses will have larger samples, additional longitudinal data, and better detection of possible within- and between-group differences (e.g., in dissociation levels). Future work should address whether there are health care cost savings for patients who participate in this program, whether group presentations of this program could be beneficial, and whether using the workbook that offers this program's written and practice exercises (H. J. Schielke et al., 2022) is as beneficial as the videos in FSG.

Conclusions

This RCT shows that FSG is an evidence-based stabilization-focused program for individuals demonstrating high levels of trauma-related dissociation and substantial comorbidities. The effect sizes were large for symptom improvements after 1 year of FSG. In view of the challenges and high health care costs associated with trauma and dissociation, it is promising that this program is associated with amelioration of severe symptoms, adaptive capacities, and self-compassion. The inclusion of patients irrespective of the severity of their symptoms, safety issues, or other comorbid conditions suggests broad applicability of this program.

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