Assessment and Treatment Tools for Dissociative Disorders

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Chapel Hill, NC

Clinical Lecture Series
UNC-CH School of Social Work
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DSM-IV Dissociative Disorders

- Dissociative Amnesia
- Dissociative Fugue
- Depersonalization Disorder
- Dissociative Identity Disorder
- Dissociative Disorder NOS
DSM-V Dissociative Disorders (see www.dsm5.org)

- Dissociative Amnesia
  (includes a Dissociative Fugue subtype)
- Depersonalization/Derealization Disorder
- Dissociative Identity Disorder
  (includes Dissociative Trance Disorder)
- Dissociative Disorder NOS
Dissociative “continuum”

- Normal adaptive dissociation
- Dissociative experience
- Dissociative disorder
- Atypical DID
- DID
- Polyfragmented DID
Associated Symptoms Common to Other Disorders

- Amnesia
- Hallucinations
- Mood disturbance
- Self-injurious behavior
- Sleep disturbance

- Anxiety/panic
- Flashbacks
- Sexual dysfunction
- Substance abuse
- Somatic symptoms
ASSESSMENT INSTRUMENTS FOR DISSOCIATIVE DISORDERS

- Structured Interviews
- Clinician/Parent Rating Scales
- Self Report Rating Scales
ASSESSMENT INSTRUMENTS
Structured Interviews

• Dissociative Disorders Interview Schedule (DDIS)

• Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D)
ASSESSMENT INSTRUMENTS
Clinician Administered Measures

- Clinician Administered Dissociative States Scale (CADSS)
ASSESSMENT INSTRUMENTS
Clinician/Parent Rating Scales

- Child/Adolescent Dissociative Checklist
- Child Dissociative Checklist
ASSESSMENT INSTRUMENTS
Self Report Rating Scales

• Dissociative Experiences Scale (DES)
• Questionnaire of Experiences of Dissociation (QED)
• Dissociation Questionnaire (DIS-Q)
• Somatoform Dissociation Questionnaire (SDQ-20)
ASSESSMENT INSTRUMENTS
Self Report Rating Scales (cont.)

• Multidimensional Inventory of Dissociation (MID)
• Multiscale Dissociation Inventory (MDI)
• Adolescent Dissociative Experiences Scale (ADES)
Epidemiology

• ~1% of general adult population with DID
• 1-20% of inpatients with DID
• Similar proportion for children and adolescents
• Female to male ratio increases from about 1:1 in childhood to 9:1 in adulthood
• DID begins in childhood
Developing DID

- Propensity to dissociate
- Trauma and maltreatment
- Non-supportive environment
- “Encapsulated” experiences
- Reinforcement over time
- Autonomous self-states
Definition of Terms

Commonly accepted definitions

- Identity = personality state = self-state = alter
- Integration = coming together of distinct parts of the mind (self-states)
- Fusion = complete loss of subjective separateness between two or more identities
- Final fusion = meld into to a unified subjective sense of self
Associated Experiences

• Missing blocks of time
• Meeting strangers
• Telephone calls
• Being accused of lying
• Peculiarities with food
• Bewilderment with clothes
• Unrecognized notes
• Visual distortions
Confirming Diagnosis for DID

- Observed switch
- Autonomous self-state
- Enduring “separateness”
- Missing blocks of time
- Supporting history
- Responsive to treatment
## Characteristics of Identities

<table>
<thead>
<tr>
<th></th>
<th>Adult</th>
<th>Child</th>
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<tbody>
<tr>
<td>2 or more identities</td>
<td>mode = 3-4</td>
<td>&lt;10</td>
</tr>
<tr>
<td>- pathognomonic</td>
<td>median = 10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>mean = 13</td>
<td></td>
</tr>
<tr>
<td>Dominating identity</td>
<td>Generally true</td>
<td>Usually true</td>
</tr>
<tr>
<td>determines behavior</td>
<td></td>
<td>Others try to exert influences w/o emergence</td>
</tr>
<tr>
<td>Characteristics of Identities</td>
<td>Adult</td>
<td>Child</td>
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<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td>Complex unique identities</td>
<td>At least some</td>
<td>Muted and attenuated</td>
</tr>
<tr>
<td>Elaboration of differences</td>
<td>Common and often strong</td>
<td>Uncommon</td>
</tr>
<tr>
<td>Distinct roles and purposes</td>
<td>Special purpose fragments</td>
<td>Less elaborated</td>
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# Characteristics of Identities

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<thead>
<tr>
<th>Adult</th>
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<tr>
<td>Investment in separateness</td>
<td>Common</td>
</tr>
<tr>
<td>Distinct internal worlds (distinct systems of personalities)</td>
<td>Not infrequent</td>
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1. Safety, stabilization, and symptom reduction
2. Processing traumatic experiences
3. Fusion and post fusion treatment
Treatment Overview

1. Stabilization Phase

- Safety from self injury, drugs, promiscuity, destructive relationships
- Stabilization of mood, affect tolerance, switching among alters, functioning in daily life, relationships
- Symptom reduction, learning to self-soothe, containment of re-experienced traumas
Treatment Overview

2. Trauma-Processing Phase

- Re-experiencing, abreacting, desensitizing, and detoxifying traumatic events
- Reframing context of the abuse
- Tolerating feeling helplessness, confusion, grief, shame, horror, terror, anger and rage
- Sharing traumatic memories among alters
Treatment Overview

3. Fusion/Post-Integration Phase

- Grapple with loss, grief, mourning, loneliness
- Practice new skills
- Tolerate not relying on dissociation
- Deal effectively with everyday problems
Treatment Overview

- The patient may be quite a way along in therapy before the diagnosis is clear.
- Patient and therapist may come to doubt the diagnosis during the course of therapy.
- Therapeutic principle for DID - increase communication and decrease barriers between identities.
Treatment Overview

**Duration of treatment**

<table>
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<th>For Children</th>
<th>Heavily dependent on environment. Few sessions to many years.</th>
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<tbody>
<tr>
<td>For Adolescents</td>
<td>May have to accept stabilization and support until early adulthood</td>
</tr>
<tr>
<td>For Adults</td>
<td>Usually several (2-5) years</td>
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Individual therapy

• Psycho-dynamically aware psychotherapy.

• For children, use therapy techniques commonly used with abused and traumatized children.

• Direct addressing of self-states.
Other interventions

• Dialectical Behavior Therapy – A cognitive behavior therapy that incorporates mindfulness and a series of exercises to help the patient decrease trigger responses to internal and external stimuli. Helps with self-soothing.
Other interventions

• Internal Family Systems Therapy –
  Uses family system theory to address disparities in perceptions and projections of “subpersonalites”.

• Ego-state therapy –
  Uses hypnosis. Focuses on utilizing separateness between ego shifts.
Interventions, continued

• Transactional Analysis – Formally uses Parent-Adult-Child ego states as theoretical basis. Has many useful techniques to address quandaries of those with DDNOS.

• Eye Movement Desensitization and Reprocessing – Accelerated information processing uses alternating focus across the midline. Resource installation is used to bolster the patient’s internal resources such as self-confidence.
Family interventions

- Family environment is critical to progress and success.
- Screen for dissociative symptoms in family members.
- In unstable settings, focus on environment consistency and ego strengthening.
Group therapy

- DID in groups can be problematic.
- Agreements need to be made about control of child alters during sessions.
- Therapists have to be careful not to prematurely expose trauma to group members.
- Have ongoing individual psychotherapy to absorb the trauma of the group.
Expressive therapies

• May be very useful to allow the patient to spill the feelings without the cognitive self-judgment that may accompany “talk therapy.”
Hypnotherapy

- Therapist training in hypnosis is highly useful in the treatment of dissociative patients, especially DID. It gives the therapist a broader awareness of the patient’s experiences as well as powerful techniques that can benefit the patient.

- Formal inductions are usually not needed on a regular basis.

- Some therapists use hypnosis intensely.
Psychopharmacotherapy

• Treat symptomatically, in accordance with concurrent diagnosis.

• DID has no published controlled psychopharmacology studies.
Some cautions and limits to the approach

- **Importance of “safety”** - Be alert to decrease family chaos and violence. Be aware of impulsively and dissociative processes in family members.

- **Boundaries of therapy** - Do not change your usual rules or routines of therapy without a clear therapeutic reason. Document why.
Some cautions and limits to the approach

- **Premature divulging of trauma** - Outside of forensic and safety reasons, there is little reason to pull for traumatic experiences. They will float to the surface as the patient learns how to handle them.

- **Developmental psychology** - Consider the patient’s age, cognitive ability, social and sexual maturity when developing treatment approaches.
Useful Resources

Online Resources

• International Society for the Study for Trauma and Dissociation  www.isst-d.org

• David Baldwin's Trauma Information Pages  www.trauma-pages.com

• Energy Healing Resources  www.energyhealing.net
Contact Information

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