BEST PRACTICES WITH THE DISSOCIATIVE DISORDERS: CURRENT RESEARCH AND CORE COMPETENCIES

Don Beere, Ph.D., ABPP

7000 Houston Road
Building 200 Suite 15
Florence, KY 41042
(859) 746-1006 Fax (859) 746-1496
donaldbeere.com

CORE AREAS OF COMPETENCE

I. Complex trauma: Effects and responses
II. Understanding the concept of dissociation
III. Assessment
IV. Treatment
V. Ethical-legal, risk management, and forensic issues

TREATMENT

• Establishing and conducting effective trauma therapy vs. How trauma therapy goes awry
• Memory, trauma, and suggestibility
• Relational challenges in trauma/dissociation therapy
• Transference/Countertransference
• Treatment approaches
• Models of treatment of posttraumatic disorders

DISSOCIATIVE IDENTITY DISORDER

complex,
chronic,
childhood PTSD
that persists into adulthood.

CONCLUSIONS

• Trauma is a frequent issue symptomatically and etiologically for many mental health clients.
• Trauma and dissociation have been ignored in the training and practice of the majority of mental health professionals.
• Trauma is possibly a significant contributor to severe mental illness.
• Dissociation is a frequent but undiagnosed disorder amongst mental health clients.
• Dissociation is often misdiagnosed as schizophrenia, bipolar disorder, or borderline disorder or masquerades as addictions, eating disorders or self-harm.
• Early trauma leads to physiological dysregulation and affective difficulties.
• Early relational trauma and borderline disorders.

"An appreciable disparity exists between the need for services by professionals with expertise in psychological trauma and the availability of these services. Despite the establishment of a solid base of scientific literature on trauma and the growing attunement of society and the media to the adverse psychological impact of traumatic events, this area has yet to be decisively incorporated into the core curriculum of graduate training in psychology and other professions (p. 3)."

"Trauma has also rarely been a focus of the education or training of mental health professionals. . . . Mental health training programs (e.g. psychiatry residencies, psychology doctoral programs, social work training programs) still provide little training in trauma and dissociation." p. 586


80.0% of adults in the general population report having experienced DSM-IV Criterion A for PTSD: a serious threat to life or physical integrity.

10% to 25% of those traumatized develop ASD or PTSD.

http://www.isst-d.org/education/faq-trauma.htm

In two studies with children 40.5% and 67.8% experienced trauma by age 16

violent victimization, attempted kidnapping, attempted sexual molestation and a serious threat to life or physical integrity

Sexual assault on women

- 50 to 66% worldwide
- 25 to 50% in the United States
Prevalence of Interpersonal Violence (IPV) in Primary Care


Observations about IPV

• About (33-55%) women will have been abused in their lifetime
• 5-33% victims in last year
• Sociodemographic features
  — 90% are women
  — Young (< 25)
  — Single, separated, divorced
  — Low income
  — No consistent racial differences

Prevalence of Abuse in This Sample (n=1,952)

• 5.5% current abuse (within last year)
• 21.4% abuse in adult life
• 22% abuse before age 18
• 32% abuse as child or adult

Medical Symptoms Associated with Current Abuse

PHYSICAL SYMPTOMS
• Headaches
• Chest Pain
• Fainting
• Shortness of Breath
• Breast Pain
• Abdominal Pain
• Constipation
• Broken Bones, Frequent or Serious Bruises

• Diarrhea
• Pelvic or Genital Pain
• Vaginal Discharge
• Problem Passing Urine
• Problem with Sleeping
• Nightmares
• Loss of Appetite
• Eating Binges or Self-Induced Vomiting

Medical Symptoms Associated with Current Abuse

• Headaches
• Chest Pain
• Fainting
• Shortness of Breath
• Breast Pain
• Abdominal Pain
• Constipation
• Broken Bones, Frequent or Serious Bruises

• Diarrhea
• Pelvic or Genital Pain
• Vaginal Discharge
• Problem Passing Urine
• Problem with Sleeping
• Nightmares
• Loss of Appetite
• Eating Binges or Self-Induced Vomiting
<table>
<thead>
<tr>
<th>Psychological Symptoms Associated with Current Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Depression</td>
</tr>
<tr>
<td>• Anxiety</td>
</tr>
<tr>
<td>• Somatization</td>
</tr>
<tr>
<td>• Self esteem problems</td>
</tr>
<tr>
<td>• Suicide Attempts/Current suicidal ideation</td>
</tr>
<tr>
<td>• Substance abuse (current and past)</td>
</tr>
<tr>
<td>• Not more likely to have a Psychiatric Admission</td>
</tr>
</tbody>
</table>

Childhood abuse is a risk factor for adult abuse.

50.4% of women abused as children were also abused as adults.

<table>
<thead>
<tr>
<th>Characteristics of women with childhood abuse (CA) histories</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Compare never abused women to those abused exclusively in childhood (CA) (&lt; 18) to determine differences in symptoms</td>
</tr>
<tr>
<td>• Determine if there was a dose relationship between multiple forms of abuse and number of symptoms</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Symptoms (CA Compared to Never Abused)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physical symptoms almost identical to those of women experiencing current abuse</td>
</tr>
<tr>
<td>• CA had more physical symptoms</td>
</tr>
<tr>
<td>- (6.2 Vs. 4)</td>
</tr>
<tr>
<td>• Psychological symptoms:</td>
</tr>
<tr>
<td>- More likely to be depressed, anxious, somatizing, suicide attempts</td>
</tr>
<tr>
<td>- More likely to have current suicidal ideation</td>
</tr>
<tr>
<td>- Past but not current substance abuse</td>
</tr>
<tr>
<td>- More likely to have had a psychiatric admission</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Abuse, either physical or sexual, child or adult, is associated with multiple health problems including dissociation</td>
</tr>
<tr>
<td>• Women frequently do not volunteer an abuse history due to shame or denial or lack of perception of connection of physical to mental symptoms</td>
</tr>
<tr>
<td>• Preliminary evidence that intervention helps.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Serious Mental Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Journal of Psychological Trauma, Volume 6 (2/3), 2007, editors Steve Gold and Jon Elha was devoted to this topic.</td>
</tr>
<tr>
<td>The severity of early trauma was significantly linked to the severity of later symptoms of serious mental illness.</td>
</tr>
</tbody>
</table>
Data: SMI linked to early trauma

Bebbington et al. (2004). 8,580 British adults showed strong relationship between victimization and later psychosis.

Janssen et al. (2004). 4,045 Dutch adults demonstrated that adverse events increase chances of psychosis as well as a dose-response effect and of actual causality.

Hammersley, P., Read, J., Woodal, S., & Dillon, J. (2007.) Childhood Trauma and psychosis. The genie is out of the bottle. Psychological Trauma, 6, 7-20.

Schneiderian First Ranked Signs of Schizophrenia

* Audible thoughts  
* Voices heard arguing  
* Experience of influences playing on the body  
* Thought withdrawal  
* Thought insertion - Thoughts are ascribed to other people who intrude their thoughts upon the patient  
* Thought diffusion (also called thought broadcast)  
* Delusional perception  
* Made feelings  
* Made impulses  
* Made acts

Adverse Childhood Events Studies (ACE)

V. J. Felitti, MD & R. F. Anda, MD

Survey of over 17,421 adults in the Kaiser Permanente HMO in California

<http://www.acestudy.org/>

Adverse Childhood Events (ACE)

- Recurrent physical abuse
- Recurrent emotional abuse
- Contact sexual abuse
- An alcohol and/or drug abuser in the household
- An incarcerated household member
- Someone who is chronically depressed, mentally ill, institutionalized, or suicidal
- Mother is treated violently
- One or no parents
- Emotional or physical neglect

ACE FREQUENCY

<table>
<thead>
<tr>
<th>ACES</th>
<th>PERCENT</th>
<th>CUMULATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>32.7%</td>
<td>32.7%</td>
</tr>
<tr>
<td>1</td>
<td>25.6%</td>
<td>58.3%</td>
</tr>
<tr>
<td>2</td>
<td>15.5%</td>
<td>73.8%</td>
</tr>
<tr>
<td>3</td>
<td>9.9%</td>
<td>83.7%</td>
</tr>
<tr>
<td>4</td>
<td>5.9%</td>
<td>89.6%</td>
</tr>
<tr>
<td>&gt;5</td>
<td>10.5%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Relation of ACE to Leading Causes of Death*

- Persons with > 4 ACEs had
  - 4-12x risk for alcoholism, drug abuse, depression, suicide attempt
  - 2-4x risk smoking, poor self-rated health, > 50 lifetime sexual partners
  - 2x risk of coronary heart disease, any cancer, stroke

ACEs are Cumulative

- Adolescent health
- Teen pregnancy
- Smoking
- Alcohol abuse
- Illicit drug abuse
- Sexual behavior
- Mental health
- Risk of revictimization
- Stability of relationships
- Work performance

ACEs Increase the Risk

- Heart disease
- Chronic lung disease
- Liver disease
- Suicide
- Injuries
- HIV and STDs
- Other causes of death

PTSD

Triad of PTSD symptoms

- **intrusive reminders** of the traumatic experience (memory)
- **avoidance** of stimuli linked to the trauma (behavior, environment)
- **numbing and hyperarousal** (emotion, physiological response)

Comorbid Symptoms

80% have

- anxiety (anxiety disorders),
- mood (major depression), and
- substance abuse disorders,
- eating disorders,
- dissociative disorders,
- somatic complaints,
- attention deficit hyperactivity disorder and
- personality changes and personality disorders.

http://www.isst-d.org/education/faq-trauma.htm

DISSOCIATION

CONCEPTUALIZATION

ASSESSMENT

EPIDEMIOLOGY

RESEARCH
**Dissociative Disorders (DSM-IV-R)**

Dissociative Amnesia  
Dissociative Fugue  
Depersonalization Disorder  
Dissociative Identity Disorder  
Dissociative Disorder Not Otherwise Specified


---

**Continuum of Dissociation**


---

**Figure 2. The Continuum of Awareness.**

This conceptualization no longer seems accurate, but is how many understand dissociation.

Theories of Dissociation

- Pierre Janet
- Hilgard’s Neodissociation Theory
- Federn and the Watkins’ Ego State Theory
- Diathesis-Stress: The Interaction of Hypnotizability and Trauma
- Braun’s BASK Model
- Psychobiological Theories -- Krystal
- Extension of Normal Dreaming -- Barrett
- SocioCognitive Theories -- Spanos

BASK MODEL

MEMORY OF TRAUMA

- Accuracy not essential
- Subjective reality is crucial therapeutically.
- Substance changes over time.
- A therapeutically open yet uncommitted stance.

AMNESIA

AND

RELIVING TRAUMA
Ego State: Definition

- “An organized system of behavior and experience whose elements are bound together by some common principle but that is separated from other such states by boundaries that are more or less permeable.”

STRUCTURAL THEORY

vanderHart, Neinjhuis, Steele

Charles Myers, 1940

- EMOTIONAL PART OF THE PERSONALITY
  - encodes and stores the trauma
  - relives the trauma in emotional and sensorimotor ways disoriented in time, situation, and identity
  - i.e., EP has traumatic memories

- APPARENTLY NORMAL PART OF THE PERSONALITY
  - apparent normality, but has:
    - emotional and bodily anesthesia
    - partial to complete amnesia
    - Intrusions
    - Avoidance of trauma
    - trauma left unintegrated
Tonic Immobility (TI)

Sequella [possible decrease in arousal]
- drop in body temperature (feeling cold)
- eye closure
- increased heart rate (tachycardia)
- numb
- analgesia
- uncontrollable shaking or tremors
- suppressed vocal behavior
- vivid recall of details

Attacked Prey and Somatoform Dissociation

Nijenhuis
RESPONSE OF PREY TO ATTACK

<table>
<thead>
<tr>
<th>BEFORE</th>
<th>DIFFUSE THREAT</th>
<th>STRIKE IMMINENT</th>
<th>ATTACK BEGUN</th>
<th>STIKE : NO ESCAPE</th>
<th>RECOVERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rest</td>
<td>Stilling</td>
<td>Cry</td>
<td>Fight</td>
<td>Freeze</td>
<td>Isolation</td>
</tr>
<tr>
<td>Everyday activities</td>
<td>Potentiated startle</td>
<td>Analgesia</td>
<td>Flight</td>
<td>Total collapse</td>
<td>Acute Pain</td>
</tr>
<tr>
<td>Daily activities interrupted</td>
<td>Analgesia</td>
<td>Analgesia body</td>
<td>Fatigue/rest sleep</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusive attention to potential treat</td>
<td>Analgesia</td>
<td>Analgesia body</td>
<td>Fatigue/rest sleep</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apprehension with increased arousal</td>
<td>Analgesia</td>
<td>Analgesia body</td>
<td>Fatigue/rest sleep</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapid shallow breathing</td>
<td>Analgesia</td>
<td>Analgesia body</td>
<td>Fatigue/rest sleep</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High HR &amp; BP</td>
<td>Low HR &amp; BP</td>
<td>Low HR &amp; BP</td>
<td>Low HR &amp; BP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High muscle tone</td>
<td>Low HR &amp; BP</td>
<td>Low HR &amp; BP</td>
<td>Low HR &amp; BP</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PERCEPTUAL THEORY OF DISSOCIATION

Beere

Background includes

the sense of **identity**, having a **mind** and a **body**, being in the **world** and **time**.

<table>
<thead>
<tr>
<th>Component lost or changed</th>
<th>Dissociative Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I&quot; or Identity</td>
<td>Fugue; Multiple Personality Disorder</td>
</tr>
<tr>
<td>Mind</td>
<td>Depersonalization; Amnesia</td>
</tr>
<tr>
<td>Body</td>
<td>Depersonalization (Disembodiment)</td>
</tr>
<tr>
<td>World</td>
<td>Derealization</td>
</tr>
<tr>
<td>Time</td>
<td>Changes in experienced time (Detemporalization)</td>
</tr>
</tbody>
</table>
Existence as constituted within the limits of consciousness

Alters amnestic for each other: Existence-as-constituted excludes the other

**ASSESSMENT**

**Structured Interviews**
- **SCID-R**, Structured Clinical Interview for the Dissociative Disorders-R (Steinberg, 1995)
- **DDIS**, Dissociative Disorders Interview Schedule (Ross, 1989)
- Lowenstein's Mental Status Exam (Lowenstein, 1991)

**Self-Report Instruments**
- **DES**, Dissociative Experiences Scale (Carlson & Putnam, 1994) and **DES-T**
- **DIS-Q**, Dissociative Questionnaire (VanderLinden, xxx)
- **SDQ-5 & SDQ-20**, Somatoform Dissociation Questionnaire, (Nijenhuis, 1999)
- **MID 6.0**, Multidimensional Inventory of Dissociation (Dell, 2006)
- **MDI**, Multiscale Dissociation Inventory (Briere, 2002)

**Translated Instruments**
- **DES** – Turkish
- **DES** – Herbrew
- **DES** – Spanish
- **SDQ-Turkish**
- **SDQ-Spanish**
Child and Adolescent Measures of Dissociation

- Child Dissociative Checklist (Putnam)
- DES-A, Adolescent Dissociative Experience Scale

Other Useful Measures

- Memory Line (Beere)
- PTSD Measure (e.g. Penn Inventory, PCL-C)
- Depression Measure (e.g. Beck, CES-D-R)
- Anxiety Measure (e.g. Beck)

DES Scores in Published Series of DID Cases

<table>
<thead>
<tr>
<th>Country</th>
<th>N</th>
<th>IES Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA</td>
<td>16</td>
<td>48.6</td>
</tr>
<tr>
<td>Fink &amp; Goluboff, 1990</td>
<td>9</td>
<td>47.5</td>
</tr>
<tr>
<td>Loewenstein &amp; Putnam, 1988</td>
<td>33</td>
<td>55.0</td>
</tr>
<tr>
<td>Canada/USA</td>
<td>92</td>
<td>41.4</td>
</tr>
<tr>
<td>Ross, 1990</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Carbon,1993)</td>
<td>226</td>
<td>42.8</td>
</tr>
<tr>
<td>Netherlands</td>
<td>7</td>
<td>49.3</td>
</tr>
<tr>
<td>(Estleik &amp; Otterloo, 1989)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Turbin, 1995)</td>
<td>20</td>
<td>47.2</td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>16</td>
<td>60.3</td>
</tr>
<tr>
<td>(Marttner - Tabanos, 1995)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

From Ross (2010), Plenary Presentation at EMDRIA

DES-T Items

3. Some people have the experience of finding themselves in a place and having no idea how they got there.
5. Some people have the experience of finding new things among their belongings that they do not remember buying.
7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person.
8. Some people are told that they sometimes do not recognize friends or family members.
12. Some people have the experience of feeling that other people, objects, and the world around them are not real.
13. Some people have the experience of feeling that their body does not seem to belong to them.
22. Some people find that in one situation they may act so differently compared to another situation that they feel almost as if they were two different people.
27. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing.
EPIDEMIOLOGY

PREVALENCE

<table>
<thead>
<tr>
<th>Clinical Group</th>
<th>Percent Dissociative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>5 - 20.7%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>12 - 38%</td>
</tr>
<tr>
<td>Emergency Room patients</td>
<td>24.9%</td>
</tr>
<tr>
<td>Co-morbid with BPD</td>
<td>53% dissociative</td>
</tr>
<tr>
<td>Co-morbid with Panic Disorder</td>
<td>11% DID</td>
</tr>
</tbody>
</table>

Prevalence of the dissociative disorders in inpatient units in North America

<table>
<thead>
<tr>
<th>Country</th>
<th>N</th>
<th>Source</th>
<th>%Dissociative Disorder</th>
<th>% DID</th>
<th>Structured Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA</td>
<td>201</td>
<td>Ross, 1999</td>
<td>40.8</td>
<td>7.5</td>
<td>DDIS</td>
</tr>
<tr>
<td></td>
<td>100</td>
<td>Rollin, 1998</td>
<td>n/a</td>
<td>1.0</td>
<td>SCID-D</td>
</tr>
<tr>
<td></td>
<td>175</td>
<td>Lutz, 1995</td>
<td>40.0</td>
<td>12.0</td>
<td>DDIS</td>
</tr>
<tr>
<td></td>
<td>110</td>
<td>Rate, 1995</td>
<td>15.0</td>
<td>3.6</td>
<td>DDIS</td>
</tr>
<tr>
<td>Canada</td>
<td>44</td>
<td>Ross, 1999</td>
<td>17.0</td>
<td>5.0</td>
<td>DDIS, DES (chemical dep)</td>
</tr>
<tr>
<td></td>
<td>100</td>
<td>Ross et al., 1992</td>
<td>39.0</td>
<td>14</td>
<td>DDIS, DES (CCN)</td>
</tr>
<tr>
<td></td>
<td>51</td>
<td>Ross et al., 1992</td>
<td>88.5</td>
<td>17</td>
<td>DDIS, DES (adolescents)</td>
</tr>
<tr>
<td></td>
<td>34</td>
<td>Ross, 1991</td>
<td>35.0</td>
<td>3.4</td>
<td>DDIS, DES (adolescents)</td>
</tr>
<tr>
<td></td>
<td>299</td>
<td>Ross et al., 1992</td>
<td>15.0</td>
<td>6</td>
<td>DDIS, DES (adolescents)</td>
</tr>
</tbody>
</table>

Prevalence of the dissociative disorders in International settings

<table>
<thead>
<tr>
<th>Country</th>
<th>N</th>
<th>Source</th>
<th>%Dissociative Disorder</th>
<th>% DID</th>
<th>Structured Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA</td>
<td>201</td>
<td>Ross, 1999</td>
<td>40.8</td>
<td>7.5</td>
<td>DDIS</td>
</tr>
<tr>
<td></td>
<td>100</td>
<td>Rollin, 1998</td>
<td>n/a</td>
<td>1.0</td>
<td>SCID-D</td>
</tr>
<tr>
<td></td>
<td>175</td>
<td>Lutz, 1995</td>
<td>40.0</td>
<td>12.0</td>
<td>DDIS</td>
</tr>
<tr>
<td></td>
<td>110</td>
<td>Rate, 1995</td>
<td>15.0</td>
<td>3.6</td>
<td>DDIS</td>
</tr>
<tr>
<td>Canada</td>
<td>44</td>
<td>Ross, 1999</td>
<td>17.0</td>
<td>5.0</td>
<td>DDIS, DES (chemical dep)</td>
</tr>
<tr>
<td></td>
<td>100</td>
<td>Ross et al., 1992</td>
<td>39.0</td>
<td>14</td>
<td>DDIS, DES (CCN)</td>
</tr>
<tr>
<td></td>
<td>51</td>
<td>Ross et al., 1992</td>
<td>88.5</td>
<td>17</td>
<td>DDIS, DES (adolescents)</td>
</tr>
<tr>
<td></td>
<td>34</td>
<td>Ross, 1991</td>
<td>35.0</td>
<td>3.4</td>
<td>DDIS, DES (adolescents)</td>
</tr>
<tr>
<td></td>
<td>299</td>
<td>Ross et al., 1992</td>
<td>15.0</td>
<td>6</td>
<td>DDIS, DES (adolescents)</td>
</tr>
</tbody>
</table>

Prevalence Rates (%) for Dissociative Disorders Internationally

<table>
<thead>
<tr>
<th>Any Dissociative Disorder</th>
<th>Dissociative Identity Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients</td>
<td>8.16</td>
</tr>
<tr>
<td>Victims</td>
<td>38.56</td>
</tr>
<tr>
<td>Inpatients</td>
<td>6.0</td>
</tr>
</tbody>
</table>

[Prevalence of dissociative disorders in a random, stratified sample of Winnipeg residents N=454 (from Ross, 1991)]

<table>
<thead>
<tr>
<th>Dissociative Diagnosis</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychogenic amnesia</td>
<td>7.0</td>
</tr>
<tr>
<td>DID</td>
<td>1.3</td>
</tr>
<tr>
<td>Depersonalization disorder</td>
<td>2.4</td>
</tr>
<tr>
<td>Psychogenic fugue</td>
<td>0.2</td>
</tr>
<tr>
<td>DDNOS</td>
<td>0.2</td>
</tr>
<tr>
<td>Any dissociative disorder</td>
<td>11.2</td>
</tr>
</tbody>
</table>

Prevalence Rates (%) for Dissociative Disorders Internationally

<table>
<thead>
<tr>
<th>Any Dissociative Disorder</th>
<th>Dissociative Identity Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients</td>
<td>8.16</td>
</tr>
<tr>
<td>Victims</td>
<td>38.56</td>
</tr>
<tr>
<td>Inpatients</td>
<td>6.0</td>
</tr>
</tbody>
</table>


**RESEARCH DATA**

**PREVIOUS DIAGNOSES GIVEN TO MPD PATIENTS (N=236)**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. AFFECTIVE DISORDER</td>
<td>63.7</td>
</tr>
<tr>
<td>2. PERSONALITY DISORDER</td>
<td>57.4</td>
</tr>
<tr>
<td>3. ANXIETY DISORDER</td>
<td>44.3</td>
</tr>
<tr>
<td>4. SCHIZOPHRENIA</td>
<td>40.8</td>
</tr>
<tr>
<td>5. SUBSTANCE ABUSE</td>
<td>31.4</td>
</tr>
<tr>
<td>6. ADJUSTMENT DISORDER</td>
<td>26.1</td>
</tr>
<tr>
<td>7. MULTIPLE PERSONALITY DISORDER</td>
<td>19.7</td>
</tr>
<tr>
<td>8. SOMATIZATION DISORDER</td>
<td>18.8</td>
</tr>
<tr>
<td>9. EATING DISORDER</td>
<td>16.3</td>
</tr>
<tr>
<td>10. ORGANIC MENTAL DISORDER</td>
<td>12.8</td>
</tr>
</tbody>
</table>

From a presentation by Phil Coons

**Physiological**

*FIGURE 5. The visual analogue scale scores and mean heart rate for each stage of the neutral script.*

*FIGURE 4. The visual analogue scale scores for mean heart rate for each stage of the stressful event script.*
FIGURE 2. The visual analogue scale scores and the mean heart rate response to each stage of the Dissociation 1 script.

FIGURE 21.1 Heart rate changes compared to baseline for different dissociative parts in a DID patient upon exposure to approaching picture of a man with an angry facial expression.

FIGURE 21.2 Heart rate changes compared to baseline for different dissociative parts in a DID patient upon exposure to approaching picture of a man with an angry facial expression.

FIGURE 21.3 Heart rate frequency in a patient with Dissociative Disorder NOS-1 during exposure to approaching perceived threat cue.

FIGURE 21.4 Heart rate frequency of DID patient involved in Figure 1 and 2 in response to a picture of a male with an angry facial expression that is moved from 70 cm to 5 cm in the direction of the patient’s face in a therapy session. This time, the hand of the therapist who the patient has learned to trust is on the patient’s back. The activated parts are the EPs that otherwise engage in flight and freeze. The experienced support is associated with a stable HR, which effect may reflect dominance of the central, vagal system.
EEG and Neurological

Early stress is associated with long-term alterations in brain circuits and systems that mediate the stress response. Early stressors have lasting effects on the HPA axis and norepinephrine systems. Other brain systems that are involved include benzodiazepine, opiate, dopaminergic, and various neuropeptide systems. These neurochemical systems modulate function in brain regions, including the hippocampus, amygdala, and prefrontal cortex. Long-term alternations in these brain regions are hypothesized to play a role in the maintenance of PTSD, depression, and other psychiatric symptoms after childhood abuse.


Disorganized Attachment

Summary

- Disorganized attachment, rated in infancy and pre-school, predicts later dissociativity.
- Lack of mirroring (misattunement) leads to dissociation in infants.
- Disorganized attachment leads to discrete Internal Working Models, IWMs.
- If trauma occurs, then alters can develop in such a predisposed individual.

Inner and Outer Relationships
Brain development

- Shore: Right prefrontal cortex is significantly impacted by neglect and absence of mirroring. Regulatory control structures are in the right frontolimbic system.
- Teicher: Early abuse alters brain development. Strongest impact is witnessing domestic abuse. Leads to physiological dysregulation and problems modulating affect.
- Van der Kolk: Proposes a developmental trauma disorder for DSM-V.

Amnesia

Perception

XXXX
BLUE
YELLOW
GREEN
Necker Cube in the Unstable Condition

Regular Stroop No Background

Word-Color Relationship

High Dissociators

Low Dissociators

Necker Cube Reversals

Number of Reversals

Stable

Unstable

EFT-like Tasks

High dissociators

Low dissociators

<table>
<thead>
<tr>
<th></th>
<th>High dissociators</th>
<th>Low dissociators</th>
</tr>
</thead>
<tbody>
<tr>
<td>$M$</td>
<td>36.7</td>
<td>51.3</td>
</tr>
<tr>
<td>$SD$</td>
<td>17.4</td>
<td>32.9</td>
</tr>
<tr>
<td>$t$</td>
<td>2.39</td>
<td></td>
</tr>
<tr>
<td>$df$</td>
<td>66</td>
<td></td>
</tr>
<tr>
<td>$p$</td>
<td>0.0198</td>
<td></td>
</tr>
</tbody>
</table>
Information Processing

Overview of Freyd’s Betrayal Trauma and Information Processing

- A developing infant needs to maintain a secure relationship with caregivers.
- If they have violated that trust, betrayal trauma, the child becomes dissociative.
- The dissociation allows the child to not remember or be aware of the negative, while observing and remembering the positive.
- This leads to a dissociative style of processing information, remembering and attending.

High dissociators performed better in a divided attention task (Stroop).
- High dissociation is differentially adaptive.
- High dissociators had a decreased ability to give detailed answers about a fearful as opposed to a neutral story.


TREATMENT OF DISSOCIATION
DISSOCIATIVE DISORDERS PSYCHOTHERAPY TRAINING PROGRAM

- Diagnosis
- Treatment Frame and Principles
- Transference and Countertransference
- Countertransference and Boundaries
- Communicating with "Alters"
- Treatment Pitfalls and Pacing
- Working with Traumatic and Recovered Memories
- Hypnosis, Dissociation and Abreaction
- Integration and Treatment Termination

www.issd.org

Presenting problems
- depression
- mood swings
- self-mutilatory behavior
- suicidal behavior
- apparent psychotic symptoms
- anieties and phobias
- substance abuse
- eating disorders
- sleep problems
- somatoform disorders
  - headaches
  - unexplained pain
  - gastrointestinal complaints
  - pseudoneurological symptoms such as seizure-like episodes

Other Relevant Clinical Information
- History of multiple diagnoses
- Psychological condition not responsive to treatment
- Multiple physical difficulties not responsive to treatment
- A history of abuse pre-adolescence
- Amnesia for early history; intra session amnesia
- Emotionless reporting of traumatic and abusive experience
- Use of "we" or other wording to suggest alter identities

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual</td>
<td>28.2%</td>
<td>79.2%</td>
<td>68%</td>
<td>60%</td>
<td>90.2%</td>
</tr>
<tr>
<td>Physical</td>
<td>75.0%</td>
<td>74.0%</td>
<td>60.0%</td>
<td>2.0%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Physical or Sexual or Both</td>
<td>8.5%</td>
<td>96.0%</td>
<td>95.1%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

From Ross (2010), Plenary Presentation at EMDRIA

Summary of data from the literature concerning abuse histories of DID individuals

<table>
<thead>
<tr>
<th>Category</th>
<th>Data Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported childhood sexual abuse</td>
<td>68% to 90.2%</td>
</tr>
<tr>
<td>Reported childhood physical abuse</td>
<td>85%</td>
</tr>
<tr>
<td>Reported physical abuse</td>
<td>60% to 94%</td>
</tr>
<tr>
<td>Reported physical and/or sexual abuse</td>
<td>88.5% to 96%</td>
</tr>
<tr>
<td>Mean number of types of abuse per patient</td>
<td>2.95 to 4.8</td>
</tr>
<tr>
<td>Age abuse began</td>
<td>Before 5</td>
</tr>
<tr>
<td>Duration of sexual abuse</td>
<td>11.7 years</td>
</tr>
<tr>
<td>Duration of physical abuse</td>
<td>14.0 years</td>
</tr>
<tr>
<td>Intrafamilial abuse</td>
<td>Primary kind of abuse</td>
</tr>
</tbody>
</table>

Data from Loewenstein, 1994.
DELL’S RESEARCH ON DIAGNOSIS

Stages for Psychotherapy of the Dissociative Disorders

- **Stage One**: Stabilization and Symptom Reduction
- **Stage Two**: Trauma work or working through
- **Stage Three**: Integration and Rehabilitation

“BEST PRACTICES” ENDORSED BY EXPERTS

A Survey of Practices and Recommended Treatment Interventions Among Expert Therapists Treating Patients with Dissociative Identity Disorder and Dissociative Disorder Not Otherwise Specified

Bethany L. Brand  Towson University
Amie C. Myrick  Family & Children’s Services of Central Maryland
Richard J. Loewenstein  Sheppard Pratt Health Systems, Baltimore, MD
Catherine C. Classen  University of Toronto
Ruth Lankas  University of Western Ontario
Scot W. McNary  Towson University
Claire Pain  University of Toronto
Frank W. Putnam  Cincinnati Children’s Hospital Medical Center

On-Line Survey

36 international experts in the treatment of DD
25 years (SD = 7.98) treating traumatized and
22+ years (SD = 8.39) treating dissociative disorders patients
27 trauma publications on average (mode 30)
36 DID patients treated to unification.

Rated use of interventions (never to often)
in the three stages of treatment
Stage One
Emphasized **skill building**
- to develop and maintain safety from dangerousness to self or others and other high risk behaviors,
- to regulate emotion,
- to control impulses,
- to improve interpersonal effectiveness,
- to ground, and
- to contain intrusive material.

Recommended specific trauma-focused cognitive therapy to address **trauma-based cognitive distortions**

Identified and worked with **dissociated self states**

---

More Specific Stage One Interventions
- establishing safety by discussing the frequency, antecedents to, and functions of, self-destructive, suicidal & aggressive behavior toward others,
- developing safety contracts
- crisis management plans
- daily functioning skills
- psychoeducation
- cognitive behavioral therapy (CBT) focused on changing distorted cognitions.
- relationally focused interventions to establish and repair the therapeutic alliance
- emotion regulation

---

Excluded from Stage One
- Trauma work
- Transference analysis: did not usually discuss the therapeutic relationship as a way of helping the client understand past and current relationships

---

Stage Two
Advised the use of exposure/abreaction techniques (including EMDR) –

- albeit modified to not overwhelm these complex dissociative patients –

- balanced with core, foundational interventions.

---

More Stage Two
Continue using Stage One Interventions
- **Assessment and Safety**, 
- **Daily Functioning**, 
- **Psychoeducation**, 
- **Relationally Focused**, 
- **Emotion Regulation**, and 
- **Addressing Dissociation**

---

Even More Stage Two
- discussing the therapeutic relationship, 
- developing an awareness of body sensations, 
- increasing cooperation among dissociated self states 
- using CBT techniques to alter patients’ distorted cognitions
Stage Three

There was less uniformity among therapists.

Use "very often,"
• Increasing Daily Functioning Skills
• Relationally Focused Work (most frequently endorsed) and
• Emotion Regulation and
• Psychoeducation

Across all three Stages

• stabilizing the patient after intrusions from reported perpetrators remained consistent,
• stabilizing from current day stressors and crises remained consistent but decreased slightly across the stages of treatment.

Three Treatment Issues

1. The extent to which full re-experiencing of emotion during traumatic memory processing is necessary;
2. The degree to which dissociated self states should be worked with directly in treatment;
3. Whether physical touch (such as shaking hands or hugging) should ever be used when treating DD patients.

ASSEMENT & SAFETY

<table>
<thead>
<tr>
<th>Percent Endorsing</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosing psychiatric illness</td>
<td>89</td>
<td>33</td>
<td>31</td>
</tr>
<tr>
<td>Assess response to medications</td>
<td>67</td>
<td>44</td>
<td>33</td>
</tr>
<tr>
<td>Acceptance of DD diagnosis</td>
<td>75</td>
<td>53</td>
<td>31</td>
</tr>
<tr>
<td>Establishing Safety</td>
<td>97</td>
<td>69</td>
<td>25</td>
</tr>
</tbody>
</table>

Brand et al., unpublished paper under review.

DAILY FUNCTIONING SKILLS

<table>
<thead>
<tr>
<th>Percent Endorsing</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stabilizing following intrusions from alleged perpetrators</td>
<td>58</td>
<td>39</td>
<td>39</td>
</tr>
<tr>
<td>Stabilizing from current day stressors/crises</td>
<td>81</td>
<td>56</td>
<td>47</td>
</tr>
<tr>
<td>Teaching/practicing self-care</td>
<td>86</td>
<td>50</td>
<td>44</td>
</tr>
<tr>
<td>Educate about disorders and treatment options</td>
<td>92</td>
<td>56</td>
<td>36</td>
</tr>
<tr>
<td>CBT focused on cognitions</td>
<td>64</td>
<td>72</td>
<td>25</td>
</tr>
</tbody>
</table>

Brand et al., unpublished paper under review.

RELATIONALLY FOCUSED WORK

<table>
<thead>
<tr>
<th>Percent Endorsing</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish/repair alliance</td>
<td>97</td>
<td>75</td>
<td>44</td>
</tr>
<tr>
<td>Processing patient’s reactions to therapy</td>
<td>58</td>
<td>53</td>
<td>42</td>
</tr>
<tr>
<td>Discussing therapeutic relationship</td>
<td>42</td>
<td>53</td>
<td>44</td>
</tr>
<tr>
<td>Teaching/discussing attachment</td>
<td>50</td>
<td>50</td>
<td>28</td>
</tr>
<tr>
<td>Developing healthy relationships</td>
<td>83</td>
<td>56</td>
<td>56</td>
</tr>
</tbody>
</table>

Brand et al., unpublished paper under review.
## EMOTION REGULATION

<table>
<thead>
<tr>
<th>Percent Endorsing</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching/practicing containment</td>
<td>81</td>
<td>75</td>
<td>11</td>
</tr>
<tr>
<td>Teaching/practicing grounding</td>
<td>94</td>
<td>64</td>
<td>19</td>
</tr>
<tr>
<td>Ego strengthening activities</td>
<td>78</td>
<td>59</td>
<td>42</td>
</tr>
<tr>
<td>Awareness of emotion</td>
<td>58</td>
<td>50</td>
<td>47</td>
</tr>
<tr>
<td>Awareness of body sensation</td>
<td>33</td>
<td>61</td>
<td>42</td>
</tr>
<tr>
<td>Affect tolerance and impulse control</td>
<td>82</td>
<td>70</td>
<td>36</td>
</tr>
</tbody>
</table>

Brand et al., unpublished paper under review.

## ADDRESSING DISSOCIATION

<table>
<thead>
<tr>
<th>Percent Endorsing</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Processing when and why dissociation occurs</td>
<td>67</td>
<td>56</td>
<td>36</td>
</tr>
<tr>
<td>Cooperation with parts</td>
<td>53</td>
<td>83</td>
<td>36</td>
</tr>
<tr>
<td>Identify/work with parts</td>
<td>47</td>
<td>69</td>
<td>22</td>
</tr>
</tbody>
</table>

Brand et al., unpublished paper under review.

## TRAUMA FOCUSED WORK

<table>
<thead>
<tr>
<th>Percent Endorsing</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure/abreaction to traumatic memories</td>
<td>0</td>
<td>47</td>
<td>11</td>
</tr>
<tr>
<td>Processing delayed recall of trauma</td>
<td>0</td>
<td>44</td>
<td>11</td>
</tr>
<tr>
<td>Processing trauma with EMDR</td>
<td>0</td>
<td>17</td>
<td>3</td>
</tr>
</tbody>
</table>

Brand et al., unpublished paper under review.

## POTENTIALLY RISKY INTERVENTIONS

<table>
<thead>
<tr>
<th>Percent Endorsing</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Playing with child personalities</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Using physical contact</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Brand et al., unpublished paper under review.

“One unexpected finding that has important implications is the relatively low number of DID patients treated through unification by this group of expert therapists.”

Brand et al., unpublished paper under review.

## TREATMENT OUTCOME
A naturalistic study of Dissociative Identity Disorder and Dissociative Disorder Not Otherwise Specified patients treated by community clinicians

Bethany L. Brand Towson University
Catherine C. Classen University of Toronto
Ruth Lanius University of Western Ontario
Richard J. Loewenstein Sheppard Pratt Health Systems, Baltimore, MD
Scot W. McNary Towson University
Claire Pain University of Toronto
Frank W. Putnam Cincinnati Children’s Hospital Medical Center

Published in Psychological Trauma: Theory, Research, Practice and Policy, 2009, Vol 1, 153-171.

Participants

- 292 therapists invited a single DD patient to participate.
- 280 patients participated. Had to read English.
- With no exclusion criteria: substance abuse, suicidality, hospitalization were all acceptable. Participants were international.

Obtained self-report measures from clients and from therapists and clients about treatment.

Only broad based outcome research study with DID.
The only other study followed up a sample DID inpatients who did demonstrate improvement.

Therapist Characteristics (N=292)

- From 17 countries.
- 75% female, 25% male
- 73% private practice, 17% outpatient clinic
- 21.8 average years in practice
- 12.8 average years treating DD
- 3.9 DID patients integrated on average

Patient Characteristics (N=280)

- 94% female
- Mean age = 43.7
- 89% Caucasian
- Perpetrator
  - 55% father
  - 21% mother
  - 22% brother
  - 42% other relative
  - 58% nonrelative

As a child . . .
- 79% physically abused
- 49% witnessed domestic violence
- 94% psychological or emotionally abused
- 68% neglected
- 86% sexually abused

Measures

Clinician
- Progress in Treatment Questionnaire (DID treatment steps)
- Clinical data form
  - Clinical information
  - GAF score
  - Therapist training
  - Therapist experience

Patient
- Behavioral checklist
- DES-II
- PCL-C
- SCL-90-R
**Patient Outcomes**

<table>
<thead>
<tr>
<th></th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>DES</td>
<td>43.3</td>
<td>34.0</td>
<td>30.0*</td>
</tr>
<tr>
<td>PCL-C</td>
<td>64.8</td>
<td>58.7</td>
<td>53.0*</td>
</tr>
<tr>
<td>SCL-90 Total</td>
<td>2.1</td>
<td>1.9</td>
<td>1.6*</td>
</tr>
<tr>
<td>SCL-90 Depression</td>
<td>2.5</td>
<td>2.4</td>
<td>2.1</td>
</tr>
</tbody>
</table>

**Therapist Responses**

<table>
<thead>
<tr>
<th></th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress in therapy</td>
<td>140.7</td>
<td>212.0*</td>
<td>259.3*</td>
</tr>
<tr>
<td>Adaptive functioning</td>
<td>6.7</td>
<td>7.9</td>
<td>9.2*</td>
</tr>
<tr>
<td>GAF</td>
<td>44.7</td>
<td>50.2*</td>
<td>63.7*</td>
</tr>
</tbody>
</table>

**Outcomes by Stage**

<table>
<thead>
<tr>
<th>Percent of Patients</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past 30 days</td>
<td>Patient Report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hurt self</td>
<td>53</td>
<td>38</td>
<td>6*</td>
</tr>
<tr>
<td>Attempted suicide</td>
<td>16</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Did st dangerous</td>
<td>43</td>
<td>28</td>
<td>13</td>
</tr>
<tr>
<td>Did st impulsive</td>
<td>81</td>
<td>66</td>
<td>72</td>
</tr>
<tr>
<td>Worked for pay</td>
<td>44</td>
<td>45</td>
<td>54</td>
</tr>
<tr>
<td>Selfmanaged symp</td>
<td>89</td>
<td>87</td>
<td>94</td>
</tr>
<tr>
<td>Had good feelings</td>
<td>86</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Participated social activities</td>
<td>77</td>
<td>92</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Past 6 months</th>
<th>Therapist Report</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalized</td>
<td>40</td>
<td>6*</td>
<td>5</td>
</tr>
<tr>
<td>Self harm attempt</td>
<td>56</td>
<td>54</td>
<td>17*</td>
</tr>
<tr>
<td>Suicide attempt past year</td>
<td>38</td>
<td>16</td>
<td>0*</td>
</tr>
</tbody>
</table>

**Author’s summary**

The study’s “patients have a high degree of acuity, are highly symptomatic, and most have had along-term course with the mental health system” (p. 164). This is consistent with other data on DID individuals.

- Severe polysymptomatology
- High rate of hospitalization
- Distress equivalent to inpatients
- Seriously impaired in the ability to function
- Dissociation severe

**Author’s conclusions about contemporary treatment of DID**

“Despite severe poly symptomatology and long-term mental health difficulties, there are consistent declines in symptomatology and improvements in functioning ...” (pp. 164-5).

The later stages of treatment show less dissociation, distress, PTSD symptomatology (hyperarousal and flashbacks), self-harm, and need for hospitalization.

**Author’s conclusions about contemporary treatment of DID**

- The treatment effect sizes in this study are comparable to randomized clinical trials for PTSD and borderline personality disorder.
- Despite long-term treatment, patients in the third stage had clinically elevated symptoms: dissociation, PTSD, and general distress.
THE THREE STAGES OF TREATMENT A SECOND TIME

STABILIZATION -- BASIC
- Go to “work” – function consistently
- Sleep – regular and sound
  no or few nightmares
- No intrusions
- No emotional upheavals
- Be safe
- Engage in relaxation
- Exercise regularly

STABILIZATION -- IDEAL
- Eat a healthy diet
- Have friends
- Engage in satisfying activities/have fun
- Expand range of current functioning
- Increase being assertive
  taking a position
  expressing and gratifying needs

Beginning Therapy
- Take an active, warm, and
  flexible therapeutic stance.
- Begin slowly!

The beginning steps
1. Mutual Voluntary Participation
2. Pragmatic Arrangements
3. A Facsimile of Trust
4. Aspects of Safety
5. The Treatment Frame
6. The Therapeutic Alliance
7. Self-Psychological Interventions
8. Demonstration of Expertise
9. Dealing with the Diagnosis
10. Dealing with Concerned Others

Preliminary Interventions (Kluft, 1993)

(1) develop and enhance communication within
and between various alters in the system and
the therapist and

(2) engage the alters in conflict resolution,
cooperation, distress reduction, planning,
and task execution.

This is the foundation for the later work.

EARLY INTERVENTIONS

- Alleviating punitive superego attitudes:
- Shame management
- Gaining access to alters
- Contracts
- Fostering communication and cooperation and
expanding the therapeutic alliance
- Ego strengthening and system strengthening:
- Offering symptomatic relief
- Hypnosis
- Ascertaining core conflictual relationship themes

Safety

- Steps to help patients work through safety
problems.
- Why do patients become self-destructive
and/or suicidal? Explore the functions of
destructive
- ideation, impulses, and behavior.
- Experiences and thinking patterns that could
trigger safety problems with dissociative
patients.

Disorder. Journal of Trauma & Dissociation, 2, 133-155.

Boundaries

- Maintain firm and secure boundaries, but
flexibly

- Issues
  - Phone calls
  - Payment
  - Session starting and ending

Suicide and self-mutilation

Cognitive behavioral approaches [Linehan’s (1993)
dialectical behavioral therapy]
- identifying events that precipitate self harm,
- teaching emotional regulation,
- improving distress tolerance and problem solving,
and
- developing self-management and interpersonal skills
- Challenge the cognitive distortion that death will not
kill all alters.
- Emphasize responsibility.

Suicide and self-mutilation

Supportive psychodynamic interventions
- building a solid therapeutic alliance,
- setting limits,
- emphasizing strengths, and
- using both praise and suggestions.
**Suicide and self-mutilation**

Empathic understanding of the need to self harm or suicide and trauma.

- Sense of being worthless and not worth self-care taking due to trauma.
- Re-enactment of the trauma.
- A mode of communicating in the absence of a support group or language.
- Perhaps a physiological tendency, based on the poor early attachment, to act on impulses rather than to verbalize.
- Activated by the distress of trauma work. Pacing is important.

**Suicide and self-mutilation**

Five steps [from Brand, 1991]:

1. Is the action outside the awareness of the host?
2. What are the triggers and function of the destructive urges or actions?
4. Build alliance with the persecutory (self harming) alter.
5. Resolve the conflict and/or teach new coping skills.

**Understanding the function of self-harm**

- Influencing others;
- Expressing feelings, particularly anger;
- Avoiding feelings;
- Facilitating a release of tension;
- Inducing exhalation, with or without a sexual component;
- Providing escape from psychic pain and/or dissociative states;
- Enhancing a sense of power and control;
- Providing distraction from traumatic memories; and
- Providing self-punishment

**Six Cognitive Distortions**

1. "If I hurt myself, no one else will hurt me" (Watkins & Watkins, 1988).
2. To punish oneself due to a sense of inherent "badness" (Coons and Milstein, 1990; Osuch et al., 1999).
3. The patient themselves is the abuser. "Have you ever felt threatened in a manner similar to the threats you are making to these aspects of yourself?"
4. Dissociated parts are separate people, which can survive the suicide or "homicide" by another part. "What happens to a human body when its brain or heart dies?" All parts are crucial to the healthy functioning of the whole body and person as are major organs to the functioning of the body.
5. The fear of annihilation: Parts may believe that they will be "killed off" by the therapist or one of the parts (Putnam, 1989).
6. Talking about abuse may lead to actual harm from abusers.

**Countertransference**

Severe trauma naturally activates very human responses. Countertransference is inevitable.

- The uncaring parent – the neglected child
- The sadistic abuser – the helpless, impotently rageful victim
- The idealized, omnipotent rescuer – the helpless or entitled victim
- The seducer – the seduced

**Communicating with Alters**

- Increase cooperation and reduce conflict amongst alters
- Congruence of perception for alters
- Treat all alters evenly and consistently
- Address and correct cognitive errors
- Creating alliances with internal persecutors

**Empathic strain**
Specific Treatment Techniques

- Fraser’s Dissociative Table Technique
- Hypnosis
- Fractionated Abreactions
- EMDR

Dimensions of Therapeutic Movement Instrument

- 1. Therapeutic Alliance
- 2. Integration
- 3. Capacity for Adaptive Change
- 4. Management of Life Stressors
- 5. Alter’s Responsibility for Self-Management
- 6. Restraint from Self-Endangerment
- 7. Quality of Interpersonal Relationships
- 8. Need for Medication
- 9. Need for Hospital Care
- 10. Resolution of Transference Phenomena
- 11. Intercessions Contacts
- 12. Subjective Well-Being

KLUFTISMS

- “The slower you go the faster you get there.”
- “The first final integration isn’t.”
- “An integration is solid after two years and three months.”
- The rule of “thirds”
- “DID is a multiple reality disorder.”
- “After multiple personality disorder, you still have a personality disorder.” Bennett Braun

Issues

- What is dissociation?
- Relation to hypnosis?
- Establishing better measures
- Getting better treatment outcome data
- Educating more people about dissociation and trauma.