

DISSOCIATIVE DISORDERS

DSM-IV TR Diagnostic Code	300.12 Dissociative Amnesia
	300.13 Dissociative Fugue
	300.14 Dissociative Identity Disorder
	300.6 Depersonalization Disorder
	300.15 Dissociative Disorder Not Otherwise Specified

Diagnostic Guidelines

1. Establish diagnostic accuracy as defined in DSM-IV TR.
 - “A mental status examination augmented with questions concerning dissociative symptoms is an essential part of the diagnostic process. Specifically the client should be asked about such areas as amnesias, fugue states, experiences of derealization and depersonalization, the experience of identity confusion, and/or identity alteration, age regressions, autohypnotic experiences, hearing (usually internal) voices, and feeling compelled from within the psyche to behave in an uncharacteristic way.” (The International Society for the Study of Dissociation, 1994) Particular emphasis should be placed on assessment of ego strength and capacity for treatment.
 - “Psychological testing cannot rule out Dissociative Identity Disorder... It may help improve understanding of the client’s personality structure, strengths and weaknesses (Armstrong, 1991) and it may be helpful in treatment planning.”
2. Rule out common co-morbid diagnoses including mood disorders, anxiety disorders, psychotic disorders, substance abuse disorders, eating disorders, sexual disorders and personality disorders.
3. Goals of treatment should focus on “symptom stabilization, control of dysfunctional behavior, restoration of functioning and improvement of relationships.” (The International Society for the Study of Dissociation, 1994) Identifying dysfunctional behaviors for treatment intervention should include consideration of behaviors which place the client’s safety at risk.
4. Maintain awareness that the impact of trauma is frequently manifested in three primary developmental arenas: attachment, self-regulation and self-perspective. (Friedrich, 1995).

Treatment Guidelines

1. A clear statement regarding therapeutic boundaries should be provided at the beginning of treatment. Periodic reinforcement of boundaries will continue to be necessary. This discussion might include:
 - Length, time and frequency of sessions;
 - Fee and payment arrangements;
 - The use of Health Insurance;
 - Confidentiality and its limits;
 - Therapist availability in between sessions;
 - Procedure if hospitalization is necessary;
 - Client charts and who has access to them;
 - The use (or non-use) of physical contact with the therapist;
 - Involvement of the client's family or significant others in the treatment;
 - Discussion of the therapist's expectations concerning management by the client of self destructive behavior;
 - Legal ramifications of the use of hypnosis as part of the treatment (i.e., material recalled in trance is not likely to be admissible evidence in any legal action undertaken by the client), etc.; (The International Society for the Study of Dissociation, 1994)
2. Initial focus should be on teaching and supportive practice of self-soothing behaviors and teaching and supportive practice of specific techniques aimed at symptom containment.
3. There should be clear expectations for positive change.
4. Symptomatic behavior should be approached using inquiry into the potential benefits or advantages gained through the behavior. Understanding how the behavior developed in the context of symptom control, i.e. the behavior is used to prevent a more serious behavior, can help the clinician and therapist develop an alternative coping mechanism which will achieve the same result. (Gil, 1996).
5. The treatment plan should clearly define a series of behavioral goals.
 - The patient should be assessed for target symptoms which may be medication-responsive (mood disorders, eating disorders, anxiety disorders) and appropriate psychiatric referral made if indicated. Psychotropic medication is not a primary treatment for dissociative disorders. However, various medications have been used for treating some anxiety-related dissociative symptoms, post-traumatic stress

disorder symptoms, and coexisting affective symptoms or disorders, (The International Society for the Study of Dissociation, 1994)

- “Inpatient treatment should be used for the achievement of specific therapeutic goals and objectives. Treatment should occur in the context of a goal-oriented strategy designed to restore the patient to a stable level of function so that he or she may resume outpatient treatment expeditiously...Emphasis should be placed on identifying the factors which have destabilized or threaten to destabilize the patient and on building strengths and skills to cope with the destabilizing factors.” (The International Society for the Study of Dissociation, 1994)

6. Cognitive/behavioral techniques which emphasize stress and anger management training are important. Participation in a Dialectical Behavioral Therapy group will enhance coping skills and is highly recommended.

7. The following precautions should be observed:

- The use of Eye Movement Desensitization and Reprocessing (EMDR) with a client who had learned to use dissociation as a coping strategy is risky. The clinician who utilizes this technique should have Level II training recognized by the EMDR Institute plus extensive experience in the treatment of dissociative disorders.
- The clinician should be careful to ensure that teaching the client alternative coping mechanisms is not seen as a criticism and that the client understand that she/he has been coping to the best of her ability, (Simonds, 1994)
- Poly-pharmacy without clear indications should be avoided.
- Be aware of the extreme suggestibility of dissociative clients. (Yapko, 1994)
- Ongoing supervision is highly recommended and may be required by the Expert Panel.
- Intrusive techniques such as body massage, Rolfing, primal scream therapy, acupressure, etc., can be over stimulating and lead to triggering phenomena which may overwhelm the client’s ability to utilize coping mechanisms. (Courtois, 1988) Such techniques should be utilized with extreme caution, if at all.

Please note--before entering the following phase of treatment, there should be evidence in the clinical record that all of the steps in the preliminary treatment recommendations have been achieved.

Supplemental Treatment Guidelines Regarding the Use of Uncovering Psychotherapy**

**Use of Uncovering Psychotherapy with clients who have Dissociative Identity Disorder should be reserved for exceptional circumstances and only conducted by a therapist who is specifically trained using this technique. Clinical supervision is required.

1. Indications for Uncovering Therapy:

- A strong therapeutic alliance has been developed between client and therapist.
- Client has learned coping techniques which can be utilized in stressful situations, [(Slaikou, 1984), (Horowitz, 1986)].
- “Client has learned and is able to utilize rest, containment, and supportive techniques for intrusive phase symptoms such as flashbacks, hyper-arousal, hyper-vigilance, sleep disturbance, exaggerated startle response and mild to severe cognitive impairment.” (Courtois, 1988, p. 190).
- Client understands the importance of maintaining safety and is able to ask for help and reliably contract for safety when learned coping mechanisms and stress management techniques are overwhelmed. Most of the time, client is able to self-soothe. The need for emergency contact is minimal.
- Client understands the importance of controlling substance abuse problems and is participating in a substance abuse program, if necessary.
- Client is able to understand the symptoms of dissociation and to differentiate between dissociative symptoms and psychosis.

2. Treatment Guidelines:

- Techniques for ventilation, expression and catharsis should be introduced and applied with caution only after careful preparation and should be interspersed with containment techniques. Expressive and

cathartic techniques which are the least threatening and least intense should be applied first. The clinician must be careful to respect the defenses of the client and “not move too quickly to dismantle them.”

(Courtois, 1988, p. 192).

- Treatment plan should specifically identify how uncovering therapy will lead to a higher level of functioning and establish interim measurable treatment goals related to breaking through denial, promoting ventilation, catharsis and abreaction of the trauma. (Courtois, 1988)
 - Ventilation, catharsis and abreaction should be carefully planned and enough time allowed for assessing the reactions of the client and practice of relaxation and other self-soothing exercises before the session is ended. (Courtois, 1988).
 - Therapists providing uncovering therapy must demonstrate specialized training and experience and access to regular supervision.
3. When the diagnosis is Dissociative Identity Disorder, treatment should move the client toward a sense of integrated functioning. Therapeutic work needs to establish communication between the different alternate personalities with an ultimate goal of an increased sense of connectedness or relatedness as well as cooperation among the alternate personalities. (The International Society for the Study of Dissociation).

Supplemental Treatment Guidelines Regarding the Evaluation and Treatment of Children and Adolescents (The International Society for the Study of Dissociation, 2003)***

1. “. . .dissociation in children may be seen as a malleable developmental phenomenon which may accompany a wide variety of childhood presentations. Symptoms of dissociation are seen in populations of children and adolescents with other disorders such as Post Traumatic stress Disorder (PTSD; Putnam, Hornstein & Peterson, 1996), Obsessive-compulsive Disorder (OCD, Stien & Waters, 1999) and reactive attachment disorder, as well as in general populations of traumatized and hospitalized adolescents (Sanders & Giolas, 1991; Atlas, Weissman, & Leibowitz, 1997).”
2. Literature reviewed spanning over 16 years of reporting on dissociative phenomena in children already shows shifts in emphasis and recommendations over time (Silberg, 2000). Despite the changing and provisional nature of our knowledge in this area, it is still important to have some guidelines in approaching dissociative symptomatology for the following reasons:
 - 2.1 Treatment strategies aimed at increasing integration and reducing dissociation can be highly effective in treating some of the most seriously impaired child victims of maltreatment who are engaged in disruptive and self destructive behavior.

- 2.2 Information on the treatment of dissociation was not available when most clinicians did their training, and it is important to organize clinical information to help familiarize clinicians with current treatment approaches.
 - 2.3 Without careful consideration of developmental issues, the simplistic application of treatment approaches for adult dissociation to children may be potentially dangerous to children.
3. Qualifications of Child and Adolescent Practitioners:
- 3.1 A solid grounding in child development.
 - 3.2 Clinicians who treat dissociative children should have training in child therapy and child development through accredited programs in their respective disciplines and be familiar with a variety of treatment approaches for traumatized children (Cohen & Mannarino, 1998b; Deblinger & Heflin, 1996; James, 1989, 1994; Myers, Berliner, Briere, Hendrx, Jenny, & Reid, 2002; Pearce & Pezzot-Pearce, 1997; Prior, 1996; Terr, 1991; Tinker & Wilson, 1999; Wieland, 1997, 1998.)
 - 3.3 Continuing education, supervision, and currency with related research/literature.

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