Complex Trauma:
What's New? What's Old? What's Recycled?

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August 9, 2013

Program Outline

9:00 am Observation, Perception, Knowledge
Historical Perspective, Developmental Theory, Trauma & Memory

10:45 am Dissociative Disorders over Time
Assessment Cues & Clues
Differential Diagnosis and Comorbid Disorders

12:00 pm Lunch (provided)

1:00 pm More on Assessment Of Dissociative Disorders
Treatment Stages

2:45 pm Transgenerational Issues
DID Intervention Decision Process
Questions and Discussion

4:30 pm Adjourn

Objectives

- Describe how childhood trauma may influence memory.
- Explain the principles of treatment for complex trauma and dissociation.
- Describe the range of dissociative presentations at different ages.
- Explain the intergenerational aspects and apply principles of family assessment for dissociative problems.

Observation, Perception, Knowledge

- We observe the world through all of our senses.
- We observe selectively so that only a very small part of what is available to observe registers in our minds.
- We experience that the best predictor of future behavior is past behavior.
- So, we tend to see again what we have seen before.

Historical Perspective

- Issues of dissociation have come forward in one form or another for hundreds of years
- Refining thoughts around dissociation and developing a treatment process is attributed to Pierre Janet

Janet's Perspective (1889)

- Asserted automatic thoughts and behaviors could be split off from one another.
- Aspects of "self" can function outside of awareness or can function independent of voluntary control (or both).
- He call this *desaggregation* (dissociation).

History of DSM Taxonomy

DSM	1952	Focuses on clinical utility
DSM-II	1957	Drops term *reaction*
DSM -III	1980	Includes diagnostic criteria & multi-axial system Etiology neutral
DSM-III-R	1987	Corrects inconsistencies Clarifies criteria
DSM-IV	1994	Includes literature reviews, data reanalysis, field trials
DSM-IV-TR	2000	"Text Revision"
DSM-5	2013	Restructures diagnostic categories Recognizes gender and cultural issues

Describing "Complex Trauma"

- An emotional state experienced by people who are exposed to repeated and prolonged trauma. This kind of trauma usually occurs in situations where the victim is unable to flee and is under the control of the perpetrator. (www.itn.org.za)

Describing "Complex Trauma" (Cont)

- Often the victim has a close relationship with the perpetrator. Survivors of domestic violence and child sexual abuse are groups at particular risk of developing complex trauma.

Related Concepts

- Complex PTSD (Herman, 1992)
- Disorders of Extreme Stress, Not Otherwise Specified (DESNOS) (van der Kolk et al. 2005)
- Developmental Trauma Disorder (van der Kolk, 2005)

Defining "Dissociation"

- Today's definition is not concise
- The splitting off of clusters of mental contents from conscious awareness – DSM-5
- "I know it when I see it?"

Dissociative Disorder in DSM-5

Characterized by a disruption of, and/or discontinuity in, normal integration of consciousness; memory; identity; emotion; perception; body representation; motor control, and behavior

DSM-IV-TR Dissociative Disorders

- Dissociative Amnesia
- Dissociative Fugue
- Depersonalization Disorder
- Dissociative Identity Disorder
- Dissociative Disorder NOS

DSM-5 Dissociative Disorders

- Dissociative Amnesia
  (includes a Dissociative Fugue subtype)
- Depersonalization/Derealization Disorder
- Dissociative Identity Disorder
- Other Specified Dissociative Disorder
- Unspecified Dissociative Disorder

Dissociative Identity Disorder DSM-IV-TR Criteria

- Distinct Identities or personality states
- 2 or more take recurrent control
- Amnesia for important personal information
- Not due to substance abuse; not due to medical condition

Dissociative Identity Disorder DSM-5 Criteria

- Personality states or possession
- Amnesia inconsistent with ordinary forgetting
- Clinical distress or impairment
- Not broadly accepted in culture or religion
- Not due to substance abuse or other medical condition

Personality (DSM-5)

- Enduring patterns of perceiving, relating to, and thinking about the environment and oneself.

Post-traumatic Stress Disorder DSM-5 Criteria

- Exposure to extreme event
- Intrusive symptoms
- Persistent avoidance
- Alterations in cognition and mood
- Beginning or worsening after event
- Alterations in arousal and reactivity
- > 1 month duration
- Clinical distress or impairment
- Not substance abuse or other medical issues

Developing DID

- Propensity to dissociate
- Trauma and maltreatment
- Non-supportive environment
- "Encapsulated" experiences
- Reinforcement over time
- Autonomous self-states

Confirming Diagnosis for DID

- Observed switch
- Autonomous self-state
- Enduring "separateness"
- Missing blocks of time
- Supporting history
- Responsive to treatment

Child Attachment Patterns

- Secure
- Avoidant
- Ambivalent/Resistant
- Disorganized

Adult Attachment Styles and Dissociation

- Secure
- Anxious-preoccupied
- Dismissive-avoidant
- Fearful-avoidant

Dissociative "continuum"

- Normal adaptive dissociation
- Dissociative experience
- Dissociative disorder
- Complex Trauma
- DID
- Polyfragmented DID

Assessment Cues & Clues

- There is no one way that these clients present.
- You have to your ears and eyes open for things that just don't fit.
- Giving the DES at intake can help.
- Follow up on hunches and inconsistencies in patient behavior or report.

Associated Experiences

- Missing blocks of time
- Meeting strangers
- Telephone calls
- Being accused of lying
- Peculiarities with food
- Bewilderment with clothes
- Unrecognized notes
- Visual distortions

Differential Diagnosis

- Clients rarely come into therapy with a chief complaint of dissociation.
- They come in with many symptoms common to the general clinical population.

Presenting diagnostic areas

- **Borderline Personality Disorder**
- **Bipolar disorder**
- **Schizophrenia**
- **Eating Disorders**
- **Substance abuse disorder**
- **Impulse Control Disorder**
- **Seizure Disorder**
- **Malingering**
- **Factitious Disorder**
- **Other organic disorders**

Associated Symptoms Common to Other Disorders

- Amnesia
- Hallucinations
- Mood disturbance
- Self-injurious behavior
- Sleep disturbance
- Anxiety/panic
- Flashbacks
- Sexual dysfunction
- Substance abuse
- Somatic symptoms

Comorbid Disorders

- Having a dissociative disorder does not preclude one from having other mental disorders.
- Common presenting symptoms include depression, anxiety, and relationship problems.
- On average, DID patients have 3.5 diagnosable mental disorders.

Integration Terminology

- Integration = work on the dissociated mental processes throughout treatment
- Fusion = complete loss of subjective separateness between two or more identities
- Final fusion = consolidation of identities into a unified, subjective sense of self

Terminology used for Self-states or Identities

Commonly Used Terms

- **Personality**
- **Personality state**
- **Self-state**
- **Part**
- **Part of the mind**
- **Part of the self**
- **Alter**
- **Alter personality**
- **Alternate identity**
- **Dissociative part of the personality**
- **Entity**

Terms Patients Use to Refer to Their Identities or Self-states

Commonly Used Terms

- **Parts**
- **Parts of me**
- **Parts inside**
- **Aspects of me**
- **Ways of being**
- **Parts of the self**
- **Others**
- **People**
- **Persons**
- **Individuals**
- **Friends**
- **Companions**
- **Spirits**
- **Demons**

Distinguishing/Naming Parts

- Parts may have names from early on.
- Some patients may have no designations for different parts.
- There are differing opinions as to whether distinguishing parts is helpful or harmful.
- Therapist inquiry about inner experiences has been criticized, but is now regaining popularity in mainstream dissociation treatment.

Physiological Differences Among Alternate Identities

- **Visual Acuity**
- **Medication response**
- **Allergy**
- **Plasma glucose levels**
- **Electro-encephalography**
- **fMRI activation**
- **Heart rate**
- **Blood pressure**
- **Galvanic skin response**
- **Muscle Tension**
- **Laterality**
- **Immune function**
- **Evoked potentials**
- **SPECT scans**

Characteristics of Identities

	Adult	Child
2 or more identities	mode = 3-4 median = 10 mean = 13	<10
Dominating identity determines behavior	Generally true	Usually true Others try to exert influences without emergence

Characteristics of Identities

	Adult	Child
Complex unique identities	At least some	Muted and attenuated
Elaboration of differences	Common and often strong	Uncommon
Distinct roles and purposes	Special purpose identities	Less elaborated

Characteristics of Identities

	Adult	Child
Investment in separateness	Common	Less common
Distinct internal worlds (distinct systems of personalities)	Not infrequent	Rare

Imaginary Companions

- **Normal occurrence in childhood**. Usually occurs from three to nine years of age.
- Often experienced as children a little younger than themselves and/or anthropomorphized animals and inanimate objects.
- **Characteristics**: Girls choose males more often than boys choose females. The brighter the child, the more elaborate the imaginary companion.
- **Implications for dissociative disorders:** Dissociative children over age seven still experience the imaginary companion as "real." They cannot "own" their projection, just as they cannot "own" the self-states that consider themselves autonomous.

Epidemiology for DID

- ~1-3% of general adult population
- 1-20% of inpatients with diagnosable DID
- Similar proportion of children and adolescents
- Female to male ratio increases from about 1:1 in childhood to 9:1 in adulthood
- DID begins in childhood

Impact of Trauma on Memory

- Individuals can experience traumatic events and be unable to recall them later on.
- Traumatic states may remain isolated from the normal integrative functioning and thus impair development. (Siegel, 1999)

Trauma & Memory for Abuse

- In cases of physical and sexual abuse the greater the victim's dependence on the perpetrator, the more likely that memory for the abuse will be impaired or disrupted
- Age was not a significant predictor of memory impairment, while caretaker status was. (Freyd et al, 2001)

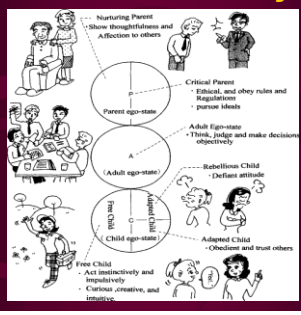
Developmental Theory

- Conceptual Models
- Polyvagal Theory
- Epigenetics

Conceptual Models in Dissociation

- Ego State Model (Berne, Watkins)
- BASK Model (Braun)
- Structural Model (Van der Hart, et al.)

Ego State Model Transactional Analysis



Ego-State Therapy

- *Psychodynamic approach in which techniques of group and family therapy are employed to resolve conflicts between various "ego states" that constitute a "family of self" within a single individual. (Watkins & Watkins)*

Ego States in Ego State Therapy

- Represent patterns of behavior and experience that are clustered and organized under some common principle
- The boundaries between these entities are very flexible and permeable.

Ego-State Therapy

- For example, if a child introjects and forms an ego state around its perception of a punitive parent, that ego state (an internalized object) may be punitive to the child, as was the original parent. The individual may then experience depression or some equivalent painful symptom. The punitive parent continues to live inside the individual, even into adulthood.

Ego State in DID (MPD)

- Ego states that are cognitively dissociated from one another or have contradictory goals often develop conflicts with each other. When they are highly energized and have rigid, impermeable boundaries, multiple personalities evolve. Many such conflicts manifest covertly between ego states.

Ego-State Therapy: Treatment

- It is a kind of internal negotiation that may employ any of the directive, behavioral, abreactive, or analytic techniques of treatment, usually under hypnosis.
- Through hypnosis we can focus on one segment of personality and temporarily ablate or dissociate away other parts.

BASK Model (Braun, 1988)

	Ablation	Intrusion
Behavior	Hysterical paralysis	Automatism
Affect	Blunting	Irritability
Sensation	Anesthesia	Somatic memory Refractory pain
Knowledge	Amnesia	Flashback Nightmare

Structural Dissociation of the Personality (van der Hart et al)

- The term “structural” refers to the dynamic organization of dissociative parts within a single personality.
- Dissociative parts are not completely separate, static structures.

Commonly used terms

- (Alter) personalities
- Identities
- Discrete behavioral states
- Ego-states
- Dissociative/dissociated self-states
- Modes
- Dissociative parts

Special Terms for this Model

- Structural Dissociation
- Apparently Normal Personality
- Emotional Personality
- Action Systems
- Phobias

Process of the work

- "All clinicians working with dissociative parts to foster integration of the personality base their approach on a theory of (structural) dissociation of the personality."

Why "Structural" in "Structural Dissociation of the Personality"?

- "Out of necessity, given the confusion about the concept of dissociation.
- Dissociation of the personality does not take place at random, but likely occurs along existing 'fault lines'.
- Hence, there is a (dynamic) organizational structure among dissociative parts of the personality."

Dissociative Points of View

- "Dissociative parts have different points of view involving different ideas of self world and self-in-the-world (Ellert Nijenhuis, 2008).
- These ideas encompass different perceptions and related action tendencies.
- These various points of view are often highly conflictual."

Points of View

- Points of view are determined by our needs and perception of salient stimuli (i.e., interoceptive and exteroceptive stimuli) including those of significant others.
- In any given situation, various points of view are possible. The challenge is to make the decision for the most adaptive approach and related actions.
- In structural dissociation, this adaptive decision-making is hampered by the rigidity of parts and the extreme difficulty of resolving these inner conflicts.

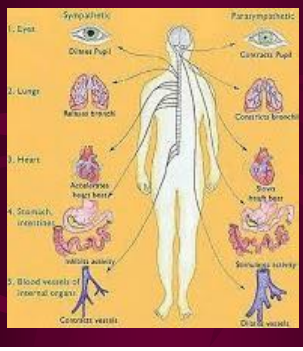
Structural Dissociation of the Personality and Action Systems

Hypothesis: Trauma-related dissociation involves

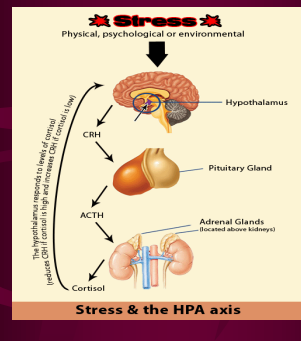
- a structural dividedness of the organization of the personality into two or more parts
- that are essentially mediated by
- different action systems
- or constellations of action systems.

(Relatively) integrated action systems	The personality at large											
Primary structural dissociation: Simple PTSD	Emotional Part of the Personality						Apparently Normal Part of the Personality					
Action systems	The system dedicated to survival of the severely threatened individual: the defensive system						Systems dedicated to survival of the species & to managing daily life					
Secondary structural dissociation: Complex PTSD, Disorders of Extreme Stress, DDNOS	Dividedness of the Emotional Part of the Personality											
Action systems: sequential dissociation*	Apprehension	Flight	Freeze; Analgesia	Fight	Total submission Anesthesia	Recuperation Return of pain sensitivity						
Action systems: parallel dissociation*	Observing part of the personality											
	Experiencing part of the personality											
Tertiary structural dissociation: DID	Emancipation of Emotional Parts of the Personality; development of more than one EPs that represent a defensive subsystem, e.g., freezing due to chronic traumatization						Dividedness of the Apparently Normal Part of the Personality					
Action systems dedicated to defense, daily life, attachment, and survival of the species*	Apprehension	Flight	Freeze; Analgesia I	Fight	Total submission Anesthesia I	Recuperation Return of pain sensitivity	Attachment to offspring	Performing professional activities	Generally numb, depersonalized, and avoidant personality			
	X	X	Freeze; Analgesia II	X	Total submission Anesthesia II	X						

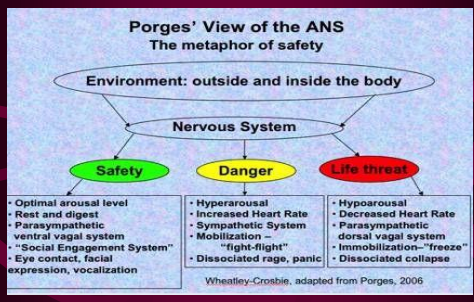
Autonomic Nervous System



Stress and the HPA Axis



Polyvagal Theory Sequence



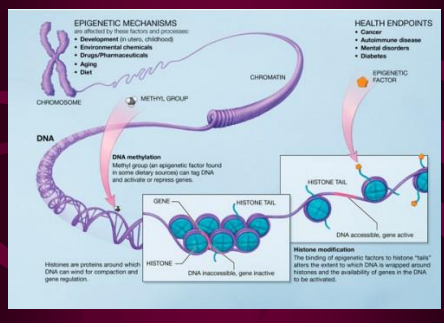
Epigenetics

- Environmental influences affect the genetic expression of DNA
- Epigenetic modifications can be inherited from one generation to the next.

Epigenetic Mechanisms

- DNA methylation and histone modification can regulate gene expression without altering the underlying DNA gene sequence.

Epigenetic Modification



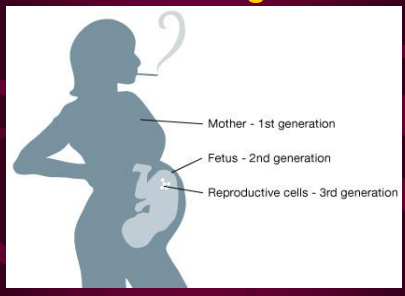
Epigenetics and Environmental Stress

- Children living in poor, stressful environments were tested as having more methylation of their genes than a population living in a supportive neighborhood.

Epigenetic Inheritance

- DNA sequencing of genes is unchanged.
- Some epigenetic tags remain in place from generation to generation.
- The new embryo's epigenome is not completely erased and rebuilt from scratch.

Intergenerational effects of smoking



Epigenetics and psychotherapy

- "Successful psychotherapy may activate epigenetic mechanisms in brain circuits to reduce psychiatric symptoms by improving the efficiency of information processing in these circuits, just like effective drug therapy is thought to do."

J Clin Pharm Ther 2012 p253

ASSESSMENT INSTRUMENTS FOR DISSOCIATIVE DISORDERS

- Structured Interviews
- Child Rating Scale
- 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
Child Rating Scale

- 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)

Treatment Process

- Duration of treatment for DID
- Treatment overview
- A wide variety of psychotherapy interventions are being used

Duration of treatment

For Children	Heavily dependent on environment Few sessions to many years
For Adolescents	May have to accept stabilization and support until early adulthood if in a chaotic or abusive environment
For Adults	Usually several (2-5) years

Treatment Overview

Phase or Stage Oriented Approach

1. Safety, stabilization, and symptom reduction
2. Processing traumatic experiences
3. Integration or fusion, and rehabilitation

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 feelings of helplessness, grief confusion, shame, horror, terror, anger and rage
- Sharing traumatic memories among alters

Treatment Overview

3. Integration, Fusion, Rehab 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 direction - increase communication and decrease barriers between identities.

Treatment of Patients with Dissociative Disorders (TOP DD) Study (Brand et al 2009, 2010)

- Prospective observational study
- 280 DID or DDNOS patients
- 292 therapists from 19 countries
- Over 30 months of treatment

TOP DD Study Treatment Outcome

- In later stages of treatment had:
- Fewer symptoms of dissociation, PTSD and distress
- Better adaptive functioning
- Addresses the Iatrogenic Model (IM) controversy

Iatrogenic Model (IM)

- Proponents of the Iatrogenic Model (IM) of the etiology of DID have expressed concern that treatment focused on direct engagement and interaction with dissociated self-states harms dissociative identity disorder (DID) patients

Iatrogenic Model (IM) (cont.)

- Empirical data has shown that this type of DID treatment is beneficial. Analyzing data from the prospective study, Treatment of Patients with Dissociative Disorders (TOP DD), there were significant decreases in patients feeling like different people and hearing voices. (Brand, in press)

Individual therapy

- Psychodynamically-aware psychotherapy
- For children, use therapy techniques commonly used with abused and traumatized children.
- Historical controversy: Direct addressing of self-states

Favored Concepts
Kluft, *Shelter from the Storm* (2013)

- Rheostat metaphor
- "The slower you go, the faster you get there."
- Dosage control
- Preservation of function
- Avoidance of cascading

Favored Concepts (cont.)

- Virtues of cooperation
- "Getting better and feeling better are two different processes."
- Moving patients from passivity to activity and from helplessness to self-efficacy
- Personality state dynamics

Favored Concepts (cont.)

- Compassionate overall care of the traumatized individual
- Pacing
- Postpone trauma work until avoidances are resolved
- Go where the power is

Favored Concepts (cont.)

- Bring all sensory modalities to awareness
- Therapeutic alliance as the key to therapy
- Negative transferences can easily be mobilized
- Rule of Clouseau

Favored Concepts (cont.)

- Belafonte's Law
- Rationale for mapping
- Hypnosis
- Agreements between alters
- "You can't get there from here."
- Closure, containment, and safety

Favored Concepts (cont.)

- "Quit while you are ahead and while the patient feels like a winner." Joseph Wolpe, M.D.
- Kluft's "Rule of Thirds"
- Trauma work is not "time out" from the mainstream of therapy

Favored Concepts (cont.)

- "Slow leak" technique
- Nathanson's "Compass of Shame"
- Leaving session in hypnotic state
- Addressing aspects of closure

Cautions in Psychotherapy

- 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, documenting why.

More cautions and limits

- Premature divulgence of trauma - Outside of forensic and safety reasons, there is little reason to pull forward 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, and social and sexual maturity when developing treatment approaches.

Ego state **interventions**

- **Internal Family Systems Therapy**
  Uses family systems theory to address disparities in perceptions and projections of "subpersonalites".
- **Ego-state therapy**
  Focuses on utilizing separateness between ego shifts. Commonly uses hypnosis.
- **Transactional Analysis**
  Uses Parent-Adult-Child ego states as the theoretical basis.

Hypnotherapy

- Therapist training in hypnosis is highly useful in the treatment of trauma and dissociation, 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 induction is not usually needed on a regular basis.
- Some therapists use hypnosis intensely.

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.
- Originally designed to treat borderline personality disorder.

Eye Movement Desensitization and Reprocessing (EMDR)

- "Accelerated information processing" targets a disturbing event and applies alternating bilateral stimulation to resolve the trauma.
- Process includes strengthening positive beliefs and increasing somatic comfort.
- "Resource installation" builds internal resources such as self-confidence.

Difficulties with using EMDR

- Training is complex/expensive
- Client preparation is elaborate
- May take more than 50 minutes
- Inter-session disturbance from incomplete reprocessing
- Premature/inappropriate application
- Uncovering unrealized dissociation

Advantages of using EMDR

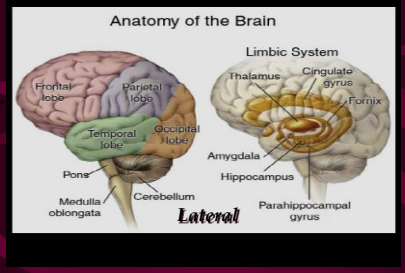
- Is established as effective for PTSD
- Brings out client's strengths
- Can be applied with any form of clinical practice
- Focuses on specific target/problem
- Results in generalized positive effects

Anatomical Planes

Dorsal

Anterior

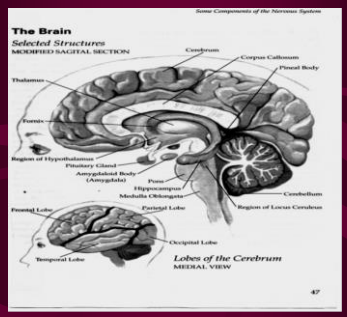
Posterior



Ventral

Cerebellum

Dorsal



Anterior

Posterior

Ventral

EMDR: Hypothesized Mechanism – Stickgold (2002)

- "Several lines of evidence suggest that EMDR may help in the treatment of PTSD by turning on memory processing systems normally activated during Rapid Eye Movement (REM) sleep but dysfunctional in the PTSD patient. Two separate memory systems store information in the brain. One, located in the hippocampus, stores 'episodic' memories, the memories of actual events in our lives. The second, located in the neocortex, stores general information and associations.

EMDR: Hypothesized Mechanism – Stickgold (2002) cont.

- EMDR through the repetitive redirecting of attention, activates brain systems normally present during REM sleep. Any alternating, lateralized stimulation regimen, whether eye movements, tapping, or binaural sound, could activate these systems by forcing the brain to constantly reorient to new locations in space. In this manner, EMDR can 'push-start' the broken-down REM machinery that is required for the brain to effectively process traumatic memories."

EMDR: Hypothesized Mechanism – Levin, Lazrove and van der Kolk (1999)

- Post-EMDR, the Rorschach Hypervigilance Index went from positive to negative, indicating that the subject was spending less time scanning the environment for threats, and available ego resources also increased, as measured by the Experience Actual variable. Upon recall of the traumatic memory during SPECT scanning, two areas of the brain were hyperactive post-EMDR treatment relative to pretreatment: the anterior cingulate gyrus and the left frontal lobe.

EMDR: Hypothesized Mechanism – Levin, Lazrove and van der Kolk (1999)

- An important implication of these findings is that, using EMDR, successful treatment of PTSD does not reduce arousal at the limbic level, but instead, enhances the ability to differentiate real from imagined threat.

Somatic Experiencing Therapy

- Using a variety of subtle methods to encourage the patient to be in touch with the body in a gentle way, by leading into and out of (pendulating) traumatic awareness.

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.
- Ongoing individual psychotherapy is needed to support the group process.

Expressive therapies

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

Pharmacotherapy

- Nearly all classes of psychotropic medications have been used empirically with DID patients.
- Treat symptomatically, in accordance with concurrent diagnoses.

Pharmacotherapy with Complex Trauma

- Antidepressants: SSRIs treat depression/PTSD
- Anxolytics: Short term for anxiety
- Neuroleptic/antipsychotics: Treat overactivation; thought disorganization; intrusive PTSD symptoms; chronic anxiety; insomnia; irritability
- Opioid antagonist, naltrexone, decreases some depersonalization disorder symptoms

Insomnia with DID

- Whenever possible, address within treatment framework
- Negotiate with fearful and nocturnal self-states
- Trauma resolution to decrease PTSD reactivity
- Judicious use of medication

Family Assessment and Intervention

- On the average, each person with DID has 1.5 first-degree relatives with a dissociative disorder.
- Children of MPD patients
- Mothers with MPD
- Abuse intervention

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.

Intervention with Abusive Mothers

- Agency/Legal Intervention
- Ongoing Supervision
- Teaching parenting skills
- Intensive psychotherapy for MPD pt
- Tx & long term f/u for children
- Support/education/advice for spouse

Kluft, 1987

Mothers with MPD

- Competent/exceptional 39%
- Compromised/impaired 45%
- Grossly abusive 16%

Kluft, 1987

Trauma Avoidance Symptoms

- Characterized by an unwillingness to address thoughts, emotions, sensations or memories of early traumas.
- Interfered with mothers' ability to talk with their children about the child's emotions Vanentino, 2013

Residential Hospital Treatment

- Treating DID is fundamentally an outpatient process
- Treatment may be punctuated by short hospitalizations
- Dynamics between staff and patient vary by setting
- Specialized units are decreasing

Some Active Hospital Programs

- Del Amo Hospital, Torrance, CA.
- Forest View Hospital in Grand Rapids, MI
- Psychiatric Institute, Washington, DC
- Sheppard-Pratt, Baltimore, MD
- McClean Hospital, Belmont, MA
- Timberlawn Mental Health System, Dallas, TX

Useful Resources

- Baars et al. (2013) Predicting Stabilizing Treatment Outcomes for Complex Posttraumatic Stress Disorder and Dissociative Identity Disorder
- Boon et al. (2011). Coping with trauma related dissociation
- Courtois & Ford. (2009). Treating complex traumatic stress disorders
- Chu, J.A. (2011). Rebuilding shattered lives
- Howell, E. F. (2011). Understanding and Treating DID
- Kluft, R.P. (2013). Shelter from the storm.
- Ross & Halpern. (2009). Trauma Model Therapy
- Silberg, J.L. (2013). The child survivor

Online Resources

- International Society for the Study for Trauma and Dissociation (ISSTD) http://www.isst-d.org
- Dissociative Disorders listserv http://listserv.icors.org/scripts/wa-ICORS.exe?A0=DISSOCIATIVE-DISORDERS
- Adult Survivors of Child Abuse (ASCA) Guidelines http://ascasupport.org
- David Baldwin's Trauma Information Pages http://www.trauma-pages.com

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