Management of Complex PTSD / DID

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Introduction
COMPLEX PTSD

- Based on the notion of a spectrum of responses to traumatic events
- Developmentally Based, Chronic, Post-Traumatic Condition
COMPLEX PTSD
DIAGNOSTIC FEATURES
(HERMAN, 1997)

1. History of subjection to totalitarian control over a prolonged period
   – Hostages, pow’s, political detainment, child abuse, domestic abuse, organized sexual exploitation
2. ALTERATIONS IN AFFECT REGULATION

- Persistent dysphoria
- Chronic suicidal preoccupation
- Self injury
- Explosive or inhibited anger
- Compulsive or inhibited sexuality
3. ALTERATIONS IN CONSCIOUSNESS

- Amnesia or hypermnesia
- Transient dissociative episodes
- Depersonalization/ derealization
- Intrusive PTSD sx.’s or ruminative preoccupation
4. ALTERATION IN SELF PERCEPTION

- Sense of helplessness or paralysis of initiative
- Shame, guilt, self blame
- Sense of defilement or stigma
- Sense of alienation (specialness, aloneness, belief no other person can understand, sense of self as nonhuman)
5. ALTERATIONS IN PERCEPTION OF PERPETRATOR

- Preoccupation with relationship (including revenge)
- Attribution of total power
- Idealization or paradoxical gratitude
- Acceptance of belief system of perpetrator
- Sense of special or supernatural relationship
6. ALTERATIONS IN RELATIONSHIPS WITH OTHERS

- Isolation and withdrawal
- Disruption in relationships
- Inability to trust
- Revictimization
- Repeated search for rescue
- Victimization of others
7. ALTERATIONS IN SYSTEMS OF MEANING

- Hopelessness and despair
- Loss of previously sustaining faith or belief system
8. SOMATIZATION (DSM-IV FIELD TRIALS)

- GI symptoms
- Chronic pain
- Cardiopulmonary symptoms
- Conversion symptoms
- Sexual symptoms
SOMATIZATION DISORDER
DSM-IV

- 1859- Paul Briquet
- Hysteria
- Multiple physical symptoms
- Not explained by a general medical condition
**F62.0 ENDURING PERSONALITY CHANGE AFTER CATASTROPHIC EXPERIENCE (ICD-10 WHO, 1992)**

- Extreme stress (torture, concentration camp experiences, disasters, captivity, hostage situations)
- PTSD may precede
- Features such as
  - Hostile/mistrustful attitude toward the world
  - Social withdrawal
  - Feelings of emptiness / hopelessness
  - Chronic feeling of being “on edge” as if constantly threatened
  - Estrangement
- 2 year duration
COMPLEX PTSD

- Complicated PTSD (Brown and Fromm, 1986)
- Post traumatic character disorder (Horowitz, 1986)
- DESNOS (DSM-IV field trials)
Dissociative Disorder

- Essential feature is a disruption in the usually integrated functions of consciousness, memory, identity, or perception - DSM-IV-TR (2000)
- Dissociation involves the segregation of some subsets of information from other subsets of information in a relatively rule-bound manner - David Spiegel (1986)
**DSM-IV Criteria for Dissociative Identity Disorder**

- Presence of two or more distinct identities or personality states
- At least two identities or personality states recurrently take control of behavior
- Inability to recall personal information; too extensive for forgetfulness
- Disturbance not due to direct physiological effects, substance abuse, or general medical condition
Dissociative Identity Disorder

- Inpatient Studies (internationally) demonstrate 4-6% prevalence
- Childhood onset, but usually diagnosed after age 40 (but this is changing)
- Average of 6-7 years after entering the mental health system before the diagnosis is made
Dissociative Identity Disorder

- Symptoms are generally covert, unless pt. is in crisis.
- “window of diagnosibility”
TREATMENT MODELS
JANET (1919)
STAGES OF TREATMENT FOR PTSD

- Stabilization and symptom reduction
  - Rest ... isolation ... simplification
- Modification of traumatic memories
- Personality reintegration and rehabilitation
TREATMENT STAGES (HERMAN, 1992)

- Safety
- Remembering and mourning
- Reconnection
Abuse and neglect leads to symptom formation through:

- Altering attachment dynamics
- Effects of early PTSD on development
- Motivates the development of “primitive” coping strategies
- Distorts child’s cognitive view of self, others, and future
BRIERE (1996)

- Intrusive PTSD symptoms seen as reflecting the imbalance of the trauma relative to the self capacities of the individual
- Sx’s seen as serving an adaptive psychobiological function
SELF-TRAUMA MODEL (BRIERE, 1996)

- Trauma disrupts the development of self capacities such as boundary regulation, affect modulation and tolerance, and identity.
- Treatment involves balancing exposure to distressing material with self capacities by working within a "therapeutic window"
TENSION REDCTION BEHAVIORS

- Substance abuse
- Sexual acting out
- Eating behaviors
- Suicidality
- Self mutilation
- Reenactments
POSTTRAUMA TREATMENT MODEL (COURTOIS, 2009)

- Evolving consensus model
- Based on a triphasic treatment model (Janet, Herman)
- Stage specific goals, tasks, and outcome measures
EARLY PHASE

- Establish the treatment frame
- Development of the therapeutic alliance
- Informed consent
- Initial tasks and goals defined
- Focus on safety
- Self care
- Symptom stabilization
EARLY PHASE

- Development of skills and self functions
- Development of support systems
- Renegotiation of therapeutic contract if proceeding beyond early phase work
MIDDLE PHASE

- Deconditioning
- Mourning
- Resolution and integration of the traumatic experiences
- Follows only after careful assessment of goals and client variables
LATE PHASE

- Establishment and continuance of secure social relationships
- Continued self development
- Life reconsolidation and restructuring
- Development of non trauma focused lifestyle
Management of Dissociative Identity Disorder & DDNOS
Early Phase Management of DID

- Making the Diagnosis
- Symptomatic relief
- Treatment of Pt as a complex “self system”
- Empathy and mutual identification with self system
- Focus on self states as a source of strength, adaptation, and recovery
- Interventions to increase internal awareness, communication, cooperation and empathy
Early Phase Management of DID

- Education re: trauma
- Establishing the “frame” of treatment
- Addressing dangerousness
- Boundary Issues
- Identifying and working with trauma based cognitive distortions
DID Therapeutic Techniques

- “talking over”
- Ideomotor signals
- Therapeutic writing tasks
- “Mapping” of the dissociative surface
- Teaching grounding and containment skills
Grounding and Containment

- Allow the dissociative capacity to be utilized for therapeutic aims
- Grounding involves sensory awareness in the present
- Containment involves shaping the dissociative capacity to manage distress, intrusive recollections, and build mastery, and ego strengthening
Containment Techniques

- Benign trance
- Safe place
- Time vault
- Cue words
- Screen imagery
- Rheostats
- Internal meeting place
DID Middle Phase Management

- Learning history of the self system
- Working with traumatic memory
- Grief work
- Preparing for unification / integration
Post Unification Treatment

Issues

- Coping with psycho-physiological changes associated with unification
- Working through of the meaning of what was learned about the patients history
- Development of non dissociative coping strategies
- Interpersonal adjustments
- Termination / Follow up
“The patient unconsciously expects that the therapist, despite overt helpfulness and concern, will covertly exploit the patient for his or her own narcissistic gratification”
TRAUMATIC TRANSFERRENCE

- Victim, perpetrator, rescuer triad
- Represent an interpersonally cued form of post-traumatic intrusion
TRANSFERENCE IN DISSOCIATIVE DISORDER PATIENTS (LOEWENSTEIN, 1993)

- Multilevel and simultaneous transferences
- Traumatic transference
- Flashback transference
- Scenario transference
- Projective identification
COUNTERTRANSFERENCE AND TRAUMA

TYPICAL PATTERNS INCLUDE:

– Over-involvement
– Defensive withdrawal
– Over-identification (with “secondary PTSD” / VT)
– Pressures to change the normal boundaries of the therapeutic relationship
DISSOCIATIVE PHENOMENA IN THE COUNTERTRANSFERENCE

- Amnesia
- Depersonalization
- Trance states
- Altered perceptions
- “Trance logic”
- Shared terror/ paranoia
- Secondary PTSD /VT
COUNTERTRANSFERENCE THEMES (KLUFT, 1994)

- Reactions to the pt.s “multiple reality disorder”
- Reactions to avoidance and pain evasion
- Reactions to the pt.s preoccupation with controlling the therapist
Difficulties maintaining an empathic stance with traumatic material
Reactions to negative transferences
Reactions to loss of therapeutic sense of efficacy
Isolation
Reactions to reenactments and invalidation of one's personal reality
CRISIS INTERVENTION
WITH COMPLEX PTSD
PATHWAYS TO CRISIS

- Dissociation
- Use of tension reduction activities
- Substance abuse crises
- Affective dysregulation
- PTSD symptom crises
PATHWAYS TO CRISIS

- Suicidal crises
- Reenactments of traumatic experiences
- Reenactments of relational dynamics
CRISIS MANAGEMENT

- Focus on safety first
- Use of the therapeutic alliance
- Anticipate typical crises
- Focus on collaborative solutions
- “Crisis plans” in advance
- Symptom management skills
- “Lessons learned approach”
CRISIS MANAGEMENT

- Focus on trauma reenactment dynamics of the crisis
  - Reenacting of traumatic relational dynamics
  - Reenacting of traumatic events
- Monitor pacing of work on traumatic material
CRISIS MANAGEMENT

- Reframe crisis as an opportunity to work on goals
  - Eg. Challenging cognitive distortions
- Emphasis on choices, mindfulness, and empowerment
- Flexibility