Treatment of Complex PTSD and Dissociative Disorders in Clinical Practice

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Trauma Spectrum

- Peritraumatic reactions (dissociation, arousal, freezing, performance)
- Posttraumatic reactions
  - Critical Incident Stress
  - Normal adaptations to extreme events
- Acute Stress Disorder
  - 3 days to 4 weeks
- Posttraumatic Stress Disorder
  - immediate
  - delayed
  - chronic
Trauma Spectrum

- Complex PTSD/DESNOS
  - related to severe chronic trauma exposure, usually in childhood

- Dissociative Disorders
  - associated with disorganized attachment and/or abuse in childhood
  - can occur at any point in lifespan

- Post Traumatic Growth
Complex Posttraumatic Stress Disorder
Disorders of Extreme Stress Not Otherwise Specified (DESNOS)

- History of a Concept

- PTSD failed to identify a wider range of adaptations:
  - distinct from or co-morbid with PTSD
  - other Axis I, mainly:
    - depressive and anxiety disorders
    - substance abuse/other addictions
    - impulse control/compulsive disorders
  - Axes II and III
History of subjection to totalitarian control over a prolonged period
  - Hostages, pow’s, political detainment, child abuse, domestic abuse, organized sexual exploitation
Complex PTSD Adaptations

1. Alterations in regulation of affect and impulses
   - a. Affect regulation
   - b. Modulation of anger
   - c. Self-destructiveness / self mutilation
   - d. Suicidal preoccupation
   - e. Difficulty modulating sexual behavior
   - f. Excessive risk taking

2. Alterations in attention or consciousness
   - a. Amnesia
   - b. Transient dissociative episodes and
3. Alterations in self-perception
   - a. Ineffectiveness
   - b. Permanent damage (defiled, stigmatized)
   - c. Guilt and responsibility
   - d. Shame
   - e. Isolated and not understood by others
   - f. Minimizing

4. Alterations in perception of the perpetrator
   - a. Adopting distorted beliefs
   - b. Idealization of / identification with the perpetrator
   - c. Preoccupation with the perpetrator
5. Alterations in relations with others
   • a. Inability to trust
   • b. Revictimization
   • c. Victimizing others
   • d. Chronic chaotic relationship patterns

6. Somatization
   • a. Digestive system
   • b. Chronic pain
   • c. Cardiopulmonary symptoms
   • d. Conversion symptoms
   • e. Sexual symptoms

7. Alterations in systems of meaning
   • a. Despair and hopelessness
   • b. Loss of previously sustaining beliefs
Somatization Disorder

- 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)
Dissociative Disorders

- Dissociative Amnesia
- Dissociative Fugue
- Depersonalization Disorder
- Dissociative Disorder NOS
- Dissociative Identity Disorder
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”
- Most Common Presentation?
Psychotherapeutic Approaches
TREATMENT STAGES
(HERMAN, 1992)

- Safety
- Remembering and mourning
- Reconnection
POSTTRAUMA TREATMENT MODEL (COURTOIS, 2009)

- Evolving consensus model
- Based on a triphasic treatment model (Janet, Herman)
- Stage specific goals, tasks, and outcome measures
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
Treating Dissociative Identity Disorder

- ISSTD Guidelines (3rd Revision) serve as a best practice statement.
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
Therapeutic Alliance

- Mutual voluntary participation
- Safety first
- Semblance of trust
- Socialization to the therapy
- Ground rules
- Psychoeducation
- Assignments
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 TRANSFERENCE

- 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
KLUTF, (1994)

- 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
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
Principles of Successful Psychotherapy for DID (Kluft, 2004)

- Therapist consistency across self states is optimal stance
- Pace the therapy carefully ("rule of thirds")
- Empathic therapeutic stance when confronting is helpful
- Identify and address trauma based cognitive distortions / beliefs
CRISIS INTERVENTION WITH COMPLEX PTSD AND DD
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
Discussion