Understanding and identifying dissociation and dissociative disorders

Webinar: 28th November 2022

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NovoPsych

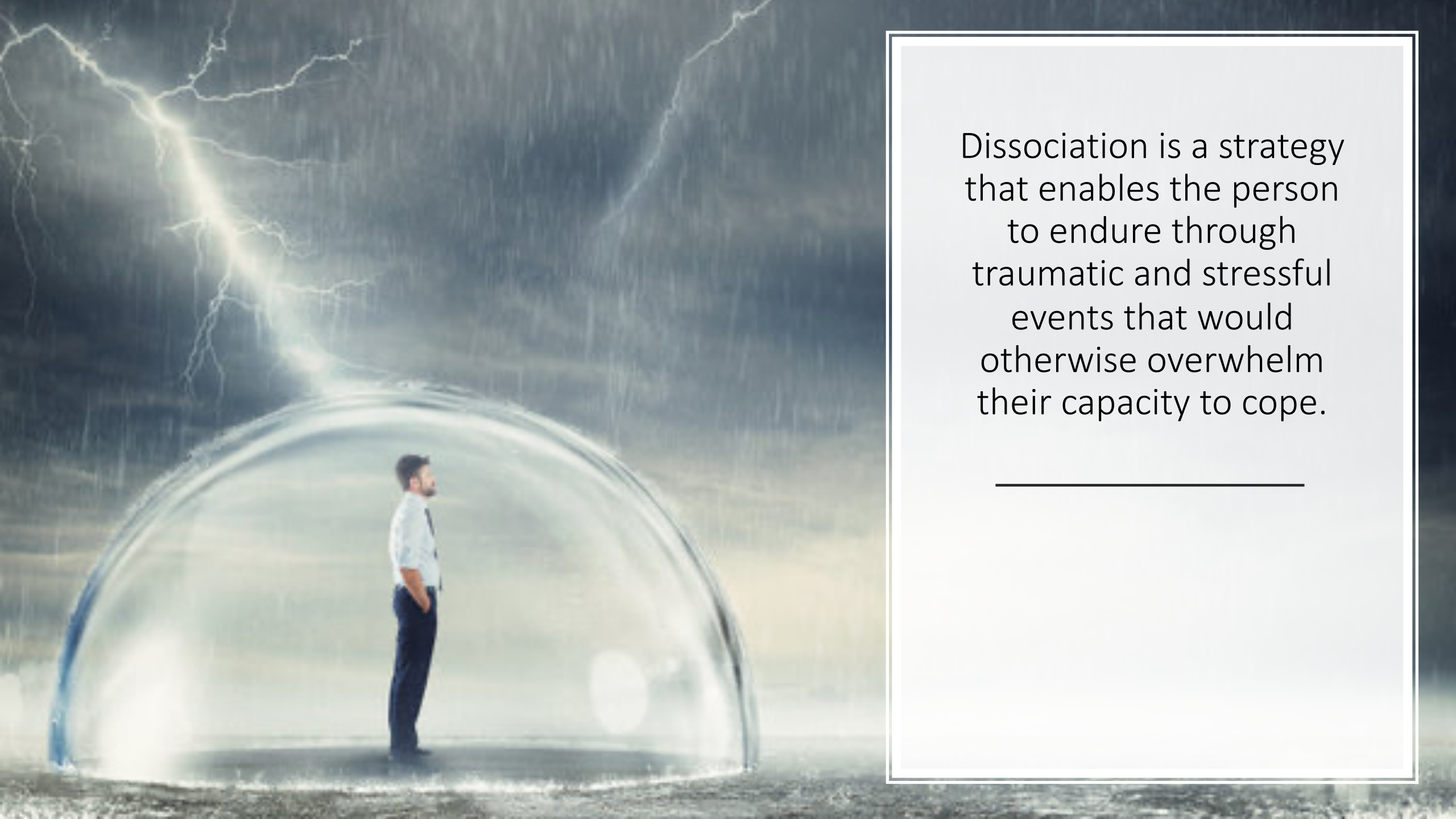
Learning Objectives

Describe	• Describe dissociative symptoms and experiences
Recognize	• Recognize who is at risk of a dissociative disorder
Identify	• Identify the symptom profile for DSM-5-TR dissociative disorders
Use	• Use the Multidimensional Inventory of Dissociation – 60 item version (MID-60) to screen for a dissociative disorder, assess the extent and type of dissociation, and to monitor progress in treatment

What is dissociation?

- **Dissociation** is when a person experiences a disconnection from their memories, feelings, actions, thoughts, body and/or identity
- **Dissociative Disorders** are characterized by a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior.

(DSM-5-TR)



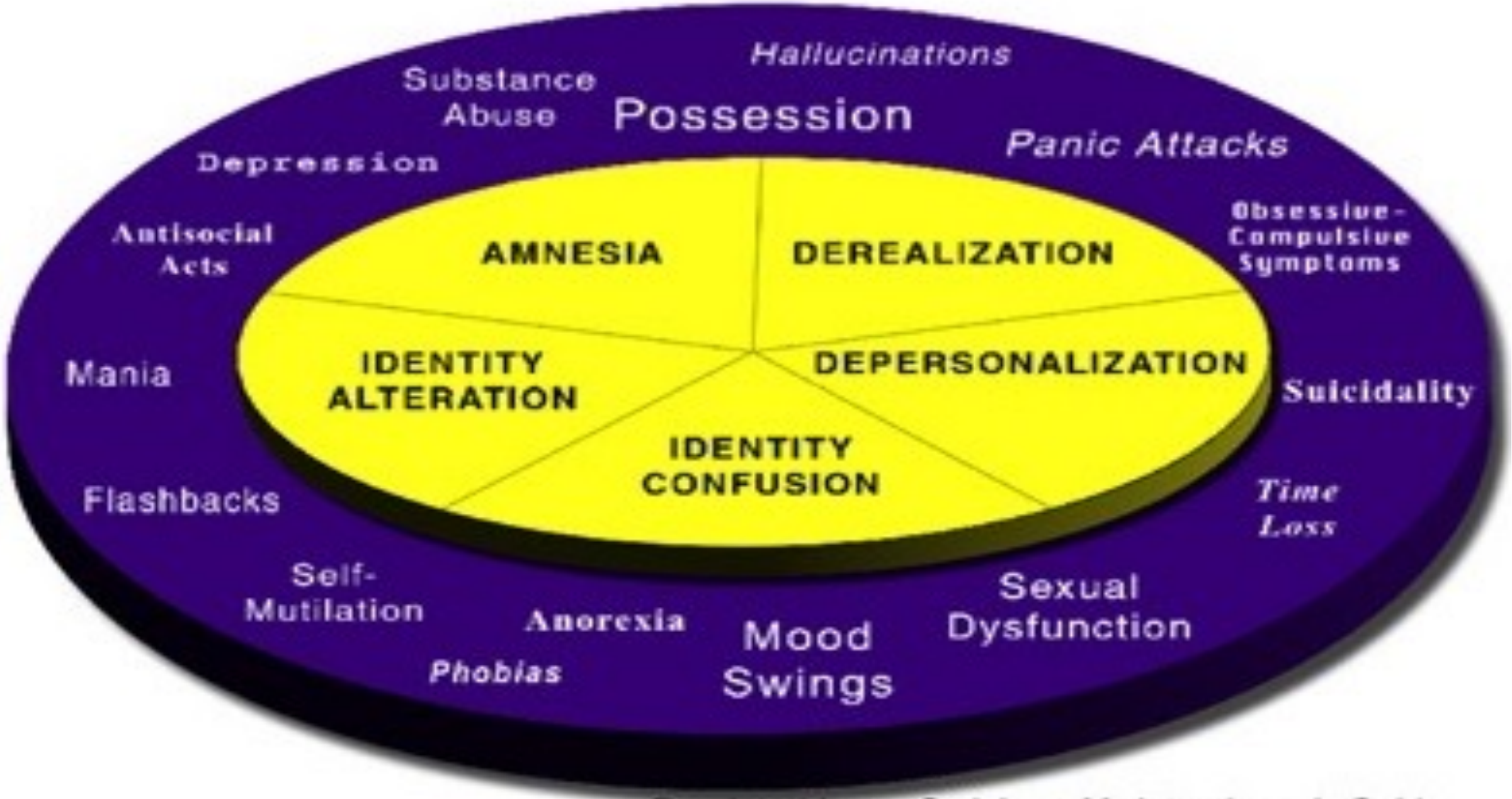
Dissociation is a strategy that enables the person to endure through traumatic and stressful events that would otherwise overwhelm their capacity to cope.

Five key dissociative symptoms

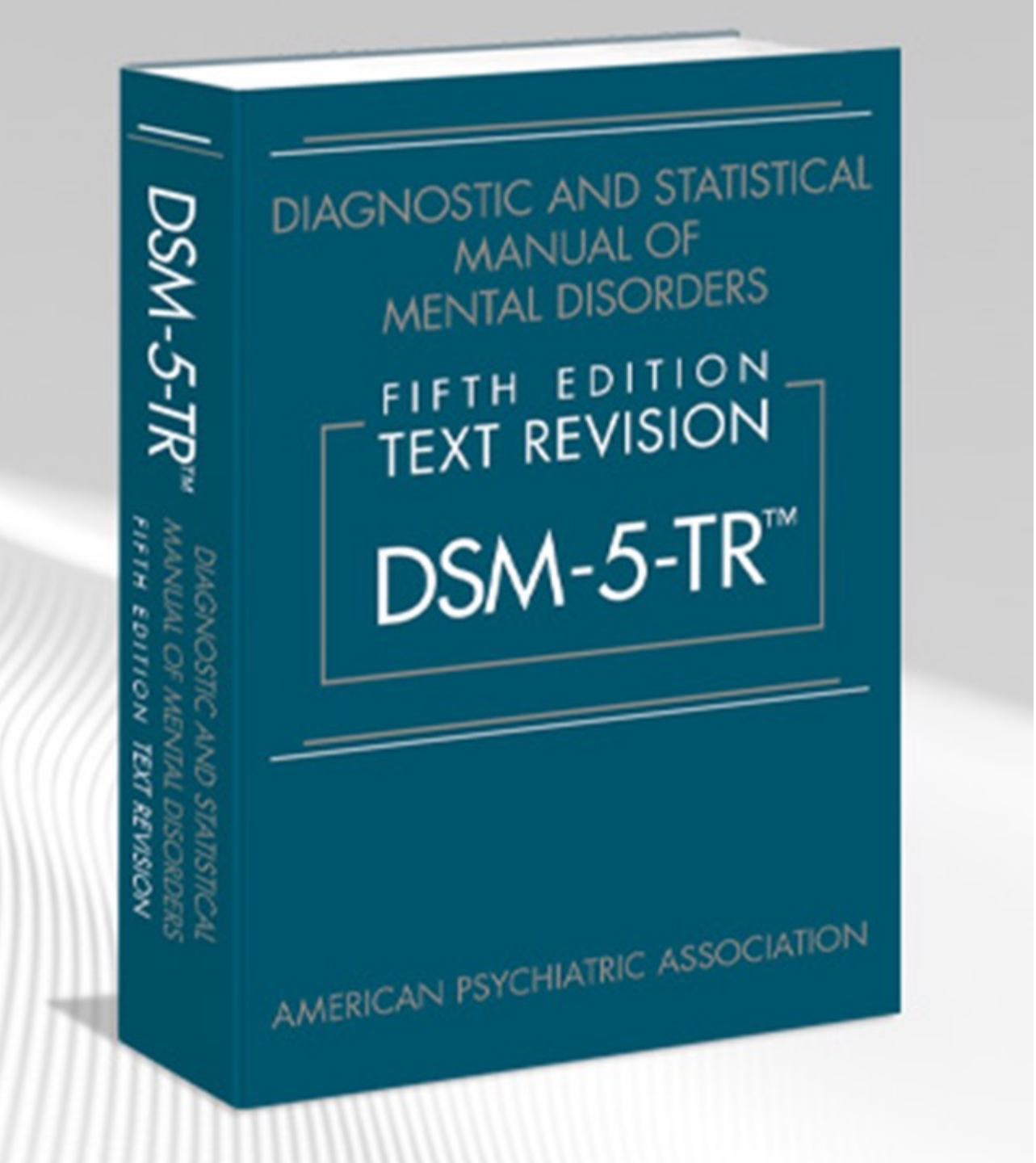
1. **Amnesia or memory problems** involving difficulty recalling personal information
2. **Depersonalization** or a sense of detachment of disconnection from one's self. A common feeling associated with depersonalization is feeling like a stranger to one's self.
3. **Derealization** or a sense of disconnection from familiar people or one's surroundings
4. **Identity confusion** or inner struggle about one's sense of self and identity
5. **Identity alteration** or a sense of acting like a different person

- Some individuals may have one or several of the symptoms of dissociation.
- A person with Dissociative Identity Disorder has all of these symptoms

(Steinberg, 1994; Steinberg & Schnall, 2001)

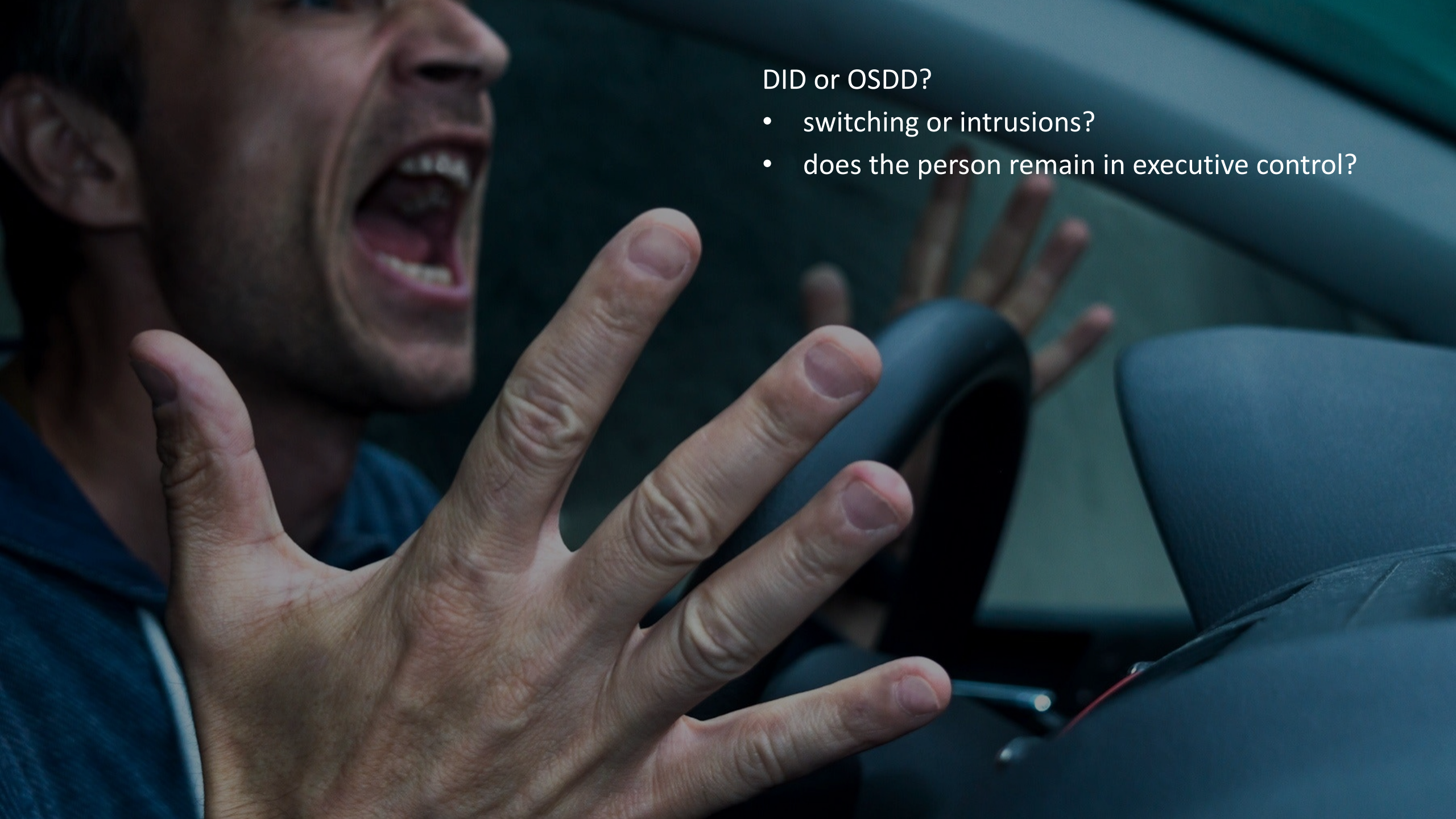


Reprinted from: Steinberg M, *Interviewer's Guide to the SCID-D*, American Psychiatric Press, 1994



Dissociative Disorders

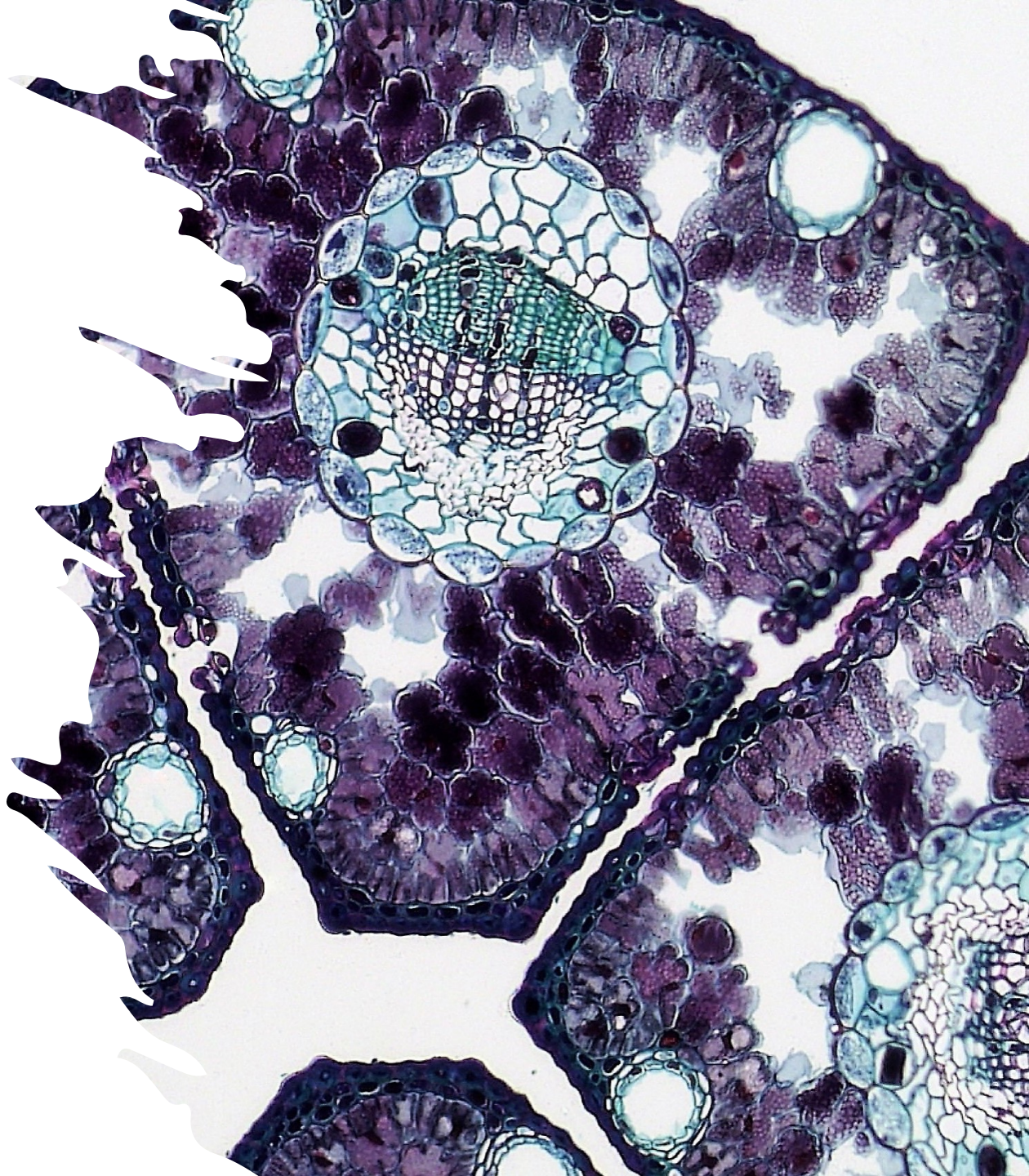
1. Dissociative Amnesia
2. Depersonalization/Derealization Disorder
3. Dissociative Identity Disorder (DID)
4. Other Specified Dissociative Disorder (OSDD)
5. Unspecified Dissociative Disorder



DID or OSDD?

- switching or intrusions?
- does the person remain in executive control?

Structural dissociation is characterized by amnestic barriers between some, or all, parts of the person



Are distinct aspects or parts of the self dissociative too?

Common treatment modalities focus on “parts” work:

- Understanding the inner critic
- Transaction analysis (Eric Berne): the person’s ego states comprise parent, adult, child
- Internal family systems (Richard Schwartz): “parts” consist of managers, firefighters, and exiles
- Schemas (Young, Klosko, and Weishaar): categories include child modes, dysfunctional coping modes, dysfunctional parent modes, and the healthy adult mode
- Inner child (popularized by John Bradshaw): focuses on healing the wounded child part of the self.

Where is the boundary between dissociation and *normal* experience?

My own perception is that these experiences of having “parts” are dissociative when there is a disconnection from overwhelming or stressful feelings and experiences. However, these experience may not meet diagnostic criteria.

Example of a teenager losing best friend to suicide during exam week who is unable to process their loss.

However, if you ascribe to structural dissociation theory, unresolved feelings of childhood, such as the inner child, are not dissociative. Ask: “What is just a feeling and not a personality.”

Colin Ross, 2022

Dissociation is a strategy that enables people to survive in the harshest of environments

“Dissociation provides the illusion that everything is okay”

- Colin Ross, 2022

Dissociation and dissociative disorders are fairly common

- 10% of the general population will meet the criteria for a dissociative disorder in their lifetime. Rates are similar in men and women
- Dissociation could usefully be conceptualised as being **similar to depression and anxiety**, in that all of these:
  - are a fairly **common reaction** to adverse experiences
  - are a fairly **common experience** amongst the general population
  - **may be clinically diagnosed** if the person experiences severe enough symptoms
  - *frequently* ***co-occur***

If you are working with clients with a history of complex trauma, you are working with clients with dissociation, many of whom will meet criteria for a dissociative disorder

What causes dissociation?

Dissociation is an attachment strategy

- Longitudinal studies demonstrate disorganized attachment predicts dissociation. Dissociation resolves the child's "fright without solution" in which the child is torn between two incompatible behaviors: wanting to seek care, comfort and protection from their caregiver, and wanting to avoid proximity as the caregiver is the source of their fear.
- Highly dissociative individuals do not have a secure attachment style.
- Dissociative individuals generally want to have a close and loving relationship, but are deeply being afraid to of being hurt. (Fearful attachment) This is heightened by paradoxical feelings in those with severe dissociation who wish to avoid relationships completely (Profound mistrust).
- (Kate, 2018)

How predictive are parent child dynamics?

Clinicians can explore the likelihood of a history of trauma and dissociation with clients by inquiring about items with high odds ratios for clinical levels of dissociation. Asking whether a female client if they:

- are comfortable seeking comfort from another person when they are hurt, unwell or upset reveals a 21-fold risk (this is also an eight-fold risk for males);
- felt they had any control over their life growing up reveals a 17-fold risk
- felt safe much of the time they were at home reveals a 10-fold risk
- knew their thoughts, feelings and beliefs mattered and they were taken seriously reveals a 10-fold risk (5-fold risk for males).
- If their parents supported them to develop the skills and knowledge needed to be independent and take charge of their own life reveals a 7-fold risk (9-fold for males)" .

(Kate, 2022)

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Routledge
Taylor & Francis Group

Childhood Sexual, Emotional, and Physical Abuse as Predictors of Dissociation in Adulthood

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ABSTRACT

This Australian study explores a person's self-reported exposure to childhood abuse to identify the characteristics that are predictive of clinical levels of dissociation in adulthood. The final sample comprised 303 participants, including 26 inpatients and outpatients (24 females and two males) receiving treatment for a dissociative disorder (DD), and 277 university participants, including 220 controls (186 females, 34 males), 31 with elevated levels of dissociation consistent with a DD or posttraumatic stress disorder (27 females and four males), and 26 with clinical levels of dissociation (20 females and six males). The findings demonstrate clinical levels of dissociation and DDs occur in individuals reporting a history of childhood abuse, particularly sexual abuse and experiences that are potentially life-threatening to a child, such as choking, smothering, and physical injury that breaks bones or teeth, or that compromise the child's survival needs, including threats of abandonment and deprivation of basic needs. Females who disclosed being sexual abused in addition to being choked or smothered had a 106-fold risk of clinical levels of dissociation. As expected, self-reported amnesia was prevalent in the dissociative groups. Yet, even in the control group, one-third of those disclosing sexual abuse reported an unclear memory of it. Strong similarities in abuse experiences were found between the clinical sample and those in the university sample with clinical levels of dissociation (which is unlikely to have previously been diagnosed). The dissociative groups reported higher rates of corroboration of their abusive experiences. The findings support the traumatic etiology of dissociation.

ARTICLE HISTORY
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KEYWORDS
sexual abuse; childhood trauma; dissociation; memory

What happens following trauma is crucial

Dissociative Disorder odds ratio for the parental role in, or reaction to, abusive experiences

- The mother's role or reaction was negative vs positive or neutral 45 : 1
- The father's role or reaction was negative vs positive or neutral 3 : 1

Kate (2018)

Common experiences in DID

- A lack of maternal care and concern
- "Behind closed doors". The family may present to the outside world as upstanding masking the high levels of dysfunction and abuse
- Gaslighting – "it's not real, you're making it up"
- "This is just what happens in my family." not realizing the abuse is not normal.
- "It's my fault" - internalizing badness
- The abuse is so bizarre it couldn't possibly be true
- Turning a blind eye – people knew, but did not intervene.
- Abuse starts before the age of six, and occurs frequently, often daily. On average 1,300 -1,400 sexually abusive experiences.
- The abuse is severe, often life-threatening.
- There are multiple perpetrators, including family members as well as organized abuse.

Kate, M.-A., Jamieson, G., & Middleton, W. (2022). "Dr Who, a Tardis, and a relocation": Women with Dissociative Identity Disorder reflect on barriers to identifying and disclosing their trauma. In: Christensen, E. (ed) *Perspectives of Dissociative Identity Response: Ethical, Historical, and Cultural Issues*. HWC Press, LLC

MID-60

Multidimensional Inventory of Dissociation

60–item version

What is the MID-60?

The MID-60 is:

- a self-report screening tool to measure dissociative symptoms and experiences
- based on Paul Dell's the 218-item diagnostic Multidimensional Inventory of Dissociation (MID) and includes the most predictive 5 factors from each of the MID's 12 scales
- a peer reviewed instrument with excellent internal reliability, and content and convergent validity. See:

  Kate, M.-A., Jamieson, G. A., Dorahy, M.J., Middleton, W. (2020). Measuring dissociative symptoms and experiences in an Australian college sample using a short version of the Multidimensional Inventory of Dissociation. *Journal of Trauma & Dissociation.* Advance online publication. doi: 10.1080/15299732.2020.1792024.

What aspects of dissociation does the MID-60 measure?

- subjective awareness of alter personalities and self-states
- angry intrusions
- persecutory intrusions
- amnesia, e.g. time loss, ‘coming to’, fugues, and disremembered actions
- distress about severe memory problems
- loss of remote autobiographical memory
- derealization/depersonalization
- trance
- flashbacks
- self-confusion, i.e., profound and chronic self-puzzlement
- somatoform symptoms
- psychogenic non-epileptic seizures

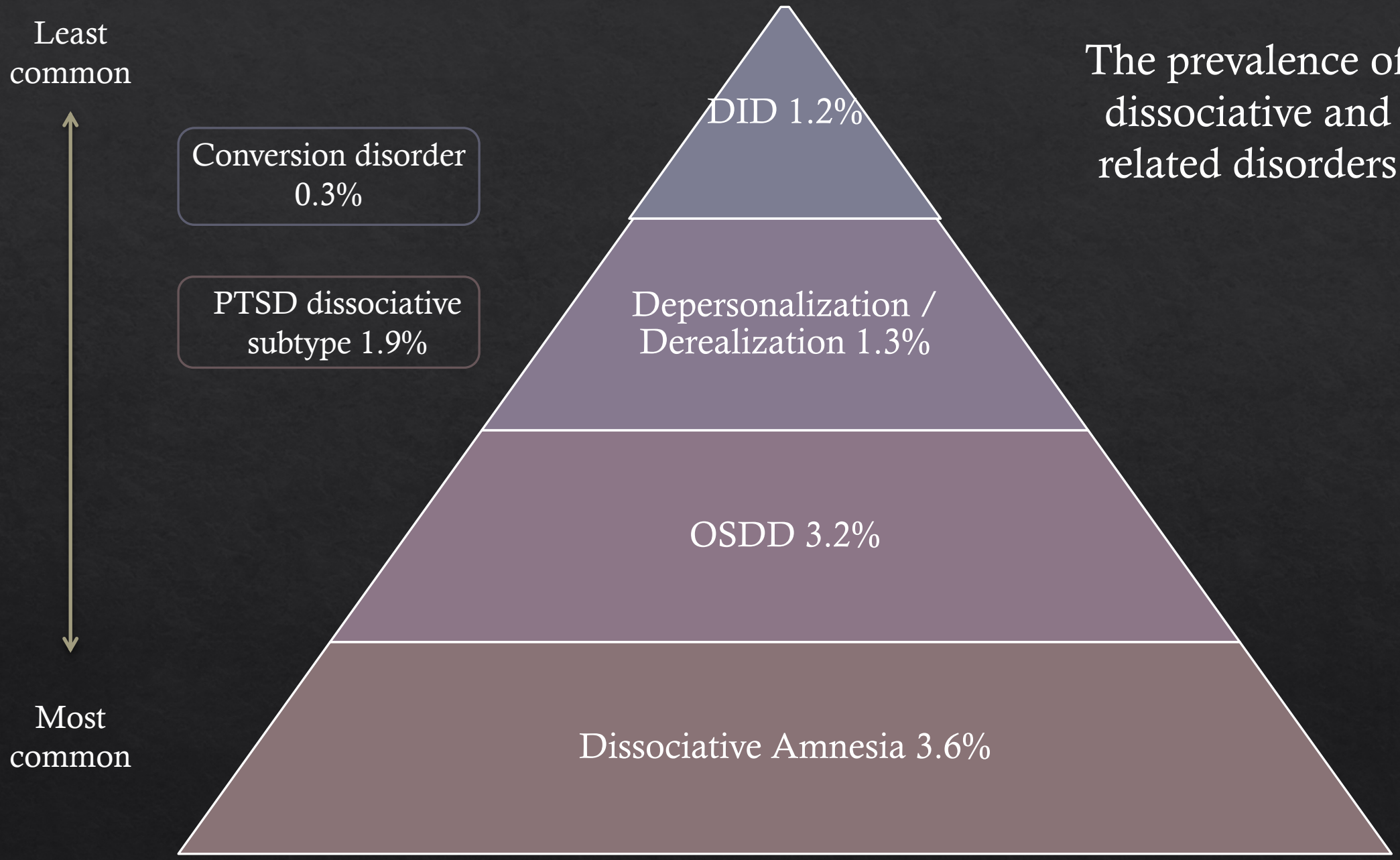
What is the difference between the MID-60 and the DES?

- The 28-item Dissociative Experience Scale (DES; Bernstein & Putnam, 1986) is the most commonly used instrument measuring dissociation in both research and clinical settings

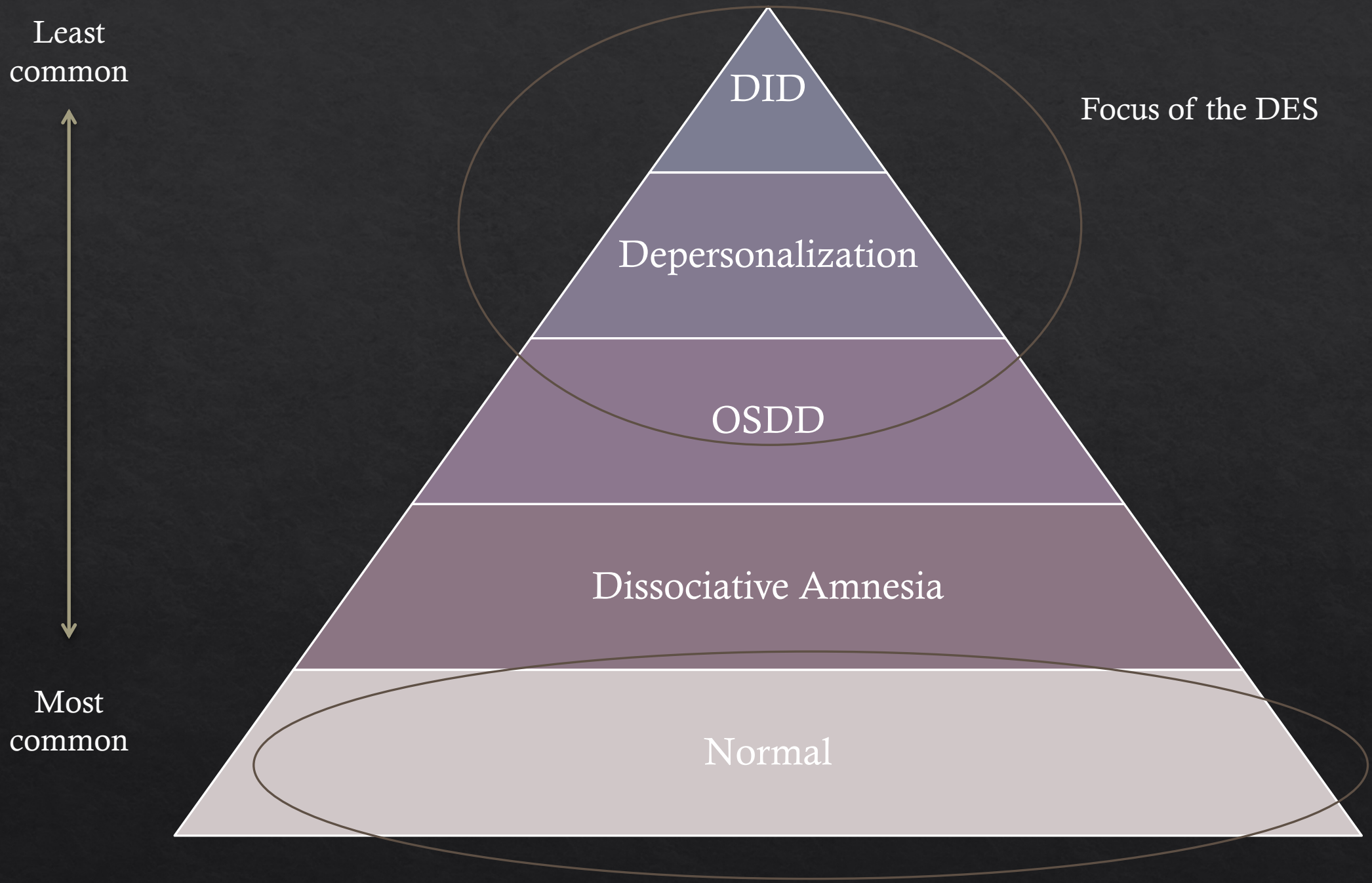
- The DES assesses mild dissociative experiences through to severe dissociative symptoms.

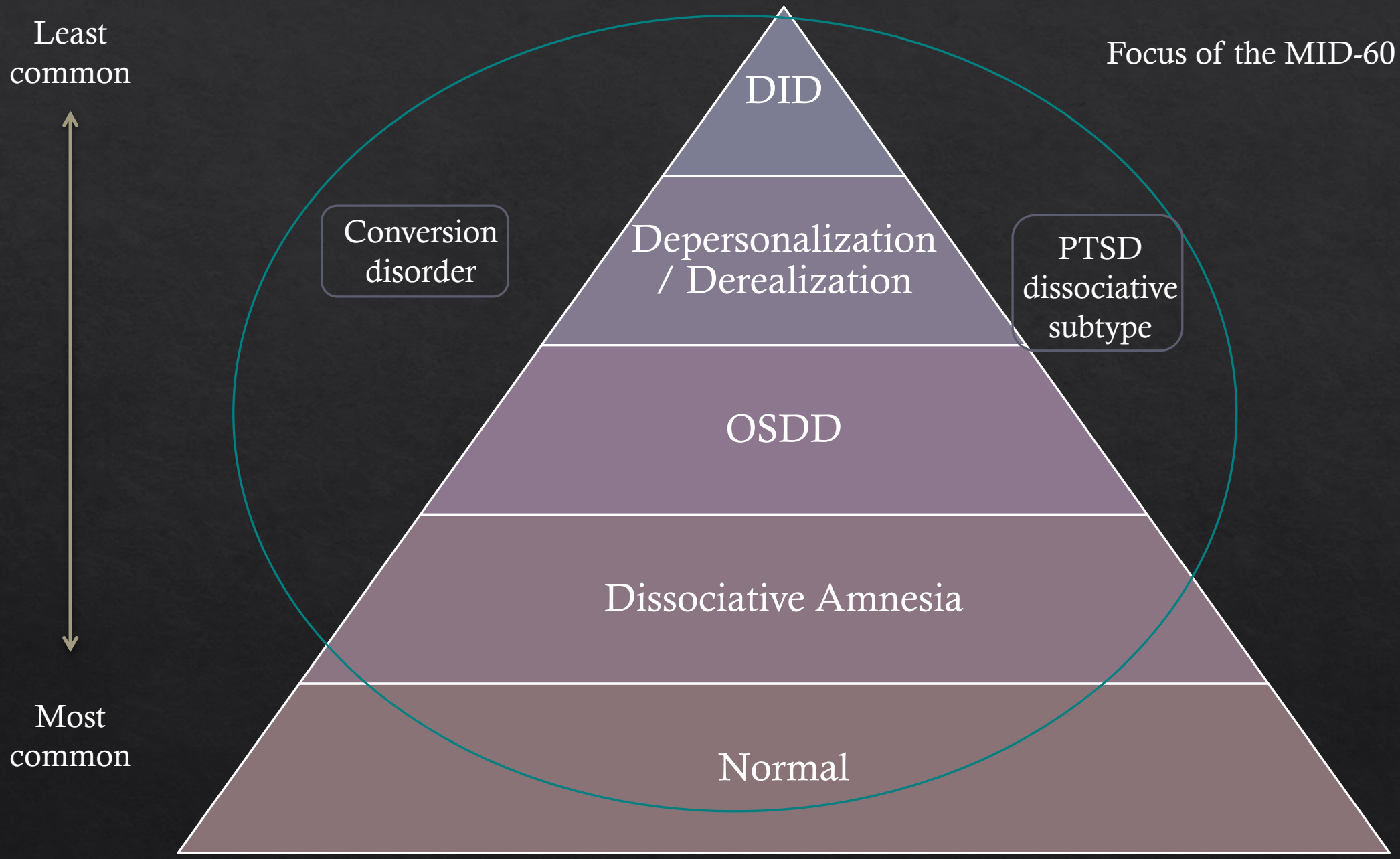
- The DES focuses heavily on the symptoms of DID but does not contain items that specifically assess amnesia for traumatic events that are characteristic of dissociative amnesia, and only contains one question about experiences of intrusions and internal dialogue characteristic of OSDD-1

The prevalence of dissociative and related disorders



Kate, Hopwood, & Jamieson, 2020


Least common
Most common
DID
Depersonalization
OSDD
Dissociative Amnesia
Normal
Focus of the DES


Least common
Most common
Focus of the MID-60
DID
Depersonalization / Derealization
OSDD
Dissociative Amnesia
Normal
Conversion disorder
PTSD dissociative subtype

The MID-60 provides insight into the diagnostic picture

- Unlike its parent, the MID, the MID-60 is a screening tool. It lacks the rigour, including the validity scales that are build into Paul Dell's robust 218-item version.
- The MID-60 may be a useful alternative to the MID if the client finds lengthy questionnaires onerous due to their dissociation, or when you are considering whether dissociation may form part of constellation of symptoms experienced by your client.
- A clinical interview is the most effective way to diagnose Dissociative Disorders:
  - Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D; Steinberg, 1994)
  - Dissociative Disorders Interview Schedule DSM-5 version (DDIS; Ross et al, 1989)

Adolescent MID-60

- Suitable for 16-19 year olds.
- This is based on the Adolescent Multidimensional Inventory of Dissociation (A-MID).
- There are only two items that contain different wording from the adult version of the MID-60, i.e. referring to school (rather than just work) and refer to cleaning “your bedroom” (rather than whole house).
- Scoring is identical. Early analysis shows no statistically significant difference between older adolescents and adults.
- The MID-60-A will be released on NovoPsych shortly

Case study 1: Deanna

Deanna is 46. She has led a complex life. She worked in health and social care in different roles and was a mother to four children. Each role (including different work roles) was the domain of a specific personality.

There are extensive chunks of Deanna's childhood she does not remember. She can barely conjure any memories of her parents, although she lived with them growing up. In her late teens she left home to live with her boyfriend, a relationship that was characterised by extreme violence and complicated by her amnestic episodes, which made effective intervention from the authorities difficult.

Deanna

Deanna was an in-patient at a private psychiatric hospital at the time she completed the MID-60.

She explains her view on being diagnosed with dissociative identity disorder:

> *I've been trying to run away from it for 10 years! Yeah, I don't want the diagnosis. I want treatment, but not with the diagnosis. But then it is hard when you've switched and you're acting in a different character*

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Client Information

Client Name	Deanna Moreanp
Date of birth (age)	1 January 1976 (46)

Assessment Information

Assessment	Multidimensional Inventory of Dissociation 60-item version (MID-60)
Date administered	24 November 2022
Assessor	Dr Mary-Anne Kate
Time taken	16 minutes 18 seconds

Results

	Mean Score	Normative Percentile	Clinical Percentile
Total	64	99.9	64.9

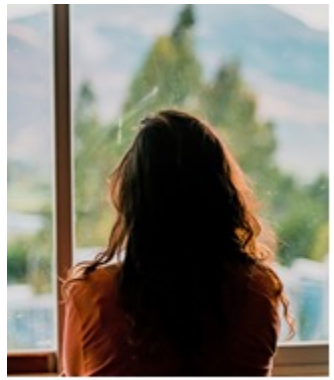
Interpretive Text

This client displays severe dissociative and post-traumatic symptoms. High scores may also reflect neuroticism, attention-seeking behavior, exaggeration or malingering of symptoms, or psychosis.

Check the subscale scores and cutoffs below for further clinical information.

Important point - 64 given is between categories:

41–64: Probably has DID or a severe dissociative disorder and PTSD



Deanna

Dissociative Identity Disorder

	Mean Score	In Clinical Range?
Amnesia (for recent events)	77.5	Yes

DID and OSDD-1

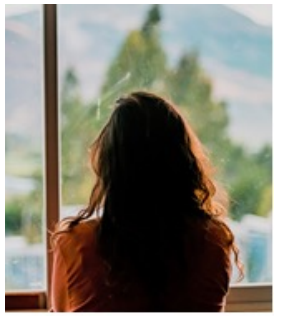
	Mean Score	In Clinical Range?
Awareness of alter personalities	80	Yes
Angry intrusions	98	Yes
Persecutory intrusions	50	Yes

Depersonalisation / Derealisation Disorder

	Mean Score	In Clinical Range?
Depersonalisation / Derealisation	80	Yes

Dissociative Amnesia

	Mean Score	In Clinical Range?
Distress about memory problems	90	Yes
Loss of autobiographical memory	100	Yes



Deanna

Post-Traumatic Stress Disorder

	Mean Score	In Clinical Range?
Flashbacks	28	Yes

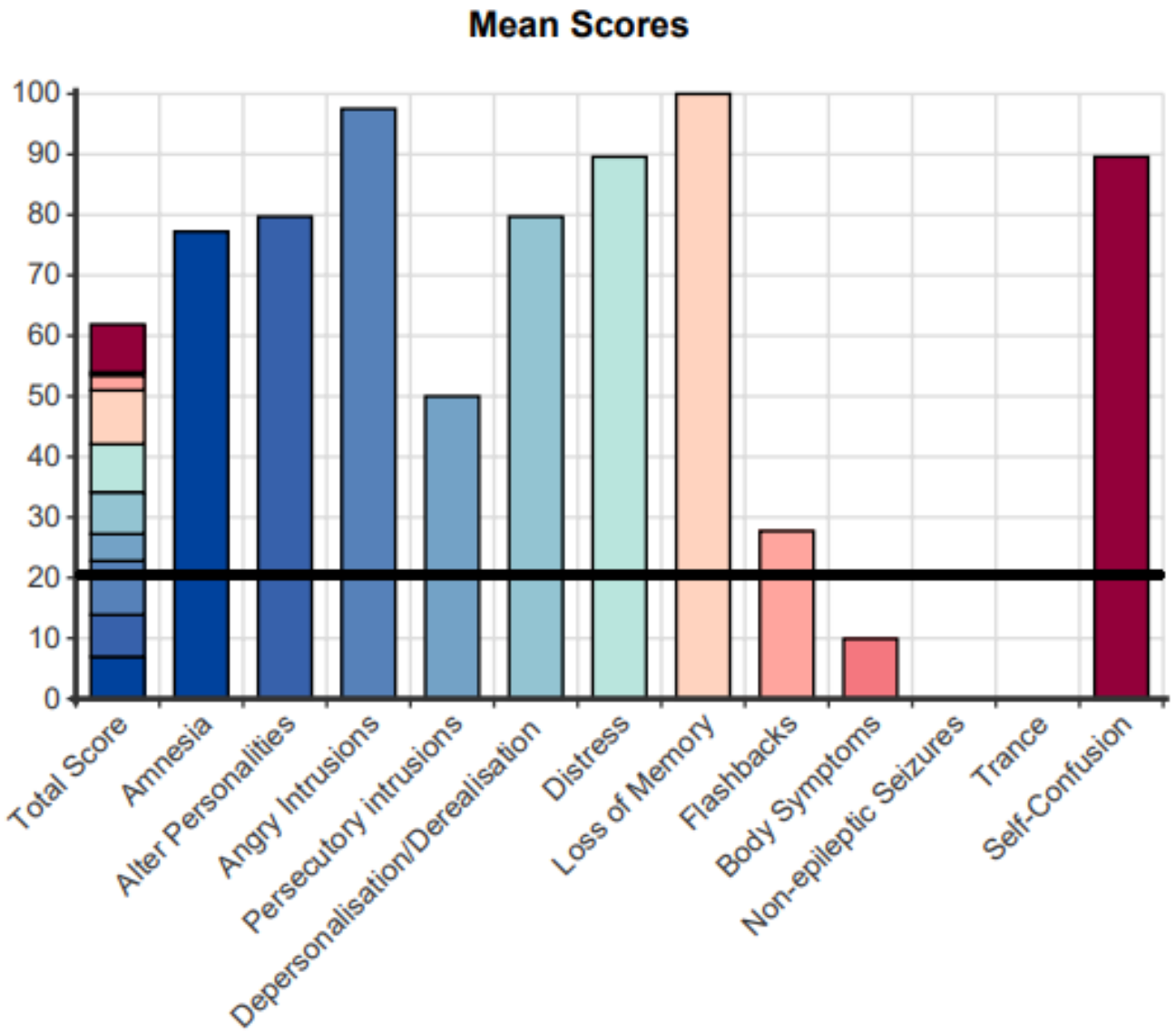
Conversion Disorder

	Mean Score	In Clinical Range?
Body symptoms	10	Yes
Pseudo-Seizures	0	No

General Subscales

	Mean Score	In Clinical Range?
Trance	0	No
Self-Confusion	90	Yes

Deanna


Mean Scores
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Total Score
Amnesia
Aller Personalities
Angry Intrusions
Persecutory intrusions
Depersonalisation/Derealisation
Distress
Loss of Memory
Flashbacks
Body Symptoms
Non-epileptic Seizures
Trance
Self-Confusion

Deanna: diagnostic impressions

Deanna is the perhaps the most dissociative individual I have met. She has resisted a DID diagnoses for years and done her best to get on with life. However, she knows she needs treatment to be able to function better.

While the evidence to support Deanna's DID was real was compelling to me following a lengthy interview, with a score as high as Deanna, it is important to rule out factitious disorder, malingering, or sociocultural presentations (we will discuss this later in "faking bad"):

- Ask questions – can you give me an example of a time when …
- Look at patterns of answering. Are the scores the same within and across subscales?

Dissociative Identity Disorder

Diagnostic Criteria (F44.81)

A. Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.

B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The disturbance is not a normal part of a broadly accepted cultural or religious practice.

Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play.

E. The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

How might DID presents in a therapeutic setting

- The overtness or covertness of these personality states varies as a function of psychological motivation, current level of stress, cultural context, internal conflicts and dynamics, and emotional resilience, among other factors.
- Sustained periods of identity confusion/alteration may occur when psychosocial pressures are severe and/or prolonged.
- Most individuals (with non-possession-form) dissociative identity disorder do not overtly display, or only subtly display, their discontinuity of identity
- Only a minority present to clinical attention with discernible alternation of identities.
- The elaboration of dissociative personality states with different names, wardrobes, hairstyles, handwritings, accents, and so forth, occurs in only a minority of individuals

APA, 2022

Plurality is an umbrella term that anyone with any kind of experience of multiplicity can self-identify with. There is a complex interplay between the following:

- Dissociative identity disorder
- Maladaptive daydreaming and reality shifting
- Autism
- Complex trauma
- Gender non-conforming
- Dissociation
- Fantasy and absorption
- Hypnotisability

Plurals who do not have traditional, traumagenic DID

This group often have elaborately developed inner world with relationships rich in detail where all parts of the system seem to have knowledge and access, as well as awareness to where they do not have access and why. They are likely to have a high number of “fictive” alters, but included extensive and detailed backstories from movies or video games.

Often, the development of the inner world and relationships between parts is something that Plurals enjoy and *find soothing*, which is distinguished from those with dissociative disorders, who are generally *phobic* of both their internal world and interaction with other parts.

This does not fit the clinical definition of DID (or partial DID, or OSDD1b). It does correspond with what Eli Somer has described as “Maladaptive Daydreaming

Christensen (2022a; 2022b)

Case study 2: Patricia

Patricia is 27. She grew up in an environment of domestic violence. Patricia experience physical abuse from numerous people. The most significant perpetrator was her father, who was a medical doctor. The abuse was witnessed by family members but no one intervened. She was not given care when she was physically or emotionally hurt by her parents. The mother was emotionally abusive towards her.

Patricia was sexually abused by her father from a young age. When she was seven, she was sexually abused by a family friend who enabled others in the family to sexual abuse as well her as well as sexual exploited her for financial gain to other perpetrators.

Her story is similar to many women with DID.

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Client Information

Client Name	Patricia Epolly
Date of birth (age)	1 January 1995 (27)

Assessment Information

Assessment	Multidimensional Inventory of Dissociation 60-item version (MID-60)
Date administered	18 November 2022
Assessor	Dr Mary-Anne Kate
Time taken	19 minutes 56 seconds

Results

	Mean Score	Normative Percentile	Clinical Percentile
Total	52	99.8	39.9

Interpretive Text

This client probably has DID or a severe dissociative disorder and PTSD.

Check the subscale scores and cutoffs below for further clinical information.

Patricia

The mean score is suggestive of DID. What do the subscales suggest?

Patricia

Dissociative Identity Disorder

	Mean Score	In Clinical Range?
Amnesia (for recent events)	5	No

DID and OSDD-1

	Mean Score	In Clinical Range?
Awareness of alter personalities	98	Yes
Angry intrusions	58	Yes
Persecutory intrusions	68	Yes

Depersonalisation / Derealisation Disorder

	Mean Score	In Clinical Range?
Depersonalisation / Derealisation	53.8	Yes

Dissociative Amnesia

	Mean Score	In Clinical Range?
Distress about memory problems	65	Yes
Loss of autobiographical memory	88	Yes

Patricia

Post-Traumatic Stress Disorder

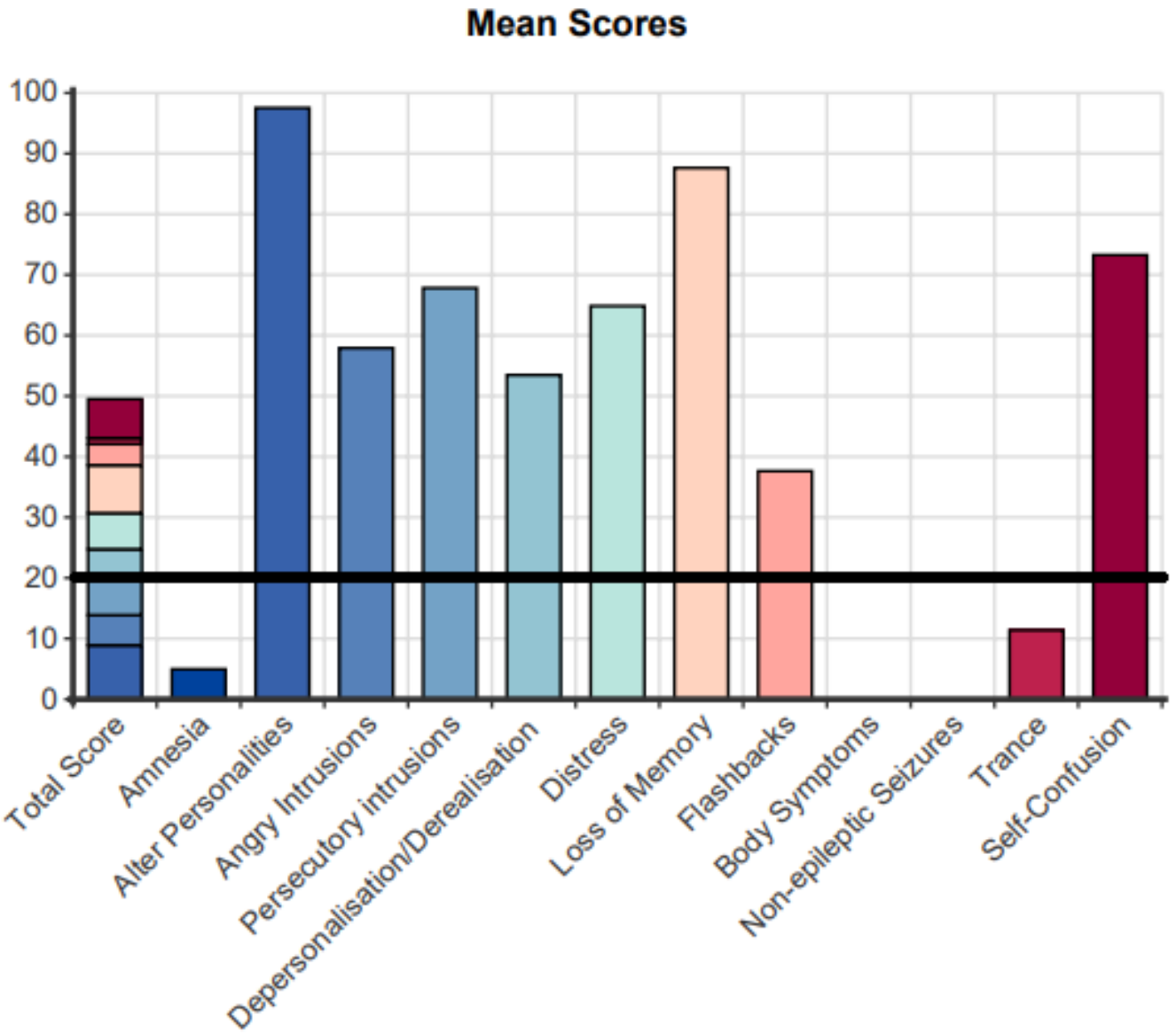
	Mean Score	In Clinical Range?
Flashbacks	38	Yes

Conversion Disorder

	Mean Score	In Clinical Range?
Body symptoms	0	No
Pseudo-Seizures	0	No

General Subscales

	Mean Score	In Clinical Range?
Trance	11.7	Yes
Self-Confusion	73.3	Yes


Mean Scores
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Persecutory intrusions
Depersonalisation/Derealisation
Distress
Loss of Memory
Flashbacks
Body Symptoms
Non-epileptic Seizures
Trance
Self-Confusion

Patricia

Diving deeper: Looking at individual items for the relevant subscale

Client Name	Patricia Epolly

Scoring and Interpretation Information

Scores for each item range from zero (never) to 10 (always). The MID-60 mean score represents the percentage of time the person self-reports having dissociative symptoms and experiences. Hence, a person with dissociative identity disorder may have dissociative symptoms and experiences around half the time (51%) whereas for a university student this may be 13% of the time. A mean score of more than 21% indicates clinically significant symptoms.

Interpretation of MID-60 mean scores is consistent with the 218-item MID. Specifically:
- 0–7: Does not have dissociative experiences
- 7–14: Has few diagnostically significant dissociative experiences
- 15–20: Mild dissociative symptoms and experiences. PTSD or a mild dissociative disorder (such as dissociative amnesia, depersonalisation / derealisation disorder) are possible
- 21–30: May have dissociative disorder and/or PTSD
- 31–40: May have a dissociative disorder (such as OSDD-1 or DID) and PTSD
- 41–64: Probably has DID or a severe dissociative disorder and PTSD
- 64 +: Severe dissociative and post-traumatic symptoms. High scores may also reflect neuroticism, attention seeking behaviour, exaggeration or malingering of symptoms, or psychosis

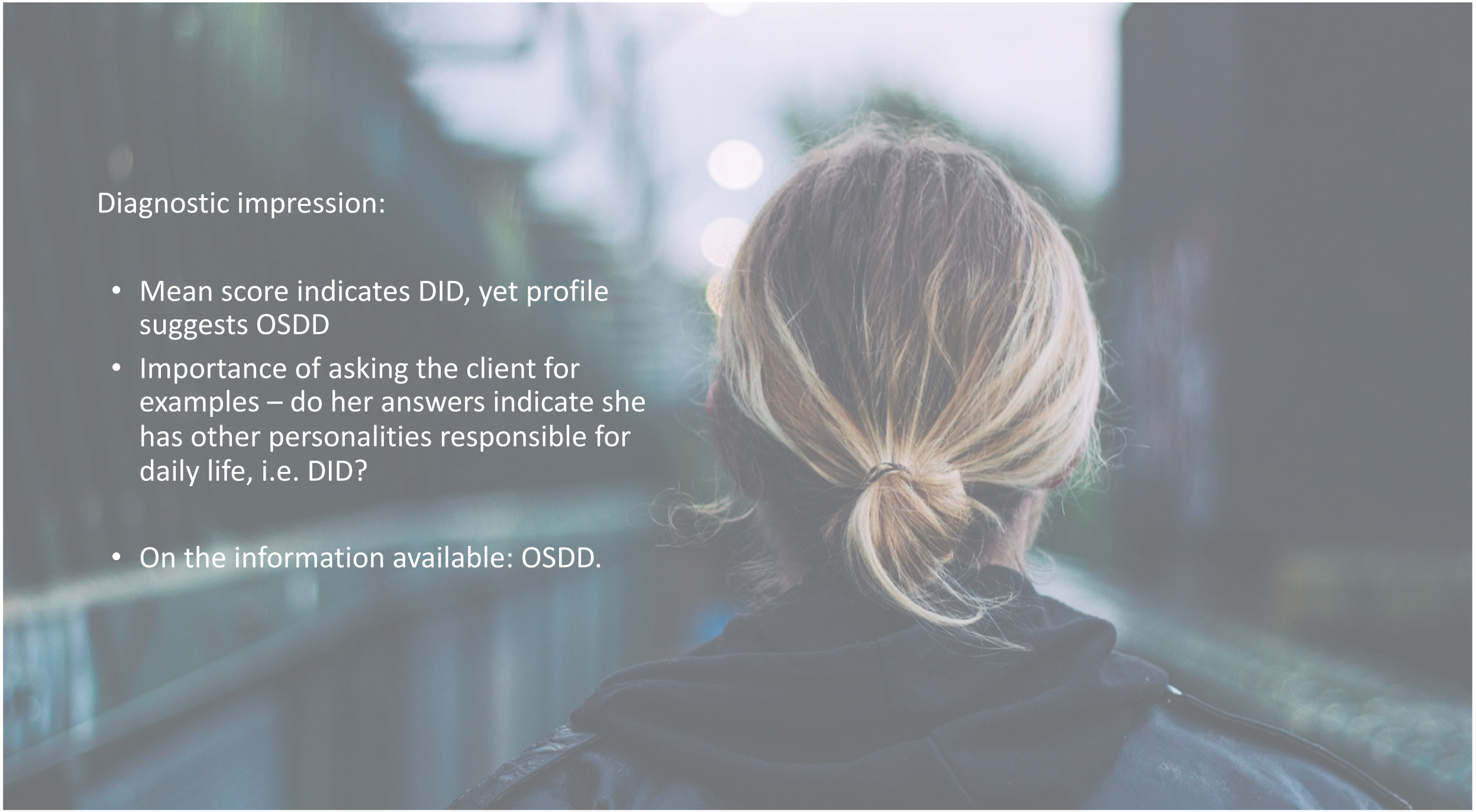
Subscales
The MID-60 provides information on subscales relevant to different diagnoses. This enables the clinician to form an impression about the likely diagnosis. For example, a score of 27% is clinically significant, but does not indicate the most likely diagnosis. If the subscales of PTSD and depersonalisation/derealisation are both above the clinical threshold, this can indicate the person has the dissociative subtype of PTSD, whereas if the memory-related subscales are above the clinical threshold this can indicate dissociative amnesia. Another example is a person who scores 45%, which would seem to indicate dissociative identity disorder. Yet, if the subscale score for amnesia (for recent events) is not elevated, this points towards a more severe case of other specified dissociative disorder. The subscales are:

DID subscale items

- DID: Amnesia (for recent events) - items 42, 45, 48, 58. Clinical cutoff = 10
- DID / OSDD-1: Subjective awareness of alter personalities and self-states - items 3, 36, 39, 49, 57. Clinical cutoff = 20
- DID / OSDD-1: Angry intrusions - items 28, 33, 35, 46, 60. Clinical cutoff = 18
- DID / OSDD-1: Persecutory intrusions - items 22, 37, 44, 56, 59. Clinical cutoff = 18
- Derealisation/Depersonalisation - items 2, 7, 9, 13, 25, 47, 50, 53. Clinical cutoff = 20
- Dissociative Amnesia: Distress about severe memory problems -

41	Going into trance several days in a row	0	1	2	3	4	5	6	7	8	9	10
42	Discovering that you have changed your appearance (e.g., cut your hair, or changed your hairstyle, or changed what you are wearing, or put on cosmetics, etc.) with no memory of having done so	0	1	2	3	4	5	6	7	8	9	10
43	Being bothered or upset by how much you forget	0	1	2	3	4	5	6	7	8	9	10
44	Hearing a voice in your head that wants you to die	0	1	2	3	4	5	6	7	8	9	10
45	Suddenly finding yourself somewhere odd at home (e.g., inside the closet, under a bed, curled up on the floor, etc.) with no knowledge of how you got there	0	1	2	3	4	5	6	7	8	9	10
46	Feeling as if there is something inside you that takes control of your behaviour and speech	0	1	2	3	4	5	6	7	8	9	10
47	Totally forgetting how to do something that you know very well how to do (e.g., how to drive, how to read, how to use the computer, how to play the piano, etc.)	0	1	2	3	4	5	6	7	8	9	10
48	Suddenly finding yourself somewhere (e.g., at the beach, at work, in a nightclub, in your car, etc.) with no memory of how you got there	0	1	2	3	4	5	6	7	8	9	10
57	Having another part inside that has different memories, behaviors, and feelings than you do	0	1	2	3	4	5	6	7	8	9	10
58	There were times when you "woke up" and found pills or a razor blade (or something else to hurt yourself with) in your hand	0	1	2	3	4	5	6	7	8	9	10
59	Hearing a voice in your head that calls you no good, worthless, or a failure	0	1	2	3	4	5	6	7	8	9	10

Patricia: diagnostic impressions



Diagnostic impression:

- Mean score indicates DID, yet profile suggests OSDD
- Importance of asking the client for examples – do her answers indicate she has other personalities responsible for daily life, i.e. DID?

- On the information available: OSDD.

Other Specified Dissociative Disorder

(F44.89)

This category applies to presentations in which symptoms characteristic of a dissociative disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the dissociative disorders diagnostic class. The other specified dissociative disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific dissociative disorder. This is done by recording "other specified dissociative disorder" followed by the specific reason (e.g., "dissociative trance").

Examples of presentations that can be specified using the "other specified" designation include the following:

1. **Chronic and recurrent syndromes of mixed dissociative symptoms:** This category includes identity disturbance associated with less-than-marked discontinuities in sense of self and agency, or alterations of identity or episodes of possession in an individual who reports no dissociative amnesia.
2. **Identity disturbance due to prolonged and intense coercive persuasion:** Individuals who have been subjected to intense coercive persuasion (e.g., brainwashing, thought reform, indoctrination while captive, torture, long-term political imprisonment, recruitment by sects/cults or by terror organizations) may present with prolonged changes in, or conscious questioning of, their identity.
3. **Acute dissociative reactions to stressful events:** This category is for acute, transient conditions that typically last less than 1 month, and sometimes only a few hours or days. These conditions are characterized by constriction of consciousness; depersonalization; derealization; perceptual disturbances (e.g., time slowing, macropsia); microamnesias; transient stupor; and/or alterations in sensory-motor functioning (e.g., analgesia, paralysis).
4. **Dissociative trance:** This condition is characterized by an acute narrowing or complete loss of awareness of immediate surroundings that manifests as profound unresponsiveness or insensitivity to environmental stimuli. The unresponsiveness may be accompanied by minor stereotyped behaviors (e.g., finger movements) of which the individual is unaware and/or that he or she cannot control, as well as transient paralysis or loss of consciousness. The dissociative trance is not a normal part of a broadly accepted collective cultural or religious practice.

People with subclinical DID will often have amnesia for traumatic events and often sections of childhood and autobiographic memory.

The DSM-5-TR would be more accurate if it was consistent with the ICD-11, i.e. stating that "individuals often do not experience amnesia during episodes of dissociative intrusions"

Case study 3: Amelia

Amelia is a 33 year old university student. She reports having a warm relationship with her mum but her relationship with her dad was difficult. He was volatile – nice one minute then nasty the next - and he was not attentive or protective.

Although hinted at, Amelia's trauma history has not been explored. She did mention being slapped and kicked when she was young, although not by whom.

Amelia has no head injuries although she reported having multiple febrile seizures as a child.

NovoPsych

Client Information

Client Name	Amelia Blanks
Date of birth (age)	1 January 1989 (33)

Assessment Information

Assessment	Multidimensional Inventory of Dissociation 60-item version (MID-60)
Date administered	24 November 2022
Assessor	Dr Mary-Anne Kate
Time taken	4 minutes 39 seconds

Results

	Mean Score	Normative Percentile	Clinical Percentile
Total	26	82.7	5.1

Interpretive Text

This client may have dissociative disorder and/or PTSD.

Check the subscale scores and cutoffs below for further clinical information.

Amelia

Dissociative Identity Disorder

	Mean Score	In Clinical Range?
Amnesia (for recent events)	0	No

DID and OSDD-1

	Mean Score	In Clinical Range?
Awareness of alter personalities	0	No
Angry intrusions	20	Yes
Persecutory intrusions	40	Yes

Depersonalisation / Derealisation Disorder

	Mean Score	In Clinical Range?
Depersonalisation / Derealisation	11.3	No

Dissociative Amnesia

	Mean Score	In Clinical Range?
Distress about memory problems	58.3	Yes
Loss of autobiographical memory	74	Yes

Amelia

Post-Traumatic Stress Disorder

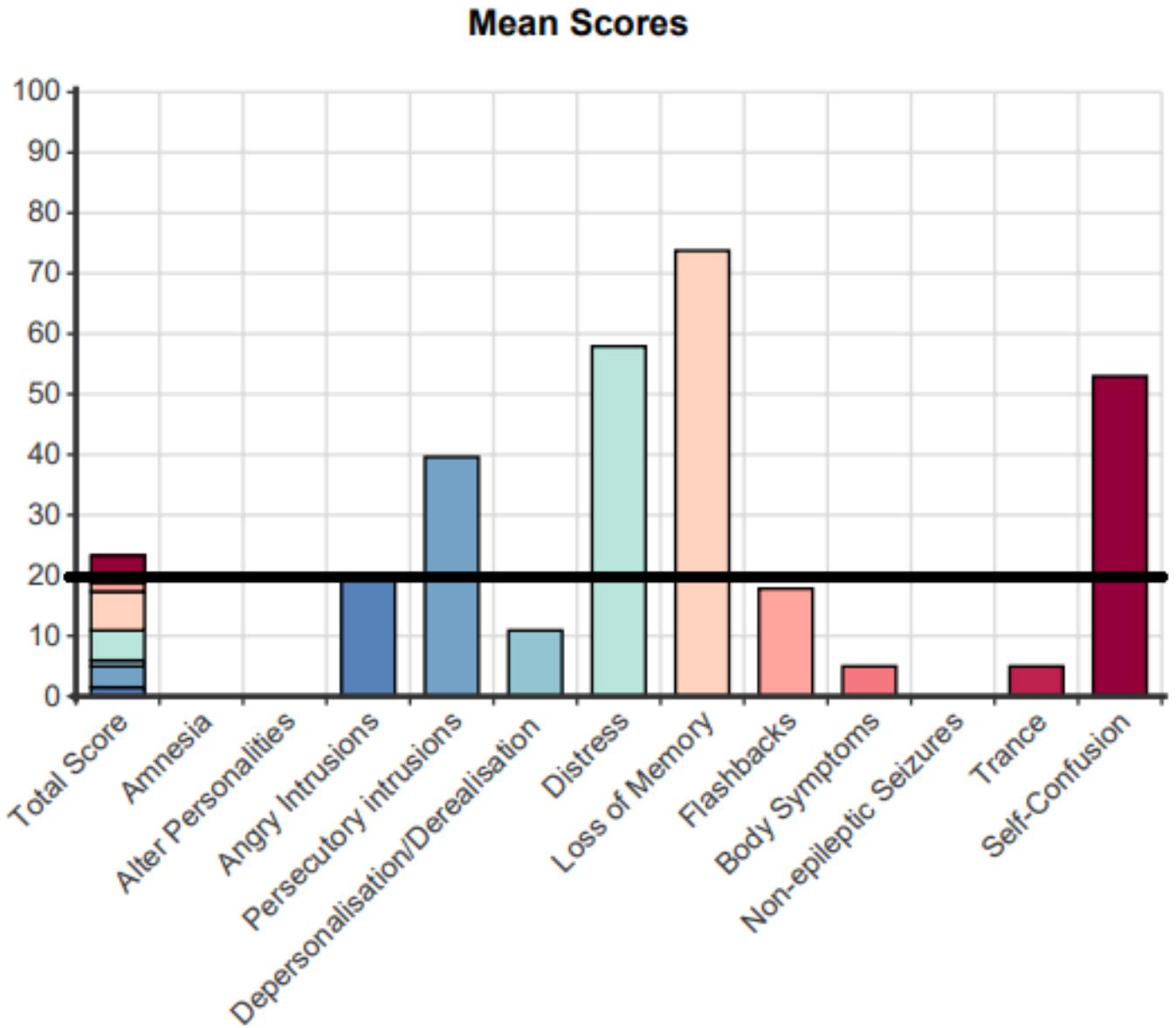
	Mean Score	In Clinical Range?
Flashbacks	18	Yes

Conversion Disorder

	Mean Score	In Clinical Range?
Body symptoms	5	No
Pseudo-Seizures	0	No

General Subscales

	Mean Score	In Clinical Range?
Trance	5	No
Self-Confusion	53.3	Yes


Mean Scores
100
90
80
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50
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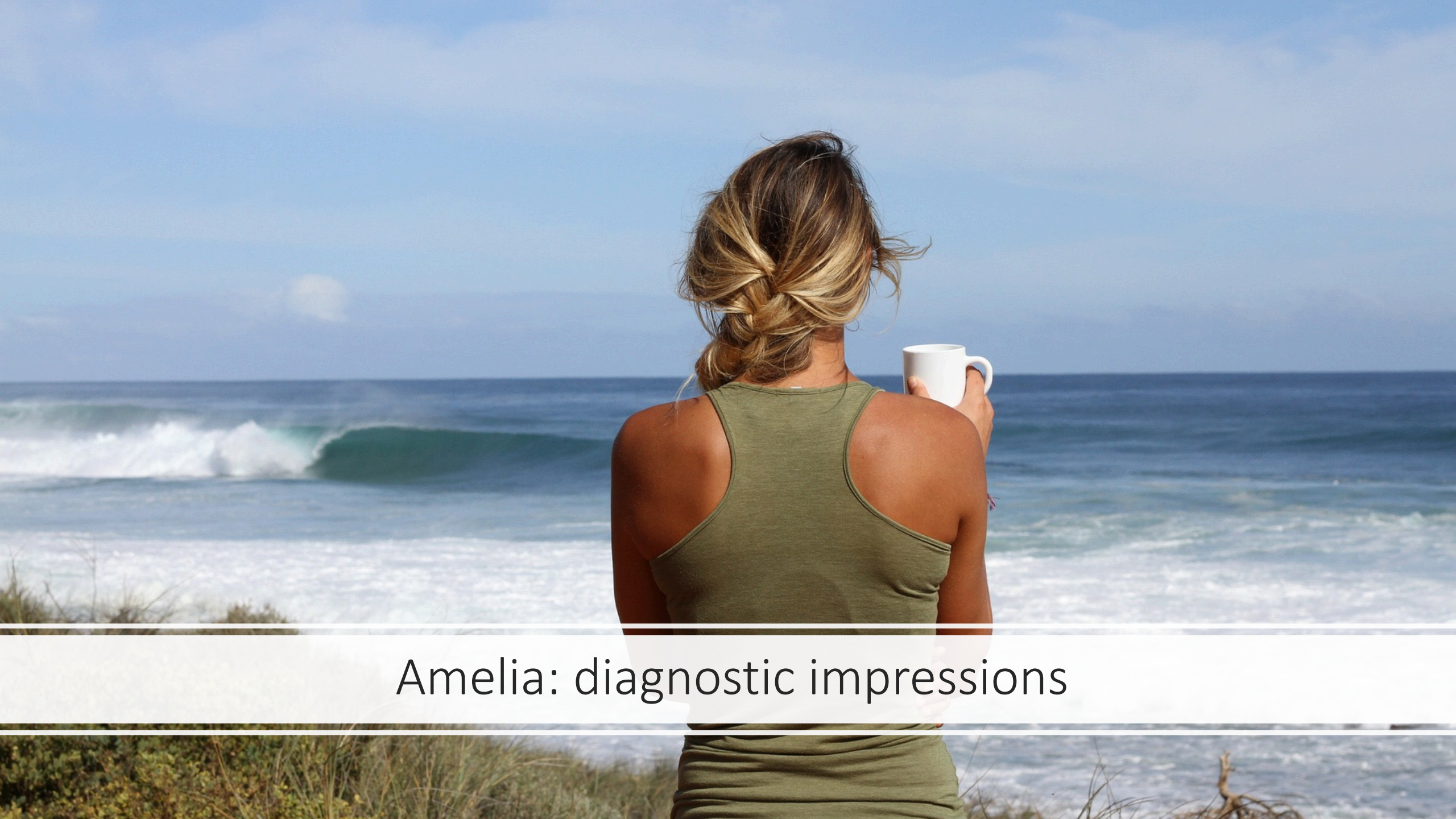
30
20
10
0
Total Score
Amnesia
Alter Personalities
Angry Intrusions
Persecutory intrusions
Depersonalisation/Derealisation
Distress
Loss of Memory
Flashbacks
Body Symptoms
Non-epileptic Seizures
Trance
Self-Confusion

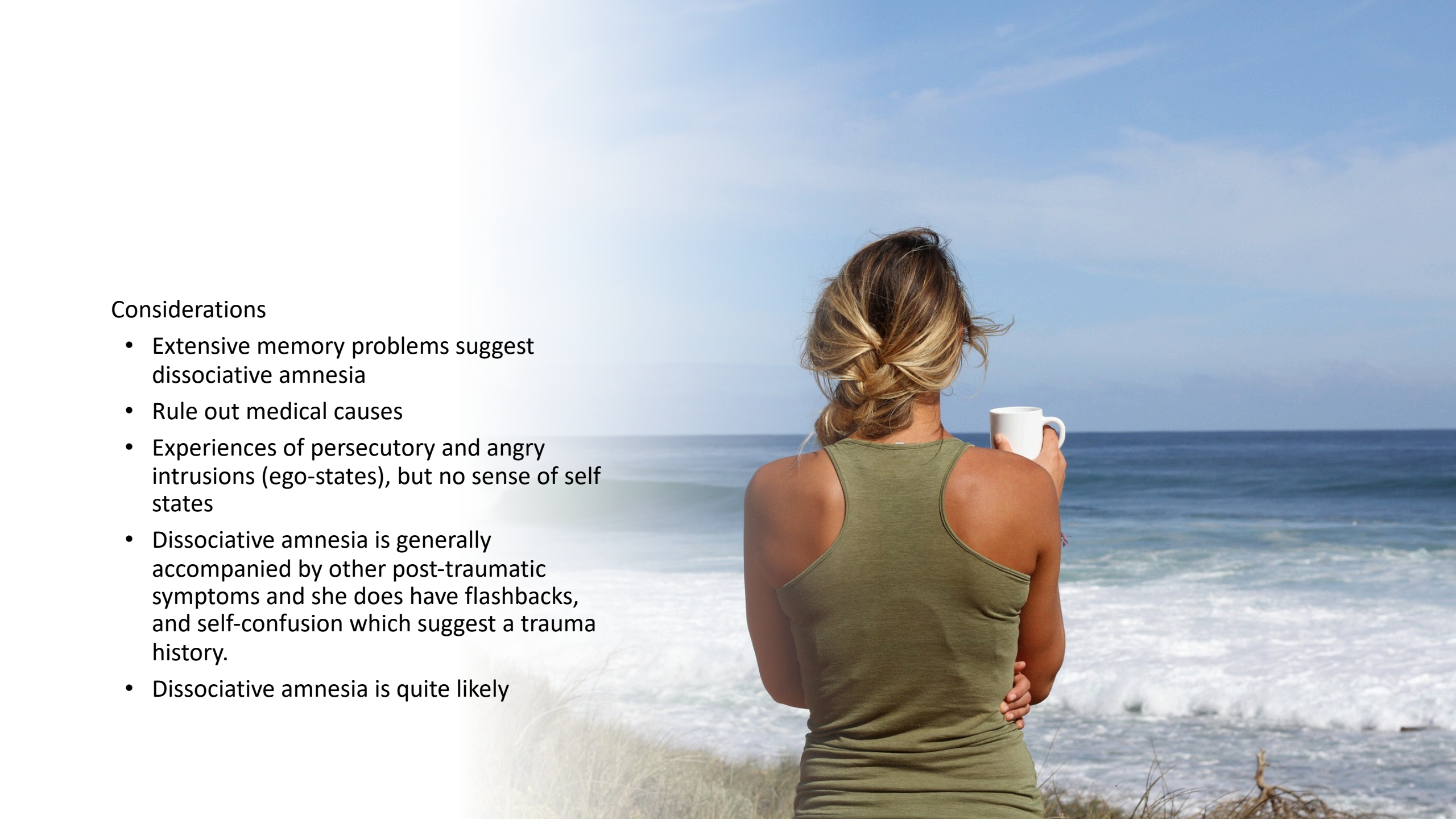
Amelia



Amelia: diagnostic impressions

Considerations

- Extensive memory problems suggest dissociative amnesia
- Rule out medical causes
- Experiences of persecutory and angry intrusions (ego-states), but no sense of self states
- Dissociative amnesia is generally accompanied by other post-traumatic symptoms and she does have flashbacks, and self-confusion which suggest a trauma history.
- Dissociative amnesia is quite likely



Dissociative Amnesia

Diagnostic Criteria (F44.0)

A. An inability to recall important autobiographical information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting.

> **Note:** Dissociative amnesia most often consists of localized or selective amnesia for a specific event or events; or generalized amnesia for identity and life history.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The disturbance is not attributable to the physiological effects of a substance (e.g., alcohol or other drug of abuse, a medication) or a neurological or other medical condition (e.g., partial complex seizures, transient global amnesia, sequelae of a closed head injury/traumatic brain injury, other neurological condition).

D. The disturbance is not better explained by dissociative identity disorder, posttraumatic stress disorder, acute stress disorder, somatic symptom disorder, or major or mild neurocognitive disorder.

Coding note: The code for dissociative amnesia without dissociative fugue is **F44.0.** The code for dissociative amnesia with dissociative fugue is **F44.1.**

Specify if:

> **F44.1 With dissociative fugue:** Apparently purposeful travel or bewildered wandering that is associated with amnesia for identity or for other important autobiographical information.

Case study 4 - Dane

Dane is a 19-year-old student. He describes his family life as fairly stable and supportive. However, his brother began being emotionally abusive towards him when he started primary school and this was ongoing. His parents did not effectively intervene to stop this.

Dan states he has never experienced physical violence or been sexual abused.

Adult stressors and trauma have not yet been explored.

Drug use is not known.

Dan experienced blackouts on around 5 occasions.

NovoPsych

Client Information

Client Name	Dane Stranger
Date of birth (age)	1 January 2003 (19)

Assessment Information

Assessment	Multidimensional Inventory of Dissociation 60-item version (MID-60)
Date administered	24 November 2022
Assessor	Dr Mary-Anne Kate
Time taken	5 minutes 15 seconds

Results

	Mean Score	Normative Percentile	Clinical Percentile
Total	33	92.6	10.3

Interpretive Text

This client may have a dissociative disorder (such as OSDD-1 or DID) and PTSD.

Check the subscale scores and cutoffs below for further clinical information.

Dane

DID and OSDD-1

	Mean Score	In Clinical Range?
Awareness of alter personalities	4	No
Angry intrusions	58	Yes
Persecutory intrusions	8	No

Depersonalisation / Derealisation Disorder

	Mean Score	In Clinical Range?
Depersonalisation / Derealisation	52.5	Yes

Dissociative Amnesia

	Mean Score	In Clinical Range?
Distress about memory problems	65	Yes
Loss of autobiographical memory	36	Yes

Dane

Post-Traumatic Stress Disorder

	Mean Score	In Clinical Range?
Flashbacks	10	No

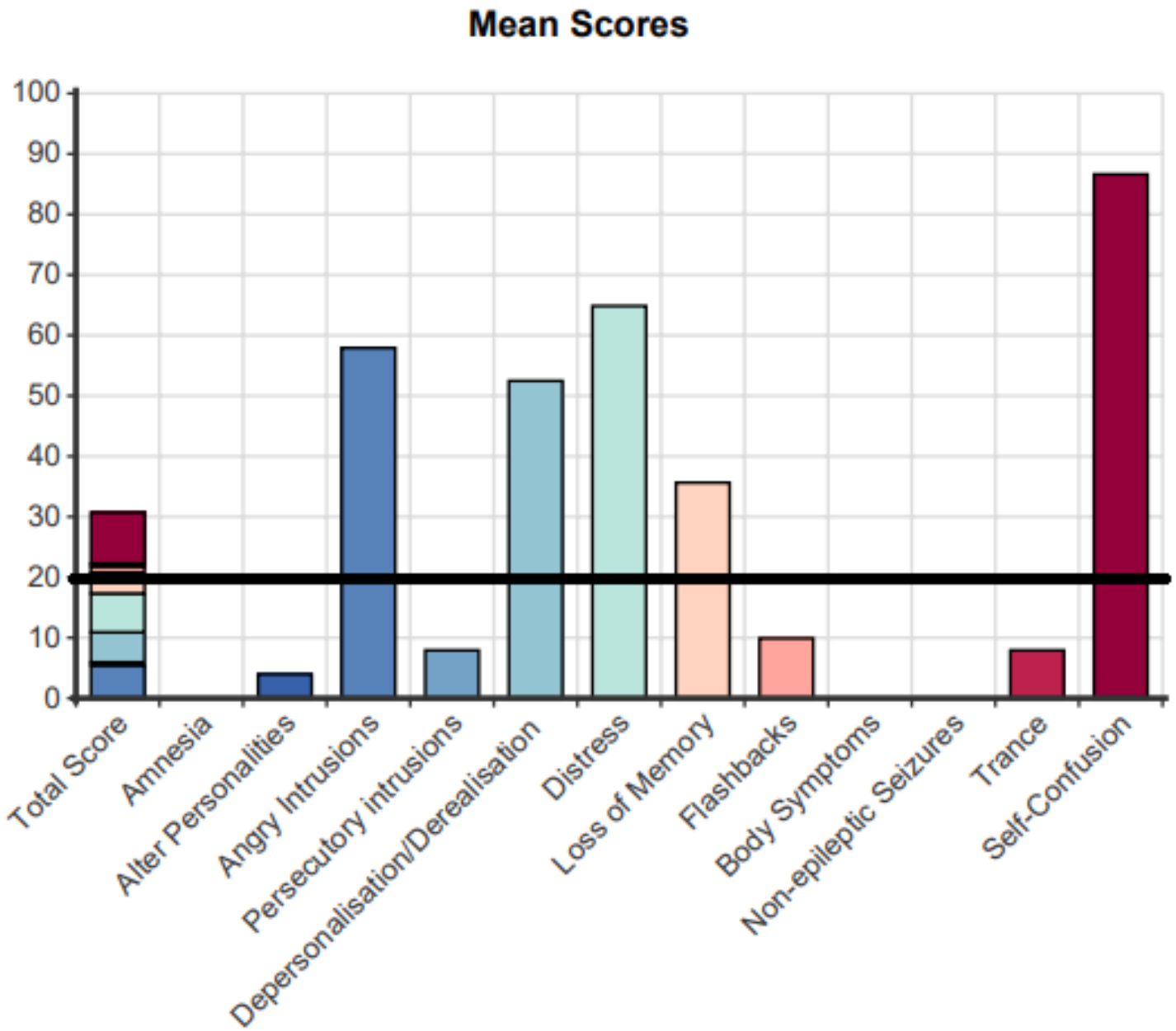
Conversion Disorder

	Mean Score	In Clinical Range?
Body symptoms	0	No
Pseudo-Seizures	0	No

General Subscales

	Mean Score	In Clinical Range?
Trance	8.3	No
Self-Confusion	86.7	Yes

Dane


Mean Scores
100
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20
10
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Total Score
Amnesia
Alter Personalities
Angry Intrusions
Persecutory intrusions
Depersonalisation/Derealisation
Distress
Loss of Memory
Flashbacks
Body Symptoms
Non-epileptic Seizures
Trance
Self-Confusion

Dane: diagnostic impressions

Diagnostic considerations:

- The depersonalization, amnesia and high levels of self-confusion do suggest a dissociative order.
- What was the onset for the amnesia and depersonalization, or are these enduring?
- Rule out medical causes, such as drug use, head injury.
- Angry intrusions are higher in young people but not this high! Differential diagnoses - Disruptive, Impulse-Control, and Conduct Disorders?

Ask more about Dane's subjective experience of depersonalization. Individual often feel subjectively detached

- from their entire being: "I am no one", "I have no self"
- from aspects of the self, including:
    - feelings, e.g., hypoemotionality: "I know I have feelings, but I don't feel them"
    - thoughts, e.g., "My thoughts don't feel like my own," "head filled with cotton"
    - whole body or body parts, or sensations, e.g., touch, proprioception, hunger, thirst, libido (APA, 2022).
    - memories, including difficulty vividly recalling autobiographical memories and "owning" them as personal and emotional

DSM-5-TR / ICD-11 (6B66).

Individuals may also experience:

- extreme rumination or obsessional preoccupation, e.g., constantly obsessing about whether they really exist, or checking their perceptions to determine whether they appear real
- Catastrophic cognitions, e.g., frequent fears of ‘going crazy’ and/or irreversible brain damage
- altered sense of time, such as the subjective experience of time slowing down or speeding up.
- physiological hyporeactivity to emotional stimuli

These are often accompanied by vague somatic symptoms, such as head fullness, tingling, or lightheadedness,

DSM-5-TR / ICD-11 (6B66).

Depersonalization/Derealization Disorder

Diagnostic Criteria (F48.1)

A. The presence of persistent or recurrent experiences of depersonalization, derealization, or both:

1. **Depersonalization:** Experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions (e.g., perceptual alterations, distorted sense of time, unreal or absent self, emotional and/or physical numbing).

2. **Derealization:** Experiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted).

B. During the depersonalization or derealization experiences, reality testing remains intact.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, medication) or another medical condition (e.g., seizures).

E. The disturbance is not better explained by another mental disorder, such as schizophrenia, panic disorder, major depressive disorder, acute stress disorder, posttraumatic stress disorder, or another dissociative disorder.

Case study 5: Alpine

Alpine is a 35 year old woman who has returned to university to study psychology.

She describers her parents as often uncaring. She had little freedom or control over her life, and felt unsafe at home. Her father was an unpredictable man.

Alpine's father was physically abusive towards her on a daily basis up until the age of 15. She suffered serious injuries, including broken bones, and recalls fearing for her life. She describes her mother as submissive and powerless against her father. Alpine was sexually abused by her brother from the age of 9 to 14. He used threats and force. She recalls feeling ashamed, scared, confused, and she continues to feel shame and sadness about it.

NovoPsych

Client Information

Client Name	Alpine Flash
Date of birth (age)	1 January 1987 (35)

Assessment Information

Assessment	Multidimensional Inventory of Dissociation 60-item version (MID-60)
Date administered	24 November 2022
Assessor	Dr Mary-Anne Kate
Time taken	5 minutes 44 seconds

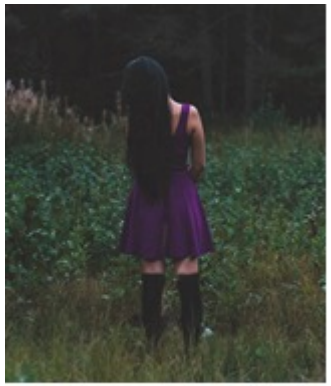
Results

	Mean Score	Normative Percentile	Clinical Percentile
Total	29	87.7	6.9

Interpretive Text

This client may have dissociative disorder and/or PTSD.

Check the subscale scores and cutoffs below for further clinical information.



Alpine

Dissociative Identity Disorder

	Mean Score	In Clinical Range?
Amnesia (for recent events)	0	No

DID and OSDD-1

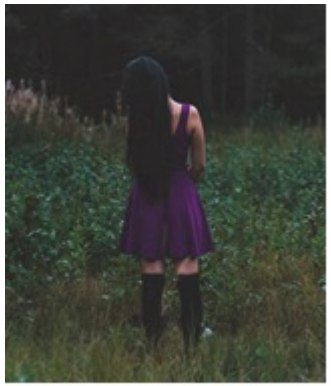
	Mean Score	In Clinical Range?
Awareness of alter personalities	0	No
Angry intrusions	6	No
Persecutory intrusions	0	No

Depersonalisation / Derealisation Disorder

	Mean Score	In Clinical Range?
Depersonalisation / Derealisation	42.5	Yes

Dissociative Amnesia

	Mean Score	In Clinical Range?
Distress about memory problems	20	No
Loss of autobiographical memory	6	No


Alpine

Post-Traumatic Stress Disorder

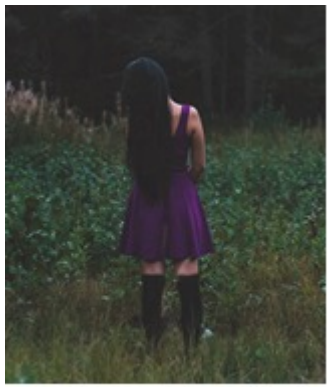
	Mean Score	In Clinical Range?
Flashbacks	98	Yes

Conversion Disorder

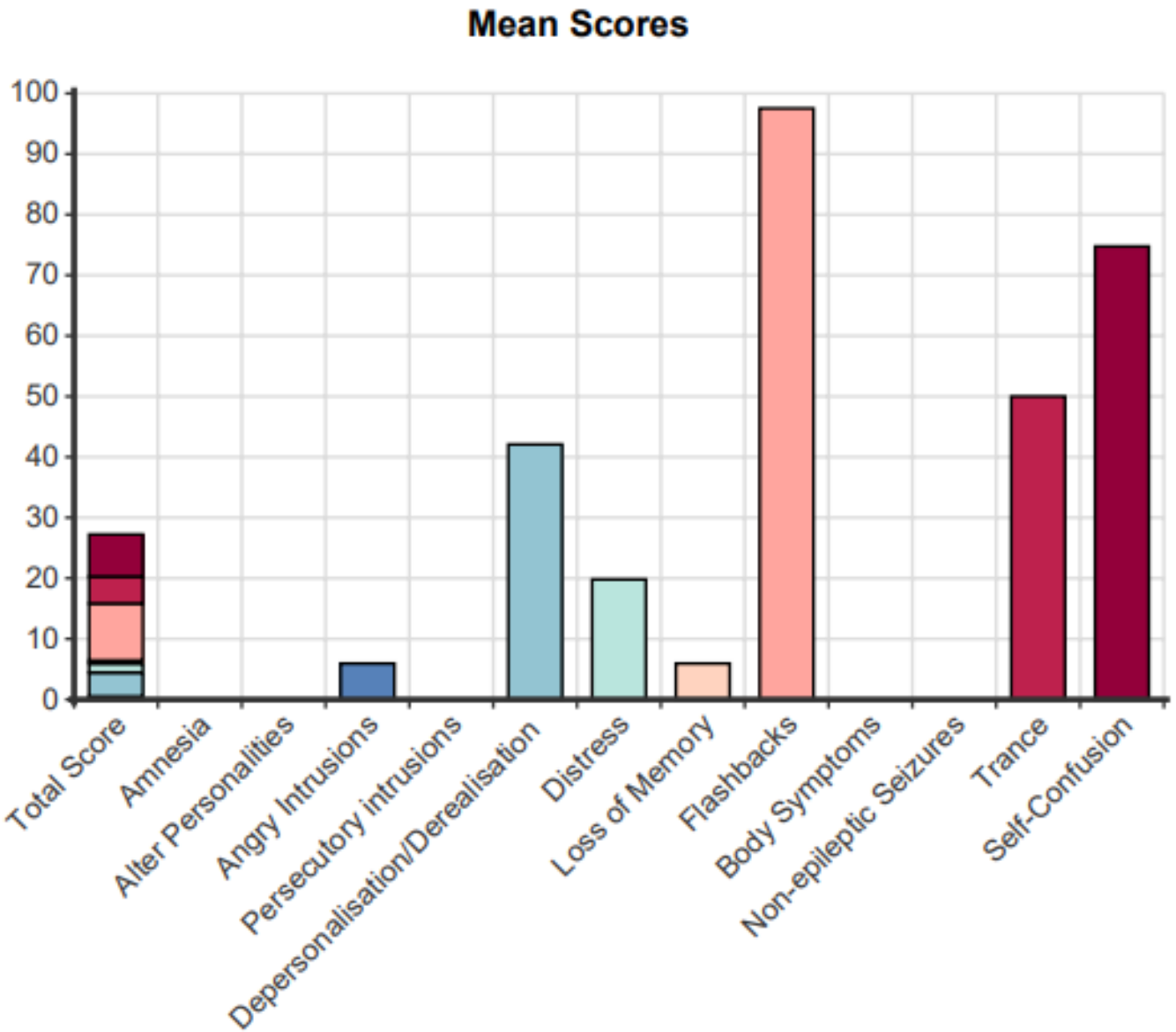
	Mean Score	In Clinical Range?
Body symptoms	0	No
Pseudo-Seizures	0	No

General Subscales

	Mean Score	In Clinical Range?
Trance	50	Yes
Self-Confusion	75	Yes



Alpine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Total Score
Amnesia
Alter Personalities
Angry Intrusions
Persecutory intrusions
Depersonalisation/Derealisation
Distress
Loss of Memory
Flashbacks
Body Symptoms
Non-epileptic Seizures
Trance
Self-Confusion

Alpine: diagnostic impressions

Considerations

- High levels of depersonalization
- Dissociative amnesia is just below the threshold (20 vs 21)
- PTSD symptoms are the extreme 98 out of 100.

- Likely diagnosis: PTSD dissociative subtype.
- Comorbid dissociative amnesia is possible.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Post-traumatic stress disorder

Dissociative clients may struggle to answer accurately

A colleague was verbally administering the MID to Rachel, a client with impaired vision.

Rachel responded to an item about voice hearing, stating clearly that she did not hear voices. Then part way through another question she stopped and appeared to be listening and said “I think it’s a 3 but Susie thinks its an 8.” When Rachel was asked how she knew what Susie thought, she replied “Well she told me. I heard her.”

Dissociative clients may think their experience is common

People with a dissociative disorder may not realise that other people don't have dissociative symptoms, for example they may believe most people, if not everyone:

- has voices in their head
- remembers their childhoods
- have problems with their memory.

This is often reinforced by people commonly saying things casually like "I'm so forgetful" "a little voice in my head said, just do it".

This may lead to under-reporting of symptoms

Faking good

It is common to fear disclosing voices for fear of being seen as crazy and being institutionalized.

> I wasn't going to tell them I had voices. The psychiatrist asked me if I had filled out the Dissociative Experiences Scale before and I said I had. She asked if I was truthful. I said no. When asked me why, I said "I don't want to have schizophrenia". She said "its not about schizophrenia, can you please fill it out and be honest". I did and she came back to my bed and looked completed shocked and said "that's pathological". Then she tried to explain what it [dissociative identity disorder] was and she asked how many people I have here. I was still confused and didn't know what she was talking about.

Kylie – Inpatient with DID

Faking bad?

- Individual may be so desperate for the diagnosis that they exaggerate their symptoms significantly. There has become increasingly common occurrence in the last couple of years in those identifying as plural, often with “fictive” alters who are self-diagnosed prior to test-taking.
- Exaggerating symptoms to receive therapeutic attention and diagnostic label might be considered factitious disorder. However, it is not that straightforward as the person may genuinely believe they have the diagnosis.
- Clients may feel angry, upset, dismissed, invalidated if they are not given a diagnosis.

Monitoring: revisiting expectations about symptom reduction

Trauma-informed psychotherapy reduces dissociative symptoms, improve mental health and global functioning, decrease distress, drug use, depression, self-harm, hospitalizations, and revictimization, while increasing safety, and quality of life (Brand et al., 2013; Myrick et al., 2017)

However, dissociative symptoms may get worse before they get better, and can fluctuate depending on current stressors

Starting therapy with a DID client:

only one aspect may be visible to the clinician or the client

People with dissociative disorders lack awareness about the extent of what is buried

Vs

Increasing scores over time may be due to:

- increasing self-knowledge: the client become aware that they are more dissociative than they realized
- processing traumatic content. This can be distressing and potentially lead to increases in all subscales. For example:
  - A person with dissociative amnesia may experience flashbacks, conversion symptoms, trance and self-confusion, they may even realise they have more extensive memory gaps
  - A person with DID/OSDD may have more intrusions and switching to avoid the painful reality of their traumatic lives.

Slow is fast in treating dissociation

It is understandable that a client may report being more dissociative, particularly in the early stages of therapy.

However, it can also serve as a warning that the therapy is moving too fast, and the client should be focussing on safety and stabilization rather than trauma processing.

All photographic images in this presentation are courtesy of BeFunky.com

NovoPsych

Southern Cross University

International Society for the Study of Trauma and Dissociation

My research participants

Everyone interested in developing skills and knowledge about trauma and dissociation

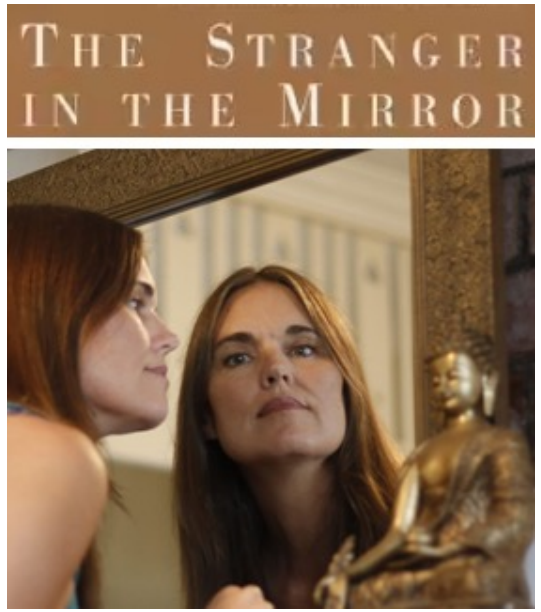
Resources

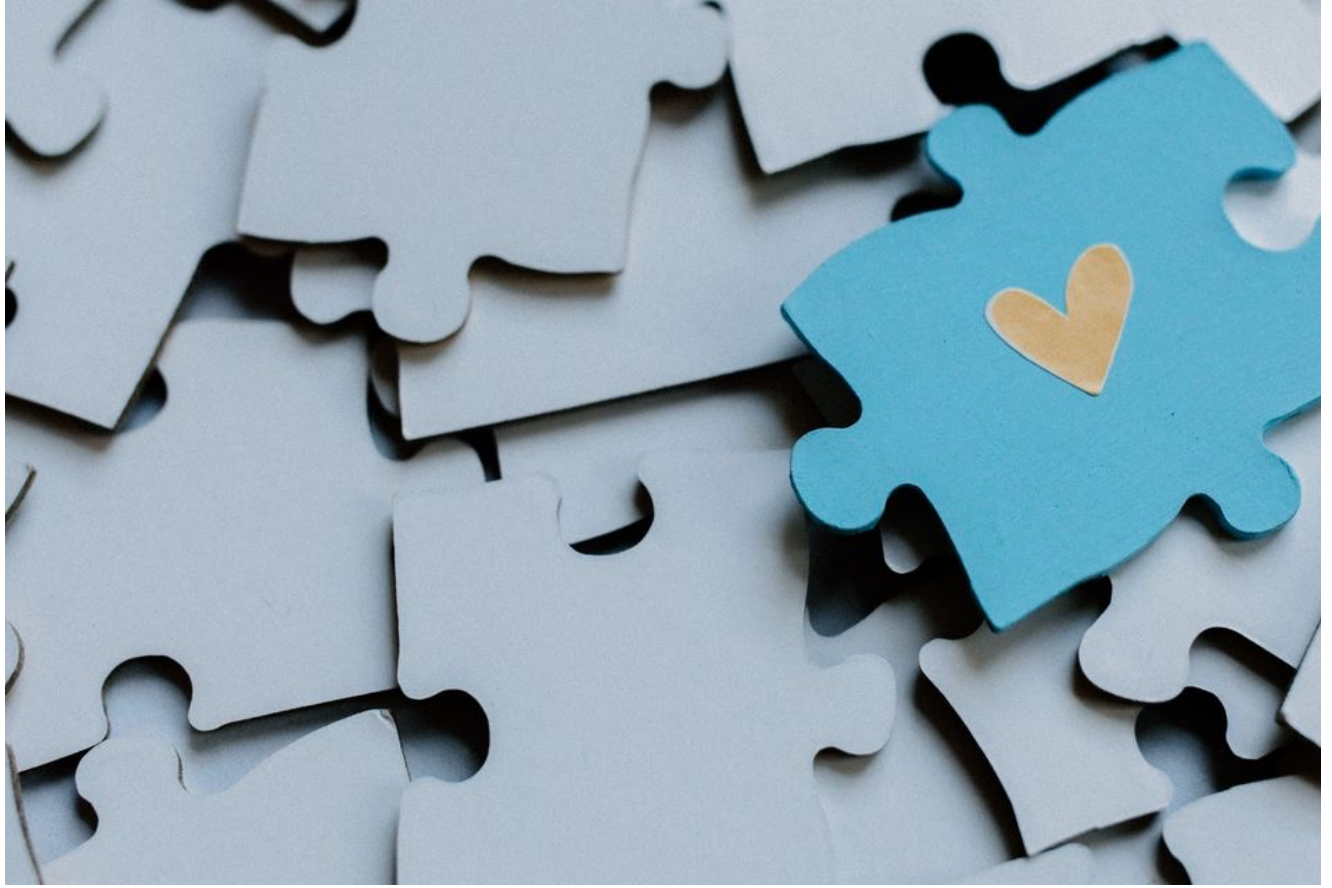
Treatment guidelines

- Guidelines for Treating Dissociative Identity Disorder in Adults (2011)
- Guidelines for the Evaluation and Treatment of Dissociative Symptoms in Children and Adolescents (2004)

DISSOCIATIVE-DISORDERS@LISTSERV.ICORS.ORG

DISSOC is a community of clinicians who are trying to understand dissociative processes and dissociative disorders in all their manifestations. To join, email moderator Richard A. Chefetz, M.D. r.a.chefetz@psychsense.net





Additional MID-60 resources, including German and Greek translations, journal article, and excel version is available here:

https://drive.google.com/drive/folders/1PijizRbu8NxArfeivVCuiM8En5kG4PTY

Email: dissociationresearcher@gmail.com

Facebook: the dissociation researcher

Researchgate: https://www.researchgate.net/profile/Mary-Anne-Kate

LinkedIn: https://www.linkedin.com/in/mary-anne-kate-28625938/