DISSOCIATION

BEHAVIORAL DEFINITIONS

1. The existence of two or more distinct personality states that recurrently take full control of one's behavior.
2. An episode of the sudden inability to remember important personal identification information that is more than just ordinary forgetfulness.
3. Persistent or recurrent experiences of depersonalization; feeling as if detached from or outside of one's mental processes or body during which reality testing remains intact.
4. Persistent or recurrent experiences of depersonalization; feeling as if one is automated or in a dream.
5. Depersonalization sufficiently severe and persistent as to cause marked distress in daily life.

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LONG-TERM GOALS

1. Integrate the various personalities.
2. Reduce the frequency and duration of dissociative episodes.
3. Resolve the emotional trauma that underlies the dissociative disturbance.
4. Reduce the level of daily distress caused by dissociative disturbances.
5. Regain full memory.

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SHORT-TERM OBJECTIVES

1. Identify each personality and have each one tell its story. (1, 2, 3)

2. Complete psychological testing designed to further understand the nature and extent of dissociative experiences and personality. (4)

3. Cooperate with a referral to a neurologist to rule out organic factors in amnestic episodes. (5)

THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with the client in individual sessions through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help increase his/her ability to identify and express feelings.

2. Without undue encouragement or leading, probe and assess the existence of the various personalities that take control of the client.

3. Conduct a functional analysis of the variables associated with dissociative states and their resolution including thoughts, feelings, actions, interpersonal variables, consequences, and secondary gains.

4. Conduct or refer for psychological testing of dissociation (e.g., *The Dissociative Experiences Scale*) and/or abnormal and normal personality features and traits (e.g., MMPI-2).

5. Refer the client to a neurologist for evaluation of any organic cause for memory loss experiences.

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9)
6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess

this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. Complete a psychotropic medication evaluation with a physician. (10)
6. Take prescribed psychotropic medications responsibly at times ordered by the physician. (11)
7. Participate in a therapy to address personal and interpersonal vulnerabilities to dissociation. (12)
8. Identify the key issues that trigger a dissociative state. (13, 14, 15)

10. Arrange for an evaluation of the client for a psychotropic medication prescription.
11. Monitor and evaluate the client's psychotropic medication prescription for compliance, effectiveness, and side effects.
12. In clients whose dissociation appears functionally related to a clinical syndrome (e.g., PTSD) or personality disorder (e.g., Borderline Personality Disorder), conduct or refer to evidence-based treatment of the disorder (e.g., cognitive processing therapy or dialectical behavior therapy, respectively).
13. Explore the feelings and traumatic circumstances that trigger the client's dissociative state (see the Childhood Trauma and Sexual Abuse Victim chapters in this *Planner*).
14. Explore the client's sources of emotional pain or trauma, and feelings of fear, inadequacy, rejection, or abuse (or assign "Describe the Trauma" from the *Adult Psychotherapy Homework Planner* by Jongsma).
15. Assist the client in accepting a connection between his/her dissociating and avoidance of facing emotional conflicts/issues and painful emotions (e.g., experiential avoidance).

9. Decrease the number and duration of personality changes. (16, 17)

10. Practice relaxation and deep breathing as means of reducing anxiety that serves as a trigger for dissociation. (18, 19, 20)

16. Facilitate integration of the client's personality by supporting and encouraging him/her to stay focused on reality rather than escaping through dissociation (or assign "Staying Focused on the Present Reality" from the *Adult Psychotherapy Homework Planner* by Jongsma).

17. Emphasize to the client the importance of a here-and-now focus on reality rather than a preoccupation with the traumas of the past and dissociative phenomena associated with that fixation. Reinforce instances of here-and-now behavior.

18. Teach the client calming techniques (e.g., progressive muscle relaxation, breathing-induced relaxation, calming imagery, cue-controlled relaxation, applied relaxation) as part of a tailored strategy for reducing chronic and acute physiological tension that triggers dissociation.

19. Role-play the use of relaxation and cognitive coping to visualized stress-provoking scenes, moving from low- to high-stress scenes. Assign the implementation of calming techniques in his/her daily life when facing these trigger situations; process the results, reinforcing success and problem-solving obstacles.

20. Assign the client to read about progressive muscle relaxation and other calming strategies in relevant books or treatment manuals (e.g., *The Relaxation*

and Stress Reduction Workbook by Davis, Robbins-Eshelman, and McKay; *Mastery of Your Anxiety and Worry: Workbook* by Craske and Barlow).

11. Identify, challenge, and replace self-talk that produces negative emotional reactions with self-talk that facilitates a better regulation of emotions. (21, 22, 23)

21. Explore the client's self-talk that mediates his/her strong negative/painful feelings and actions (e.g., "I can't face this"); identify and challenge biases, assisting him/her in generating appraisals and self-talk that corrects for the biases and facilitates a more realistic and regulated response. Combine new self-talk with calming skills as part of developing coping skills to manage negative emotions.

22. Role-play the use of relaxation and cognitive coping to visualized emotion-provoking scenes, moving from low- to high-challenge scenes. Assign the implementation of calming techniques in his/her daily life when facing trigger situations; process the results, reinforcing success and problem-solving obstacles.

23. Assign the client a homework exercise in which he/she identifies biased self-talk and generates alternatives that help moderate emotional reactions; review while reinforcing success, providing corrective feedback toward improvement.

12. Verbalize acceptance of brief episodes of dissociation as not being the basis for panic, but only as passing phenomena. (24, 25, 26, 27, 28)

24. Teach the client to be calm and matter-of-fact in the face of brief dissociative phenomena so as to not accelerate anxiety symptoms, but to stay focused on reality.

25. Use an ACT approach to help the client experience and accept the presence of painful/troubling thoughts and feelings without being overly impacted by them, and committing his/her time and efforts to activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy* by Hayes, Strosahl, and Wilson).

26. Teach mindfulness meditation to help the client change his/her relationship with painful thoughts and/or feelings, building acceptance of them without undue reactivity (see *Guided Mindfulness Meditation* [Audio CD] by Zabat-Zinn).

27. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into everyday life.

28. Assign the client reading consistent with the mindfulness and ACT approach to supplement work done in session (e.g., *Finding Life Beyond Trauma: Using Acceptance and Commitment Therapy to Heal from Post-Traumatic Stress and Trauma-Related Problems* by Follette and Pistorello).

13. Discuss the period preceding memory loss and the period after memory returns. (14, 29)

14. Explore the client's sources of emotional pain or trauma, and feelings of fear, inadequacy, rejection, or abuse (or assign "Describe the Trauma" from the *Adult Psychotherapy Homework Planner* by Jongsma).

29. Arrange and facilitate a session with the client and significant others to assist him/her in regaining lost personal information.

14. Utilize photos and other memorabilia to stimulate recall of personal history. (30, 31)

30. Calmly reassure the client to be patient in seeking to regain lost memories.

31. Review pictures and other memorabilia to gently trigger the client's memory recall.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	303.90	Alcohol Dependence
	300.14	Dissociative Identity Disorder
	300.12	Dissociative Amnesia
	300.6	Depersonalization Disorder
	300.15	Dissociative Disorder NOS
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Axis II:	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
300.14	F44.81	Dissociative Identity Disorder
300.6	F48.1	Depersonalization/Derealization Disorder
300.15	F44.9	Unspecified Dissociative Disorder
300.15	F44.89	Other Specified Dissociative Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.