Conversion Disorder, Trauma And Dissociative Identity Disorder
Dr. Wayne Sliwa & Dr. J Austin Williamson

Objectives
Connections between Conversion disorder, Trauma, and Dissociation
Types of Conversion Disorder and Differential Diagnosis
Treatment for Conversion Disorder
Treatment resistance in Conversion Disorder
Assessment of Dissociation
Treatment of Dissociation

What is Conversion Disorder?
DSM-5: Functional Neurological Symptom Disorder
Neurological Symptoms (sensory, motor, speech)
Presentation incompatible with recognized neurological/medical conditions
Onset
La belle indifference

Common Forms of Conversion Disorder
Motor
Weakness
Paralysis
Abnormal gait
Tremor
Psychogenic nonepileptic seizures

Common Forms of Conversion Disorder
Sensory
Altered/reduced/absent skin sensations
Blindness/reduced vision
Double vision
Deafness/reduced hearing
Sensations of lump in the throat

Common Forms of Conversion Disorder
Speech
Reduced speech volume
Inability to speak
Altered Articulation
Differential Diagnosis
Physiological Pathology

Psychogenic Seizures
Epileptic Seizures

<table>
<thead>
<tr>
<th>Resistance to Eye Opening</th>
<th>60%</th>
<th>0%</th>
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</thead>
<tbody>
<tr>
<td>Eyes Shut During Episode</td>
<td>33%</td>
<td>5%</td>
</tr>
<tr>
<td>Patient Responsive during generalized shaking attack</td>
<td>84%</td>
<td>20%</td>
</tr>
<tr>
<td>Memory of Seizure</td>
<td>50%</td>
<td>10%</td>
</tr>
<tr>
<td>Weeping During Seizure</td>
<td>10%</td>
<td>1%</td>
</tr>
<tr>
<td>Duration &gt; 2 minutes</td>
<td>Common</td>
<td>Rare</td>
</tr>
<tr>
<td>Purposeful Movements</td>
<td>Occasional</td>
<td>Rare</td>
</tr>
<tr>
<td>Gradual Onset</td>
<td>Common</td>
<td>Rare</td>
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Prevalence of Conversion Disorder

- 2-5 people per 100,000 [Reuber, 2008]
- 5-16% of referrals to neurology [Reuber, 2008; Stone, et al., 2010]
- 2-3 times more common in females [APA, 2013]

Risk Factors for Conversion Disorder

- Age
- Education/intelligence
- Suggestibility
- Lack of medical knowledge
- Culture
- Comorbid physical and mental health conditions
History of Conversion Disorder

1800 BC - Egyptians
430 BC - Hippocrates "Hysteria"
1697 - Thomas Sydenham
1845 - Moreau de Tours
1859 - Paul Briquet
1870s - Jean Martin Charcot
1889 - Pierre Janet

History of Conversion Disorder

1896 - Freud "The Etiology of Hysteria"

WWI & WWII

DSM - I
DSM - II
DSM - III
ICD - 10
DSM - IV & DSM - 5

Possible Causes of Conversion Disorder

Psychoanalytic Theory
Learning Theory
Biological Factors
Trauma history ≥90% have trauma histories (Reuber, 2008)

Assessment of Conversion Disorder

Referrals from physicians
Findings from physical examination and medical tests
Comorbid physical and conversion symptoms
Psychosocial Interview
Prior incidence of conversion symptoms
Comorbid psychological disorders
Postpone PTSD Assessment

Assessment of Conversion Disorder

Current Conversion Symptoms
- Onset
- Context of onset
- Nature of symptoms (self and informant-report)
- Frequency
- Duration of episodes
- Episode triggers

Assessment of Conversion Disorder

Before assessing trauma history
- Existing safety interventions
- Plan for in-office episodes
- Touching the patient
- When to call 911
- Calling a family member or friend
Assessment of Conversion Disorder

Trauma and Stress Assessment
- Recent stressful events
- Current, ongoing difficulties
- Trauma from childhood/adolescence
- Other past trauma
- Memory impairments

Standardized PTSD Assessment

Interviews
- Clinician Administered PTSD Scale for DSM-5 (CAPS-5) (45-60 minutes)
- PTSD Symptom Scale Interview (PSS-I-5) (20-30 minutes)
- Structured Clinical Interview for DSM-5 (SCID-5): PTSD Module (15 minutes)

Self-report Instruments
- PTSD Checklist for DSM-5 (20 items)
- Short PTSD Rating Interview (SPRINT)
- Impact of Event Scale-Revised (IES-R) (22 items; DSM-IV)
- Mississippi Scale for Combat-related PTSD (MISS/M-PTSD) (35 or 10 items; DSM-III)
- Modified PTSD Symptom Scale (MPSS-SR) (17 items; DSM-III)
- Somatoform Dissociation Questionnaire (SDQ-20; SDQ-5)

Treatment of Conversion Disorder

Medical Interventions
- Reassurance
- Physical Therapy
- Speech Therapy
- Medication (SSRIs, SNRIs, Prazosin)
- Transcranial Magnetic Stimulation

Non-trauma Interventions
- CBT (LaFrance et al., 2014)
- Yoga
- Reassurance
- Breathing Exercises
- Supportive Therapy
- Breathing apps.
- Behavioral Activation
- Biofeedback
- Mindfulness Approaches
- EM Wave

Hypnosis (Moene et al., 2002; Moene et al., 2003)
- Psychoanalysis
### Treatment of Conversion Disorder

**APA Recommended Treatments for PTSD**

- **Strongly Recommended:**
  - Cognitive Behavior Therapy
  - Cognitive Processing Therapy
  - Prolonged Exposure
  - Cognitive Therapy

- **Conditionally Recommended:**
  - Brief Eclectic Psychotherapy
  - EMDR
  - Narrative Exposure Therapy

### Recommended Treatments for PTSD

- **Extensive empirical support for PTSD**
- **Effective for wide range of traumas**
- **Effective in patients with comorbid diagnoses**
  - substance use disorders
  - borderline personality disorder
  - psychosis

### Recommended Treatments for PTSD

- **Theoretical Basis for PE**
  - Posttraumatic Stress Symptoms perpetuated by:
    - Avoiding external reminders
    - Avoiding memories, thoughts, feelings
    - Distorted cognitions

### Prolonged Exposure for Conversion Disorder

- **Seizure Response Plan**
  - Continued verbal communication from therapist
  - Therapist applies pressure to agreed upon body part (forearm, shoulder) for grounding
  - Slow, rhythmic breathing
  - Other sensory grounding techniques
  - Pillow for head, move furniture
Prolonged Exposure for Conversion Disorder

ΔBDI
\[\Delta d = 1.10\]

ΔPDS
\[\Delta d = 1.32\]

Limitations of PTSD Therapies

Risk Factors for Diminished Treatment Response

Prior PTSD Treatment
Ongoing stressors
Repeated traumas (Price et al., 2013)

Comorbid diagnoses

Borderline PD (Forbes et al., 2002)
Sleep Disturbance (Haagen et al., 2017a)
Depression (Haagen et al., 2017b)

Comorbid Dissociation

Conversion as a Dissociative Disorder

56% of conversion disorder patients have a dissociative disorder (D'Alessio et al., 2006)

~100% have dissociative symptoms (Bowers, 2006)

44% with psychogenic amnesia (Bowers & Markand, 1994)

<table>
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<tr>
<th>Disorder</th>
<th>Incidence</th>
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<td>Psychogenic amnesia</td>
<td>44%</td>
</tr>
<tr>
<td>Psychogenic dissociation</td>
<td>100%</td>
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Conversion as a Dissociative Disorder

Limitations of PTSD Therapies

78% of veterans still receive PTSD treatment after 4 years of treatment (Congress of the United States (CBO), 2012)
Was dissociation there before the conversion disorder?

What is Dissociation?

“The process in which normal psychological experiences and events are detached from each other, resulting in a distortion of experience with both subtle and profound alterations in interpretation of the meaning of personal and interpersonal events.” (Chefetz, 2009)

...disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior.” (APA, 2013)

...a normal process that is initially used defensively by an individual to handle traumatic experiences [that] evolves over time into a maladaptive or pathological process (Putnam, 1989)

What is Dissociation?

Non-pathological Dissociation

Daydreaming
Fantasy
Absorption in everyday experiences
(narrowing your focus)

Impairing Dissociative Symptoms

Depersonalization
Derealization
Internal Voices
Freezing
Psychogenic Amnesia
Dissociative Fugue
Conversion Disorder
DSM-5 Dissociative Disorders
- Dissociative Identity Disorder
- Dissociative Amnesia
- Depersonalization/Derealization Disorder

Other Specified Dissociative Disorder
- Chronic and recurrent syndromes of mixed dissociative symptoms
- Identity disturbance due to prolonged and intense coercive persuasion
- Acute dissociative reactions to stressful events
- Dissociative trance

ICD-10 Dissociative (Conversion) Disorders
- Dissociative Amnesia
- Dissociative Fugue
- Trance and possession disorders
- Dissociative disorders of movement and sensations
- Dissociative motor movements
- Dissociative convulsions
- Dissociative anaesthesia and sensory loss
- Mixed dissociative (conversion disorders)

ICD-10 Other Neurotic Disorders
- Depersonalization-derealization syndrome
  - Usually comorbid with depression, phobias, OCD
  - Also in preictal aura of temporal epilepsy and some postictal states
  - Sometimes in schizophrenia

Other specified dissociative (conversion) disorders
- Ganser's syndrome
- Multiple personality disorder
- Transient dissociative (conversion) disorders occurring in childhood/adolescence
- Psychogenic confusion
- Twilight state
- Dissociative (conversion) disorder unspecified
### DSM-5 Dissociative Identity Disorder
- 2+ distinct personalities
- **Psychogenic Amnesia**
- Clinically significant distress/impairment
- Not part of broadly accepted cultural/religious practice

### ICD-10 Multiple Personality Disorder
- 2+ distinct personalities
- Unique memories, behaviors, preferences
- Personalities may contrast premorbid personality
- Usually one dominant personality
- Personality unaware of each other
- First change associated with trauma
- Subsequent changes associated with stress

### Severity of DID
<table>
<thead>
<tr>
<th>Number of traumas</th>
<th>Severity of traumas</th>
<th>Number of perpetrators</th>
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### Prevalence of DID
- **General Population**
  - 1% (Johnson et al., 2006; Sar et al., 2007)
- **Psychiatric Patients**
  - up to 6% (Foote et al., 2006)
- **PTSD Patients**
  - up to 14% (Slees et al., 2013)

### Impact of DID
- 89% have suicidal ideation (Sar et al., 1996)
- 75% have suicide attempts (Sar et al., 1996)
- High treatment cost
  - 2.5% of psychiatric inpatient population, 33.5% of total costs (Macy, 2002)
- Highest number of outpatient therapy sessions (Marchfeld et al., 2010)

### Assessment of DID
- **Challenges**
  - Patients don’t recognize experiences as non-normative
  - Presence of alters or DID symptoms may be denied
  - Switching may be infrequent at times, complicating clinical observation
Assessment of DID

Psychogenic Amnesia

“Do you ever have blank spells, or periods of missing time that you can’t remember? … How often does that happen?”

“Do you ever find yourself in places but can’t remember how you got there? Like all of a sudden you’re at work, in class, or at the store … Can you give me some examples? … How often does that happen?”

“Do people ever tell you that you told them things or saw them somewhere and you have no idea what they’re talking about? … Can you give me some examples? … How often does that happen?”

“Does it ever happen that you can’t remember really important events in your life; like when you graduated from school, got married, or when a child was born?”

“Do you ever find chores or other things done around your house and think you must have been the one to do it, but you can’t remember doing it? … Can you give me some examples? … How often does that happen?”

“Do you ever find clothes or other belongings around your house and think you must have been the one to buy them, but you can’t remember buying them? … Can you give me some examples? … How often does that happen?”

Assessment of DID

Conversion Disorder (2nd most common symptom)

“Have you ever felt like you were outside of your body watching yourself? … How many times has that happened? … What was going on at those times? … When you think back to those times now, do you get a whole movie of what was happening, or is it just pictures like from a camera?”

Assessment of DID

Depersonalization

“Have you ever felt that things around you weren’t real, or like everything around you was happening in slow motion? … How many times has that happened? … What was going on at those times?”

Assessment of DID

Derealization

“Have people told you that there are times when you stare off into space and don’t seem aware of what’s going on around you? … How often does that happen?”

“Has there ever been a time when you couldn’t move, like you were paralyzed, even though there wasn’t anything medically wrong with you? … How often does that happen?”

Clinical Observation and Informant Reports
Assessment of DID

Self-alteration

“Have you ever felt like your thoughts or feelings or sensations belonged to someone else? … How often does that happen?”

Assessment of DID

Awareness of the presence of other personalities
Identity confusion
Visual hallucinations (seeing personality, flashbacks)

Assessment of DID

Schneiderian First Rank Symptoms of Schizophrenia

Sometimes Seen in DID
- voices arguing
- voices commenting
- “made” feelings
- “made” impulses
- “made” actions
- influences on the body
- thought withdrawal
- thought insertion

Not Seen in DID
- thought broadcasting
- audible thoughts
- delusions

Assessment of DID

Auditory hallucinations (hearing voices of personalities)

If patient talks to voices, ask if you can talk to one
Ask patient to repeat answers from the voice without editing
Start with closed ended questions:

- “Can you hear me?” “Are you a boy or girl?” “How old are you?”
Watch for possible switch in personality characteristics

Assessment of DID

Differentiating Schizophrenia and DID
DID patients have self-reflective capacity

Differentiating Neurocognitive Disorder and DID
Neurocognitive screening/assessment

Montreal Cognitive Assessment (MOCA)
http://www.mocatest.org/

St. Louis University Mental Status (SLUMS) Examination

Mini Mental Status Examination (link)
https://www.unity.edu/docs/Mini%20Mental%20Exam_tcm18-183319.pdf
Assessment of DID

Detecting “Switching”
Switching Process
Fixed gaze
Eye fluttering

Changes Resulting from Switch
Patterns of behavior
Patterns of speech
Interpersonal relatedness
Skills
Cognitive style/level
Style of dress (session to session)
Color of eyes change

Assessment of DID

Suicidality
Self-harm
Depersonalization during self-harm
Need for more restrictive level of care/hospitalization

Assessment of DID

Structured Interviews
Structured Clinical Interview for DSM-IV® Dissociative Disorders (SCID-D-R)
Dissociative Disorders Interview Schedule (DDIS) DSM-5 version
http://www.rossinst.com/ddis.html

Self-report Instruments
Multidimensional Inventory of Dissociation v.6.0
http://www.mid-assessment.com/
Dissociation Questionnaire (DIS-Q)
Dissociative Experiences Scale - II (DES-II)
Cambridge Depersonalization Scale (Trait & State)
Steinberg Depersonalization Test

Assessment of DID

The DID patient is a single person who experiences himself or herself as having separate identities that have relative psychological autonomy from one another
Must “meet” other identity to confirm diagnosis

Assessment of DID

Treatment of DID

Regress in the early stages of therapy
Progress is not linear
Sensitive to stress, especially revictimization
Treatment was found to be associated with improvement of functioning and decrease in symptoms of dissociation, comorbid disorders, suicidality, and substance abuse
International Society for the Study of Trauma and Dissociation
Guidelines for Treating Dissociative Identity Disorder

Phase Trauma Treatment Model

Phase one: Safety, Stabilization, and Symptom Reduction
Phase two: Confronting, Working Through, and Integrating Memories
Phase three: Integration and Rehabilitation

Phase One - Phase Two - Phase Three

“Safety Safety Safety”

Phase One

Trust and Therapeutic Alliance

Psychoeducation

- Diagnosis and treatment process
- Safety in and out of treatment office
- Safe and non-safe people in social sphere

Phase One

Keeping the patient safe

Assessment of non-safe behaviors/urges

- frequency
- context
- function

Phase One

Keeping the patient safe

Development of behaviors to remain safe
Phase One
Keeping the patient safe
Development of behaviors to remain safe
Identification of alternate identities (Mapping)

Identification of Alternate Identities (Mapping)
Conference Table:
“Look inside and create a conference table for all the parts … Ask all the parts to sit in the chairs … Count the empty chairs … Go around the table and ask each part individually—how old are you? Are you male or female? What is your job?”

Phase One
Keeping the patient safe
Development of behaviors to remain safe
Identification of alternate identities (Mapping)
Identify alters with unsafe behaviors
Development of agreements between alters to maintain safety

Agreements to Maintain Safety
Who takes care of child alters?
Who will inform therapist of suicidal or risky behaviors?
Who drives car?
Who is in charge of maintaining secrets?
Will part caution therapist if getting too close to secrets?
Resolve internal conflicts for control.

Phase One
Keeping the patient safe
Development of behaviors to remain safe
Identification of alternate identities (Mapping)
Identify alters with unsafe behaviors
Development of agreements between alters to maintain safety
Develop relationship with persecutory alters
Internal safe, healing place for vulnerable alters

Phase One
Symptom Management Strategies
Grounding
stay in your shoes! soothing behaviors
mindfulness what do see, hear, smell, taste, feel?
chewing gum distracting strategies
focusing on object in office perfumes
orientation (age, date, place) objects in hand, (e.g., stress ball, rocks, marbles)
Phase One
Symptom Management Strategies
- Grounding
- Self hypnosis
- Biofeedback
- Breathing Exercises
- Tapping
- Medications

Phase One
Co-occurring Problems
- Depression
- Addictions
- Eating disorders
- Sleep problems
- Panic attacks
- Phobias
- Lack of healthy social relationships

Phase One
Additional Agencies
- Domestic Violence
- Patient abusing children

Phase One
Teaching Management Skills
- Normalize feelings
- Mixed feelings of love and anger
- Ambivalence
- Modulate intensity of feelings
- Teach normal activities of daily living
- Pacing the therapy session with a beginning, middle, and end 10 minute wind down and grounding exercises

Phase One
Containment Skills
- Passing of time
- Star Trek force field
- Permissive amnesia
- Age regression
- Containment imagery
- Counting down
- Dialing down
- Releasing painful feeling in balloon
- Freezer (audience participation)
  Do not put offending or negative parts in containment
Phase One
Work with Alternate Identities
- Each identity will need some individual therapy
- Internal cooperation and co-consciousness
- Conversations among alters

Phase Two
Working with traumatic memories
- Remembering
- Tolerating
- Processing
- Integrating

Phase Two
Patient and therapist agree upon:
- Which memories will be the focus
- Which PTSD interventions will be used
- Which alters will participate
  - Need all alters present during the trauma
  - Alters must be ready and willing to participate
  - Treatment failure may indicate lack of participation of a traumatized alter

Phase Three
Fuse identities
Revisit traumas
Increase adaptive functioning

Treatment Modalities
Outpatient
- 1-3 days/week
- 4-10+ years
- Similar to PTSD treatments

“Safety, Safety, Safety”
References


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Treatment Modalities

Inpatient

Determine Factors leading to destabilization

Going too fast in trauma work

Family conflict

Significant losses

Victimization

Contact Information

Wayne Sliwa, Ed.D.

w.sliwa@hotmail.com

Austin Williamson, Ph.D.

iaustinwilliamson@augustana.edu

Treatment Modalities

Inpatient

What needs to be done to stabilize the patient

What coping skills need to be taught/retought

Revaluation for comorbid symptoms

Provide sense of safety

Medication reevaluation

References


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