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The Importance of Being Very Familiar with the Symptoms of Dissociative Disorders by the Interviewer

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Abstract

we will discuss three diverse types of instruments that can be used to assess dissociative symptoms or diagnoses. These tools fall into the categories of comprehensive clinician-led structured interviews, comprehensive self-report tools, and brief self-report screening tools. These guidelines are designed for use in clinical settings, so they do not discuss several other dissociation criteria used primarily for research. This is because these guidelines are designed to be clinically focused (interviews in a structured format that are comprehensive and led by a clinician). Amnesia, depersonalization, derealization , identity confusion, and identity change are the five symptoms

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assessed in the DSM-IV Structured Clinical Interview-Revised for Dissociative Disorders (SCID-DR; Steinberg, 1994a, 1994b, 1995). Most of the items have follow-up questions questioning the description of the experience, specific examples, frequency of the experience, as well as its impact on social functioning and job performance. SCID-DR not only supplies a diagnosis for each of the five DSM-IV dissociative disorders, but also supplies a score for each of the five dissociative symptoms and an overall score based on the frequency and intensity of the symptoms. SCID- DR can take 45 to 180 minutes or longer to administer. It is important that the interviewer, whether a trained technician or a clinician, is familiar with the symptoms of dissociative disorders. The Dissociative Disorders Interview Program (DDIS; Ross, 1997; Ross et al., 1989, 1990) is a structured interview consisting of 132 questions and is used to assess the symptoms of the five DSM-IV dissociative disorders as well as major disorders . depressive disorder, borderline personality disorder, and somatization disorder. In addition, the DDIS assesses issues related to drug addiction, Schneiderian first-degree symptoms , trance, childhood abuse, secondary DID traits, and supernatural or paranormal experiences. Administration of the device typically takes between thirty and sixty minutes.

Keywords: *Dissociative Symptoms or Diagnoses, SCID-DR, DSM-IV, Diagnoses of Dissociative Disorder, Dissociative Disorders Interview Program*

1. Introduction

DDIS supplies diagnoses in addition to the number of items confirmed in each part of the interview; however , it does not assess the frequency or severity of symptoms . Instrumentation is important for comprehensive self-reporting. The Multidimensional Dissociation Inventory, commonly known as MID (Dell, 2006), is a diagnostic tool that uses multiple scales to conduct an all-encompassing assessment of dissociative events. The MID is a 218-item measure with 168 dissociation items and 50 validity items. Both scale scores and diagnoses can be generated using MID and its accompanying Excel®-based scoring program, freely accessible to mental health professionals (i.e., DID, DDNOS, PTSD, and severe borderline personality disorder).

symptoms in addition to six response sets that function as validity scales . The 168 dissociation substances that make up the MID were divided into 12 first-order factors and one second-order factor. These first-order factors include self-confusion, angry interventions, dissociative disorientation, amnesia, distress with memory problems, experience of alternative identities, derealization /depersonalization, persecutory interventions, trance, flashbacks, bodily symptoms , and gaps in autobiographical memory (pathological dissociation). (Dell and Lawson, 2009). The use of brief self-report tools, brief screening tools is for screening purposes only and should not be done on their own to rule out or rule out the possibility of a dissociative disorder.

The Dissociative Experiences Scale (DES; Bernstein & Putnam , 1986, 1993) has been used more often than any other measure of dissociation in both research and clinical practice. This is true in any field. DES is a self-report tool consisting of 28 questions. The questions primarily focus on amnesia, depersonalization, derealization , assimilation, and creative participation. DES- Taxon consists of eight questions taken from DES . These questions are most closely related to a group (class) of people showing "pathological dissociation" (Waller , Putnam , & Carlson, 1996). The Dissociation Questionnaire (DIS-Q; Vanderlinden , 1993; Vanderlinden , Van Dyck , Vandereycken , Vertommen , & Verkes , 1993) is a 63-item self-report tool. The Dissociative Experiences Scale (DES), the Perceptual Change Scale (Sanders, 1986), and the Dissociative Experiences Questionnaire (Riley , 1988) were parts of the first item pool that served as the basis for the development of DISsociation .

In addition, added items were obtained from interviews with dissociative patients. DIS-Q is a test that examines identity fragmentation and confusion, as well as loss of control, forgetfulness and assimilation. Although it was developed in Belgium and the Netherlands, doctors and researchers in Europe are more likely to use DIS- Q than its North American counterparts. The Somatoform Dissociation Questionnaire-20 (SDQ-20) is a 20-item self-report measure using a 5-point Likert scale (Nijenhuis , Spinhoven , Van Dyck , Van der Hart , & Vanderlinden , 1996, 1998; Nijenhuis et al ., 1999) . (Nijenhuis , Spinhoven , Van Dyck , Van der Hart and Vanderlinden , 1996, 1998; Nijenhuis et al., 1999). Based on the clinical/descriptive study of Janet (1889), the SDQ-20 is specifically characterized as a measure of somatoform dissociation. The SDQ-20 items include tunnel vision, auditory distance, muscle spasms, psychogenic blindness, voiding difficulties,

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insensitivity to pain, psychogenic paralysis, non-epileptic seizures, and other symptoms. SDQ-5 is just a shortened version with five questions taken from SDQ-20 (Nijenhuis , 1999) .

2. Screening Tool for Dissociative Disorders

The SDQ-5 was designed as a screening tool for dissociative disorders and its results correlate well with those of the more comprehensive Integrated Functioning as Goal of Therapy inventory . It is important for clinicians to remember that a patient with dissociative identity disorder (DID) is not a community of disparate people sharing the same body, even if the patient has the subjective experience of having multiple identities.

Patients diagnosed with dissociative identity disorder (DID) should be viewed as full adults with each identity sharing equal responsibility for daily activities. Even in the presence of amnesia or a sense of lack of control or authority over behavior, clinicians collaborating with patients with dissociative identity disorder often need to hold the whole person (ie, the system of alternative identities) responsible for any individual's behavior (see Radden, 1996). Whenever medically possible, treatment should work to improve the patient's ability to function as an integrated whole. To ease the patient's eventual integration, the therapist may sometimes acknowledge that the patient's different identities feel as if they are different from each other. Despite this, one of the primary goals of psychotherapy provided to patients diagnosed with IPD is to achieve a higher level of communication and coordination among the various personalities the patient has. In most patients with dissociative identity disorder (DID), each identity appears to have a "self" first-person perspective and a "non-self" perspective of other parts as well as a sense of "his" self. The controlling identity will typically speak in the first person and will try to deny other parts of themselves or simply be unaware of their existence. Transitions between identities occur because of changes in emotional state or as a reaction to the demands of the environment, resulting in the development of another identity to ultimately take control.

As a result of the fact that many identities each have their own roles, experiences, emotions, memories, and beliefs, the therapist is constantly forced to reconcile the different perspectives of

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their patients. At the very heart of the therapeutic process is the act of helping identities recognize each other as legitimate components of the self and to negotiate and resolve any conflict that may arise between them. Treating any alternative identity as more "real" or more important than any other identity they can think of can backfire for the therapist .

should be no "favorites" among alternative identities, and the therapist should not exclude from therapy those that seem unpleasant or offensive (some may be). Such steps may be necessary for a limited period at some stages in the treatment of some patients to ensure the safety and stability of the patient or the safety of others.

The therapist must instill in the patient the belief that the patient's various identities all make concerted efforts to cope or overcome the difficulties faced by the patient. Thus, advising patients to ignore or "get rid of" their identities is an ineffective form of therapy (although it may be acceptable to provide the patient with strategies to resist the influence of destructive identities or to help control the emergence of certain identities in inappropriate situations, circumstances or times are important. it is antitherapeutic to suggest that they create alternative identities, to name identities when they do not have names (although the patient is free to choose names if they wish), or to suggest that the identities be studied in more detail and more autonomously than they already operate Achieving a viable integration or coherence between alternative identities , the goal of therapy It is a must have result.

3. Integration and Convergence

Terms such as integration and cohesion are sometimes used misleadingly. Integration is a comprehensive, longitudinal process that refers to any work on mental processes that are fragmented during therapy . RP Kluft (1993a) defined integration as an ongoing process of reclaiming all aspects of resolvable splitting that begins long before any reduction in the number or diversity of identities, continues throughout their fusion, and continues at a deeper level even after identities. It refers to an ongoing process in the tradition of psychoanalytic theories on

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structural change . (p. 109) The term "fusion" describes the moment in time when two or more alternative identities seem to come together and lose all sense of subjective separation.

The term "ultimate fusion" refers to the moment when the patient's sense of self transitions from having multiple identities to being a unified self. This occurs when the patient undergoes a process known as "ultimate fusion." To avoid confusion between early mergers and final mergers, some members of the 2010 Guidelines Task Force advocated the use of the term merge instead of merge.

RP Kluft (1993) suggested that the ultimate reunification of all identity states, including complete integration , loss of union, and separation, is the treatment outcome most likely to be successful. However, even if they receive substantial therapy , a considerable proportion of people with dissociative identity disorder (DID) will not achieve full fusion and/or view fusion as desirable. Comorbid medical conditions, advanced age, significant persistent DSM Axis I and/or Axis II comorbidities, and/or significant narcissistic investment in alternative identity may contribute to the patient's failure to achieve eventual fusion. Chronic and severe situational stress, avoidance of unresolved, extremely painful life problems, including traumatic memories, lack of financial resources for treatment, avoidance and avoidance of extremely painful life problems, including traumatic memories, are other considerations . So, a more realistic long-term outcome for certain individuals may be a collaborative arrangement, often referred to as a "solution", that is, sufficiently integrated and coordinated functioning between the various identities to support best functioning. However, patients who achieve a cooperative rather than final fusion arrangement may be more vulnerable to later decompensation (fluoride DID and/or PTSD) when sufficiently stressed.

Even after final fusion, added work may continue to integrate the patient's now dissociated ways of thinking and experiencing. For example, the therapist and patient may need to work on fully integrating a talent previously held by an alternative identity, or the patient may need to learn what the new pain threshold is or how to integrate all dissociated ages. The issue here is how to reorganize proper and healthy levels of exercise or effort for a chronological age or age . Traumatic or stressful materials may need to be reworked considering this new, unified perspective. Treatment Outcomes, Treatment Trajectories, and Cost-Effectiveness for ICD Although studies of

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ICD treatment date back more than a century (Janet, 1919; Prince , 1906), rigorous research into the treatment of IPD is still in its infancy.

Brand , Classen , McNary , and Zaveri (2009) reviewed treatment studies of various dissociative disorders, they found several factors complicating research in this area, including the lengthy treatment often required and the pragmatic need for a flexible treatment. The approach to managing the complex clinical conditions of DID patients should also be considered. Despite the challenges, treatment for DID has been explored through case studies, case series, cost-effectiveness studies, and natural outcome studies of therapeutic efficacy. This working group provides evidence of successful treatments for dissociative identity disorder (DID) and the broad spectrum of symptoms associated with it.

In the Netherlands, a chart review study involving 101 patients with dissociative disorders in outpatient treatment for an average of 6 years found that clinical improvement was related to the intensity of treatment; more extensive treatments had better results (Groenendijk & Van der Hart , 1995). Outcome data systematically collected from case series and treatment studies showed that 16.7% to 33% of these DID patients achieved full integration (ie, final fusion; Coons & Bowman , 2001; Coons & Sterne , 1986; Ellason & Ross, 1997).).

commonly develop “safety agreements” with the patient's alternate identity system to supply a framework for the patient to reduce unsafe behaviors . These agreements do not replace the clinician's judgment about patient safety, and this applies both clinically and forensically. Safety agreements should be interpreted in the context of the patient's clinical situation and patients should review these agreements regularly with their healthcare provider.

Clinicians should understand that no language is free of loopholes, insist that patients follow the spirit of the agreement, and pay attention to "expiration" dates in some safety agreements. In addition, clinicians should not have to assume the responsibility of reaching an agreement with every alternative identity. Instead, strategies (such as "talking through") should be developed to get all alternative identities to accept that they are and are committed to agreement. The clinician should always insist on more restrictive treatment alternatives if, in their clinical judgment, the patient is unsafe. It is possible that safety agreements are best thought of as strategies for

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procrastinating or postponing action that, over time, help patients understand their safety-related ambivalence and help patients realize that they have control over their own personal safety as well as helping them. The above should be considered in mobilizing their efforts towards security more effectively . The discussion of controlling insecure behaviors often brings a wealth of important material to therapy about the alternative identity system, the patient's history, transference issues (especially traumatic transference themes), and the dominant ideas and beliefs that shape the patient's behavior. All of these can clarify how the patient should be treated.

In phase 1 therapy, the management and control of post- traumatic symptoms is also considered a key area. For example, if the patient has an unprovoked return of the traumatic event or an intervening recall episode during treatment, the therapist will collaborate with the patient to teach techniques that can help control the severity of the experience.

Rather than encouraging further exploration of intrusive traumatic material, at this stage of treatment the clinician will aid the patient in improving control of post- traumatic and dissociative symptomatology and modulating levels of psychophysiological arousal. This is done in preparation for the next stage of treatment. During the DID treatment period, called "safety and stability," skills training is often an integral part. Mental processes and weaknesses that impair security are addressed by these therapies , which include emotional empowerment .

There are several related skills training programs described in the literature. Some of these programs are Systems Training for Emotional Predictability and Problem Solving (Blum, Pfohl , St. John & Black, 2002), Trauma Adaptive Recovery Group Training and Therapy (Ford & Russo, 2006), acceptance and commitment therapy (Follette & Black, 2002). Pistorello , 2007) and The Quest for Security (Follette & Pistorello , 2007). Other programs (Najavits , 2001). The use of dialectical behavior therapy (DBT; Linehan , 1993a, 1993b; see also Salsman & Linehan , 2006) as treatment for borderline personality disorder (Salsman & Linehan , 2006) and complex trauma is supported by good scientific evidence (Wagner, Shireen , Rizvi , & Harned). , 2007).

therapy (DBT) for use in Phase 1 of ICD treatment (for example, Somer, Rivera , and Berger, 2010; Van Orden , Schultz, and Foote , 2009). Elements of dialectical behavioral therapy (DBT), along with several other elements, were combined in the first educational manual specifically

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designed for dissociative disorders (Boon , Steele , & Van der Hart, 2010). Using aliases and aliases in your work. In many cases, clinicians treating dissociative identity disorder (DID) find it helpful to draw therapeutic attention to the alternative identity system as organized, subjectively "logical", rule-based interactive, and/or contradictory states. This contrasts with the fact that attention is focused only on the discrete alternative identities themselves. Patients with dissociative identity disorder (DID) must understand, adopt and access alternative identities that play an active role in their daily lives as part of the process of learning about the nature of the condition and their internal systems. At the beginning of treatment, it is widespread practice to talk to the patient about the patient's responsibility for the behavior of all different identities, both inside and outside of therapy . Techniques that promote reconciliation between alternative identities, the recognition of the importance of all alternative identities, and the establishment of commitments by all identities to avoid self-harm and/or suicidal behavior can be included in the set of strategies designed to improve internal communication .

4. Other Possible Strategies

Other possible strategies include recognizing the importance of all alternative identities. A vital part of Stage 1, carried over to Stage 2, is the development of internal cooperation and shared consciousness between identities. This goal is made more achievable by using a coherent approach to helping people with DID respect the adaptive role and validity of all identities and find ways to consider the wants and needs of all identities when making decisions and conducting life activities. Improving the level of internal support between identities is an issue that needs to be evaluated separately. Some alternative identities first ignore or reject earlier traumatic events and/or their associated effects when they first begin therapy . It is a fundamental part of treatment that these identities gradually embrace the memories and emotions they deny , while accepting the role and importance of other identities that hold them. The acceptance process can be aided by the therapist 's aid in forming internal agreements by various alternative identities (for example, "If you can acknowledge and accept some of the emotions that your 'angry side' is experiencing, perhaps that part can agree to stop some destructive behavior that threatens your safety")

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The therapist can ease the acceptance process by helping alternative identities come to terms with themselves. Clinicians must accept the fact that effective treatment of dissociative identity disorder almost always requires engagement. Talking to many of the patient 's personalities is an issue that needs to be evaluated separately. Ignoring or automatically instructing these identities to "turn in" is quite obviously counterproductive to the therapeutic process. Early in the therapy process, therapists and patients need to develop techniques for relating to different identities that are both secure and in control. This will ultimately lead to shared consciousness, shared acceptance, and deeper integration. Clinicians have the choice of directly or indirectly reaching out to different people to do their work. IDs are available directly (for example, "I need to talk to your risky sex partners who went to Atlantic City last night"). Clinicians with years of experience build a toolbox full of capabilities that allow them to access other identities in a more devious way. For example, the clinician might suggest that the patient "listen inside" to hear what other identities are saying, or ask the patient to "listen to himself," so that the clinician may suggest that the identities have internal conversations with themselves. Interaction with each other should also be considered so that they can exchange information or solve important problems. The therapist may "speak to the heart" to interact with different identities important to current therapeutic challenges or may insist on "listening to all who need to know" when dealing with vital issues.

of treatment strategies for accessing and working with alternative identities include Putnam (1989), Ross (1997), RP Kluft (2001, 2006), RP Kluft and Fine (1993), and Van der Hart et al. (2006) researched by. All these authors are quoted in the earlier sentence. Most hospital stays are quite short and are primarily conducted for the sake of safety, crisis management and stability due to limits imposed by third parties who pay. In some cases, the stability and organization provided by a hospital setting is better suited to support therapeutic work that may be difficult or uncomfortable to conduct in an outpatient setting. Inpatient treatment may include planned and vigilant working on traumatic memories, as well as working with other violent and self-destructive identities and associated behaviors when resources are available to support a longer stay. Specialized inpatient centers dedicated to the treatment of traumatic experiences and/or dissociative disorders can be particularly beneficial when it comes to helping patients develop the skills necessary to be more confident and stable.

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A general hospital's psychiatry programs typically do not offer the following services: specialized diagnostic evaluations; intensive individual psychotherapy; private group therapies; specialist psychopharmacological interventions; and specific trauma-focused work on symptom management and skill development find other key issues. If a DID patient shows aggressive behavior towards himself or others during inpatient treatment and the patient is not responding to verbal, behavioral, or pharmacological therapies, isolation and physical or chemical restraints may be necessary to control the patient's behavior.

Unfortunately, closure and restraint have the potential to be traumatic experiences for any patient, particularly those who already suffer from post- traumatic psychopathologies, requiring separate consideration. As a result, a considerable number of healthcare facilities are now working towards the ideal goal of reducing or cutting the use of isolation and restraint altogether. In this sense, these restrictive measures can often be avoided if careful planning is made in advance for symptom management and control methods. This preparation can be helpful in times of crisis.

Patients admitted to some hospital systems are asked to create so-called "personal safety plans." These plans include situations that have the potential to improve or hinder patients' ability to keep themselves safe. In the case of individuals suffering from DID , they can include naming unique post- traumatic triggers as well as actions that give calming and relaxing effects . Specific therapies for patients with DID may include communicating with helpful alternative identities, using imagery to find an internal "safe space" for overwhelmed or self-harming alternative identities, and using images to "voice" or otherwise mitigate strong effects.

Using "voluntary" physical restraints to have an alternative violent personality while dealing with the effects of trauma is no longer seen as a practical solution. Partial Hospital or Inpatient Treatment Patients diagnosed with DID can receive help from basic partial hospital programs one step further from inpatient treatment. The most effective programs for this purpose are likely to be those that allow the survivor to have a specific focus and are aware of the challenges associated with the trauma . Patients with dissociative identity disorder (DID) and others who have been severely traumatized can benefit greatly from either a step up from inpatient treatment or avoiding inpatient hospitalization and/or a specialized partial hospital or inpatient treatment as a more

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intensive outpatient treatment. Overall, these specialty programs educate participants on trauma - related illnesses, provide strategies for symptom management, and provide education in relationships and other life skills with the use of multiple groups each day. It may be possible in these programs to incorporate DDT or other more formally structured and organized approaches to symptom management. Unfortunately, only a small fraction of these specialization programs is currently available to participants.

5. Group Psychotherapy

Patients suffering from DID often perform poorly in generic treatment groups because these groups consist of people with a variety of different diagnoses and clinical problems. Traditional process-oriented psychotherapy groups, or those that encourage limited discussion of participants' traumatic experiences, can have powerful effects that many people with dissociative identity disorder (DID) find difficult to tolerate. Some of these treatment groups have led to worsening of symptoms or having group members develop problematic relationships with each other. When it comes to ICD treatment, group psychotherapy is not a practical mainstream treatment choice. However, for certain individuals with dissociative identity disorder (DID) or complicated post-traumatic stress disorder (PTSD), some time-limited group forms may be useful additions to individual therapy. Such groups can help educate patients about trauma and dissociation, help develop specific skill sets (such as coping strategies, social skills, and symptom management), and help patients understand that they are not alone in dealing with dissociative symptoms.

6. Traumatic Memories

Patients may also learn that there are other people experiencing the same things as them. Groups for this task need to have a time constraint, an elevated level of organization, and a clear concentration on the subject at hand . Some clinicians have reported that carefully selected ICD patients may receive help from longer-term, homogeneous, more process-oriented groups for DID and complex PTSD patients. These groups are specifically designed for patients with DID . The

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goals of individual therapy are supported by the International Association for the Study of Trauma and Dissociation, and its primary emphasis is on " *improving interpersonal functioning".*

For such a group to be successful, there must be a clear therapeutic framework that outlines expectations and boundaries for participants' behavior in and out of the group (e.g., limitations in discussing trauma memories within the group, no socialization among members outside the group). When it comes to dealing with drug abuse issues, some patients may receive help from attending 12-step meetings hosted by organizations such as Alcoholics Anonymous, Narcotics Anonymous or Al-Anon. However, 12-step "incest survivor" groups or "self-help" groups that are not led by a trained professional are generally considered contraindicated for DID sufferers. This is because the typical format of these groups is irregular, which can lead to emotional outbursts and other forms of psychological distress. In addition, group members are likely to engage in unhealthy behaviors for themselves and others, such as being uncomfortable, overly dependent, or exploitative. Patients diagnosed with DID who insist on joining such groups are often turned away by professional therapists who would otherwise treat them.

7. Pharmacotherapy

Primary treatment for dissociative processes does not include the use of psychotropic drugs, and specific recommendations for pharmacotherapy for most dissociative symptoms currently await the completion of systematic investigations. However, according to reports from therapists , most DID patients are also given medication as part of their treatment (Putnam & Loewenstein , 1993). Eighty percent of outpatients for dissociative disorders received adjunctive drug therapy, according to the only naturalistic study of such treatment (Brand , Classen , Lanius , et al ., 2009). Patients diagnosed with dissociative disorder typically receive pharmacotherapy that focuses on the treatment of the hyperarousal and intrusive symptoms of PTSD , as well as comorbid conditions such as mood disorders and obsessive -compulsive symptoms , among other conditions (Loewenstein , 1991b; Torem , 1996). Understanding that the prescription is mostly empirical in nature should be part of the informed consent process when it comes to medication guidelines for DID. To avoid "splitting" the treatment team, psychopharmacological management of ICD

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requires attention to boundaries and active lines of communication between treating therapists, nonpsychiatric treatment team members, and the medicating psychiatrist (especially when the psychiatrist is not also the primary therapist).

A precise definition of the roles of the therapist and the prescribing psychiatrist is extremely important. Only one clinician should be involved during the patient's intensive psychotherapy process. In general, the prescribing physician should play an auxiliary role, focusing primarily on drug therapy, and seeing the patient more often only if a psychiatric crisis or when changing medications. The primary therapist should be the person to deal with any emergencies that may arise during psychotherapy.

patient cannot communicate with the therapist ; it is not proper to look at the psychiatrist as a remedy. It is important that members of the treatment team communicate with each other regularly and share valuable information to supply a continuing context for adjustments and interventions to treatment. As with any psychopharmacological treatment, problems of non-compliance with the pharmaceutical regimen, such as overuse, underuse and/or covert use of other drugs or alcohol, should always be considered in any psychopharmacological treatment.

For a complete and correct description, it may be necessary to have working knowledge of DID psychotherapy techniques and to engage in the DID alternative identity system during investigation of suspected maladjustment . If the psychopharmacologist is not experienced in dealing with such questions, the primary therapist may manage completing this task. The same drug can cause various reactions in the individual suffering from dissociative identity disorder (DID). This may be due to various levels of physiological activation present in different identities, somatoform symptoms that can realistically mimic the adverse effects of all known drugs, and/or subjective experiences of identities being different from one another rather than different from one another. In general, the only time drugs have a chance to treat their intended symptoms is when they are reported on a "whole person." Patients with dissociative identity disorder often experience day-to- day changes in their symptoms ; this can be attributed to the modulation of dissociative defences, the individual situations of the patients and the stresses in their lives. It is therefore

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extremely helpful to pay attention to the general "emotional climate" of the patient's presentation when changing or adjusting medications.

Rather than trying to treat the daily psychological changes in the " weather" , it is preferable to deal with the general "emotional climate" of the patient. It is possible that effective psychotherapeutic skills training for the regulation, justification and management of PTSD and dissociative symptoms may be more effective than medication in the treatment of these conditions. Certain groups of alternative identities, or certain alternative identities themselves, may have experience of "blocking" or "overriding" the effects of the drug. This can take various forms, such as the basic physiological states of identities becoming more active, the basic agitation of identities increasing because of intensifying internal conflict or persecution, or any combination of these factors.

Similarly, identities can "deceive" other identities by either not taking medication or by taking more than the prescribed amount, and as a result, other identities willing to stick to their medication regimen experience amnesia for these behaviors. Similarly, identities can "fool" other identities by not taking medication or by taking more than the prescribed amount. Additionally, because of the trance logic of separation, some people with dissociative identity disorder may take excessive amounts of medication because they are under the impression that each of their alternate identities needs a dose of medication for a "separate body." In many cases, it helps a lot to think of drugs in the role of "shock absorbers" for DID rather than therapeutic interventions. Patients suffering from DID and other complex forms of post- traumatic disorder often have only a partial response to various medications. Therefore, prescribers need to have a high awareness of the possible side effects that may result from the use of many drugs in this patient group. When a crisis occurs, the psychiatrist may decide to change the dose of the patient's medication.

In many cases, this is both a more cost-effective and more beneficial intervention than starting new drug trials. Patients diagnosed with DID, just like patients diagnosed with other conditions, require a careful discussion of the risks and benefits of using medication, as well as the risks of discontinuing medications and the need for adherence to medication regimens. As with all patients,

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changes in stable and ancillary medications should be made carefully, ideally when the patient is not during a crisis or immersed in therapy and symptoms reappear.

8. Conclusion

stable in the later stages of treatment , the patient, the psychiatrist on medication, and the primary therapist should be collaborative around issues of continuing or dropping medication. This is especially important when the patient is nearing the end of treatment. Unfortunately, there are no systematic studies of drugs used for IPD, and only a few studies of drug therapy for PTSD have a pool of participants in women who have survived chronic childhood maltreatment. Pharmaceutical therapy for dissociative identity disorder (DID) will continue to depend almost entirely on empirical and clinical experience until a stronger scientific basis is established. The Role of Hypnosis as a Useful Tool in Psychotherapy Since the early 19th century, hypnosis has been used as an adjunct to the treatment of dissociative disorders (Ellenberger , 1970). There is a great deal of research focusing on the use of hypnosis for the treatment of DID (see Ross & Norton, 1989a). The addition of hypnotic techniques as a complementary treatment choice for dissociative identity disorder (DID) is supported by several compelling arguments . First, patients with dissociative identity disorder are more hypnotizable than patients in other clinical populations (Frischholz , Lipman , Braun , & Sachs, 1992). More hypnotizability when hypnosis is used is associated with an increased likelihood of therapeutic success. Second, hypnotic work has the potential to develop many different therapeutic approaches. Studies have proved the clinical efficacy of hypnosis in treating post-traumatic symptomatology (Cardeña , Maldonado , et al ., 2009), and hypnosis-facilitated interventions have played a key role in the successful treatment of many DID patients (RP Kluft , 1984, 1986, 1993a, 1994). (RP Kluft , 1984, 1986, 1993a, 1994). Third, therapeutic work with this group of highly hypnotizable patients will always involve some form of hypnosis, since hypnosis can take the form of spontaneous trance, autohypnosis , or heterohypnosis (trance induced by another person; H. Spiegel & Spiegel, 1978, 2004).

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