Jan Gysi

Diagnosing the Psychological Consequences of Trauma

A Multiaxial Trauma-Dissociation Model According to ICD-11

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About the Author

Jan Gysi, MD, is a psychiatrist and psychotherapist in private practice in Bern, Switzerland with over 20 years of experience in the field of trauma and dissociation. He is author of several publications on trauma and dissociation and its implications in psychotherapy and law enforcement. He speaks at workshops, conferences, and seminars and works as a supervisor.

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This book humbly acknowledges that its content is not perfect but embraces its identity as a work in progress. Any insights, suggestions and constructive criticism by readers are invaluable to me as I strive to improve and enhance the content. Therefore, I would like to express my sincere gratitude in advance to all those who take the time to provide feedback on this book. Your willingness to share your thoughts and perspectives is deeply appreciated, and I am grateful for your contribution to the ongoing refinement of this work. Thank you for being a part of this journey and for helping to make this book the best it can be.

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Jan Gysi, MD
Bern, July 2025

Contents

Foreword

A former president of the American Psychiatric Association (Steven Sharfstein, 2005–2006), noted that potentially traumatic experiences have the same importance in mental health care as tobacco consumption in somatic medicine: They are a risk factor that unfortunately occurs frequently and significantly increases the risk of illness. Additionally, they contribute to a spectrum of psychological syndromes, the breadth and complexity of which can be compared to the various physical consequences of smoking. Consequently, we have seen our knowledge about the importance of traumatization for mental illnesses, including those that were long seen only as "comorbidities" and not as trauma-related disorders or a part of them, grow consistently.

It is a great achievement of Jan Gysi to provide one of the first books to summarize this knowledge in its entirety and to place it so clearly in its practical applications. His starting point is "diagnosis," which, according to the Greek origin of the word, is an insight that arises when a surface is penetrated and the events behind it are understood. This is exactly what the book makes possible by providing the reader with a wealth of clinical details, vivid descriptions, and helpful information on the respective areas of diagnosis. The axis structure proposed by Jan Gysi provides a backbone that places different groups of syndromes in a comprehensive context and extensively depicts their spectrum. In doing so, he consistently follows the international diagnostic standard of ICD-11 and thus creates a cross-disciplinary, descriptive basis for understanding trauma-related disorders.

With trauma-related disorders, as with other mental illnesses, there are always phenomena that lie in the purely subjective realm or give rise to controversies for other reasons. A particularly intense, at times emotionally charged discussion has been held in recent years about the consequences of complex violence, which include forms and consequences of organized violence such as dissociative identity disorder.

The debate is marked by a particularly demanding balancing act between the important protection of patients from treatment errors and the necessary support for those severely affected by violence. The author approaches this topic and the diagnostic possibilities carefully, including the issues of artificial dissociative disorder and the nature of memory, which enables professionals to gain a comprehensive diagnostic picture.

The treatment of complex trauma-related disorders remains, not least due to their connections to urgent societal issues, a particularly challenging area of psychotherapy. At its core are particularly burdened individuals who are entitled to treatment that meets their complex needs according to the highest professional ethical standards. This can only succeed if dedicated experts take on the task, always aware that knowledge in this area, like in the entire field of medicine, is constantly evolving. Jan Gysi tackles this task with his book, which has already become one of the standard works in the German-speaking world, in an exemplary manner.

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Foreword

Jan Gysi has written a remarkable book on the complexities of diagnosis in those who have experienced trauma, in particular, complex developmental trauma. Lucid, concise, and brimming with case examples, cultural considerations, cautions, and practical suggestions and directions, this book is the ultimate guide for clinicians interested in offering excellent assessments to support effective treatment. Each symptom and disorder is exquisitely laid out both in text and tables, making the complex material clear and easy to follow. Dr. Gysi has developed a brilliant five-axis model for trauma and dissociation sequelae that organizes the most pressing challenges of differential evaluation in areas that have profound treatment implications. These include evaluation of (1) attachment and personality disorders, (2) stress-related disorders, (3) structural dissociation, (4) other dissociative disorders, and (5) comorbidity. There are scores of little gems found in the book, such as how to distinguish between obsessive thoughts and trauma-related intrusive thoughts, and how to differentiate chronic hypo-arousal from depression, and how to distinguish between symptoms of autism spectrum and dissociative disorders. The exigent challenges of identifying cases of false and imitated dissociative identity disorder (DID) are also addressed. The final chapter is a compassionate and sensitive examination of reasons why trauma survivors are not believed in legal settings – for example, not fighting back, inconsistencies in the storyline, giving unclear consent, and more. Each of these is explained in the context of trauma, and suggestions are given for helping clients with them in legal cases. *Diagnosing the Psychological Consequences of Trauma* should be on the bookshelf of every clinician.

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Abbreviations

ACE Adverse childhood experience (page 18)
ANP Apparently normal part of the personality (page 173)
BPD Borderline personality disorder (page 41)
CDS Cambridge Depersonalisation Scale (page 246)
cPTSD Complex post traumatic stress disorder (page 71)
DDIS Dissociative Disorders Interview Schedule (page 119)
DES Dissociative Experience Scale (page 118)
DID Dissociative identity disorder (page 103)
DIS-Q Dissociation Questionnaire (page 118)
DNES Dissociative non-epileptic seizures (page 214).
DSM-5 Fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association (APA)
EP Emotional part of the personality (page 173)
FDS Fragebogen für dissoziative Symptome (German version of the Dissociative Experiences Scale (DES; page 118)
GHB Gamma-hydroxybutyric acid (page 142)
ICD-11 *International Classification of Diseases, 11th Revision* (ICD)
ITQ International Trauma Questionnaire (page 70)
MID Multidimensional Inventory of Dissociation (page 118)
MHVI Maastricht Hearing Voices Interview (page 120)
pDID Partial dissociative identity disorder (page 104)
PNES Psychogenic non-epileptic seizures (page 214)
PTSD Post traumatic stress disorder (page 58)
SCID-D Structured Clinical Interview for Dissociative Disorders (page 246)
SDQ Somatoform Dissociation Questionnaire (page 246)
TADS-I Trauma and Dissociative Symptoms Interview (page 119)
TCA Trauma-coerced attachment (page 23)
TD axis Trauma-dissociation axis (page 28)

Overview of the five trauma-dissociation axes 1

Axis I: Personality disorders

Problem associated with interpersonal interactions (QE50)

Personality disorder? (37)

Level of severity
- Mild personality disorder (6D10.0) (39)
- Moderate personality disorder (6D10.1) (39)
- Severe personality disorder (6D10.2) (39)

5 Trait domain specifiers (40)
- Negative affectivity (6D11.0)
- Detachment (6D11.1)
- Dissociality (6D11.2)
- Disinhibition (6D11.3)
- Anankastia (6D11.4)

Personality disorder with borderline pattern (6D11.5) (41)

Axis II: Disorders specifically associated with stress

Post traumatic stress disorder (6B40) (58)
- Event: extremely threatening or of horrific nature (58)
- Trauma triad:
  - Re-experiencing (59)
  - Hyperarousal (62) (or hypoarousal, 65)
  - Avoidance (61)

Complex post traumatic stress disorder (6B41) (71)
- Event: extremely threatening or of horrific nature (71)
- Trauma triad (71)
- Disturbance in Self-Organization (71)
  - Affective dysregulation (72)
  - Negative Self-concept (74)
  - Difficulties in relationships (75)

Prolonged grief disorder (6B42) (84)
- Persistent and pervasive grief response
- Longing for the deceased and/or persistent preoccupation with the deceased
- Earliest 6 months after death or cultural variation

Adjustment disorder (6B43) (86)
- Psychosocial stressor
- Preoccupation with events
- Adjustment difficulties
- Start min. after 1 months, duration max. 6 months

Reactive attachment disorder in childhood (6B44)

Disinhibited social engagement disorder in childhood (6B45)

Ongoing traumatization (88)

Axis III: Structural dissociation

Dissociative identity disorder (DID; 6B64) (103)
- Loss of executive control (106)
  - Without amnesia: partly dissociated behaviours
  - With amnesia: fully dissociated behaviours
- Personality states (dissociative identities) with own pattern of experiencing, perceiving, conceiving and relating to self, the body and the environment (106)
- At least two personality states take executive control (106)
- Changes in personality state are accompanied by related alterations in sensation, perception, affect, cognition, memory, motor control and behaviour (106)

Partial dissociative identity disorder (pDID; 6B65) (104)
- Loss of executive control, but no amnesia (only partly dissociated behaviours)
- Personality states (dissociative identities)
- One personality state is dominant and normally functions in daily life, but is intruded upon by one or more nondominant personality states (dissociative intrusions)

Axis IV: Other dissociative disorders

Dissociative neurological symptom disorder (6B60) (203) with
- Visual disturbance (205)
- Auditory disturbance (206)
- Vertigo or dizziness (208)
- Other sensory disturbance (208)
- Non-epileptic seizures (214)
- Speech disturbances (222)
- Paresis or weakness (223)
- Gait disturbance (229)
- Movement disturbance (230)
- Cognitive symptoms (230)

Dissociative amnesia (6B61) (232)
- Dissociative fugue (232)
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- Anterograde amnesia (239)

Depersonalization-derealization disorder (6B66) (240)
- Depersonalization (242)
- Derealization (242)
- Desomatization (242)
- Deaffectualization (243)
- Detemporalization (243)

Trance disorder (6B62) (247)

Possession trance disorder (6B63) (248)

Axis V: Comorbid disorders

Frequent comorbid disorders for regulation of post traumatic symptoms:
- Addiction disorders (6C4ff) (262)
- Eating disorders (6B8ff) (264)
- Obsessive-compulsive disorder (6B20) (266)

Frequent comorbid disorders:
- Depression (6A7ff) (268)
- Anxiety disorders (6B0ff) (270)

Other comorbid disorders, with/without relationship with trauma:
- Bipolar disorder (6A60ff) (270)
- Schizophrenia (6A20ff) (270)
- Attention deficit hyperactivity disorder (ADHD; 6A05ff) (269) (270)
- Autism spectrum (6A02) (271)
- Maladaptive daydreaming (273)
- Physical illness (273)
- Physical injuries (274)
- Factitious disorders (275)

1
Trauma-Dissociation Axis Model for Systematic Diagnosis of Trauma Sequelae

1.1 Introduction

The treatment of trauma sequelae has made tremendous progress, especially in the past 2 decades. Research on the various forms of trauma sequelae disorders has significantly improved our knowledge of trauma and dissociation. For example, in the last 10–15 years, there has been much more literature available and better continuing education opportunities than in the past (Nijenhuis, 2015).

Nonetheless, the field of traumatic stress has a history of controversy and disagreement regarding the psychological consequences of severe adverse events and their causes. There has been significant heterogeneity in symptom expression over time, and the definitions of acute, longer-lasting and complex conditions have varied. The definitions of trauma have been debated, including biological, psychological, socioeconomic, cultural, political or legal aspects (Jongedijk et al., 2023).

As we know today, the psychological and physical consequences of traumatic experiences depend on many different psychological, physical, social and genetic factors (Herman, 2015; Maercker, 2022) and can thus also vary. Keeping track of the various symptoms following trauma is therefore challenging and demanding.

To reflect the vast variation in symptomatology, this book aims at introducing a more flexible and at the same time structured diagnostic approach for a comprehensive diagnosis of the psychological consequences of trauma.

For a simpler and systematic overview of the variety and complexity of post traumatic symptomatology, this book presents a model with five axes that can be clarified in the context of a comprehensive diagnosis. These five axes are referred to as the *trauma-dissociation axes* (*TD axes* for short). They are based on ICD-11 (WHO, 2019/2021) and include the following five domains (including chapters and sections from this present volume):

- TD Axis I: Diagnostic evaluation of attachment and personality disorders (Chapter 2, page 37)
  - Personality disorders
- TD Axis II: Diagnostic evaluation of specific stress-related disorders (Chapter 3, page 49)
  - Post traumatic stress disorder (Section 3.3, page 58)
  - Complex post traumatic stress disorder (Section 3.4, page 71)
  - Prolonged grief disorder (Section 3.5, page 84)
  - Adjustment disorder (Section 3.6, page 86)
  - Reactive attachment disorder
  - Disinhibited social engagement disorder
  - Continuous traumatic stress (Section 3.7, page 88)
- TD Axis III: Diagnostic evaluation of structural dissociation (Chapter 4, page 101)
  - Dissociative identity disorder (Section 4.2.1, page 103)
  - Partial dissociative identity disorder (Section 4.2.2, page 104)
- TD Axis IV: Diagnostic evaluation of other dissociative disorders (Chapter 5, page 197)
  - Dissociative neurological symptom disorders (Section 5.4, page 203)
  - Dissociative amnesia (Section 5.5, page 232)
  - Depersonalization-derealization disorders (Section 5.6, page 240)
  - Trance and possession trance disorders (Section 5.7, page 247)
- TD Axis V: Comorbid disorders (Chapter 6, page 261)
  - Affective disorders
  - Addiction disorders
  - Obsessive-compulsive disorder

- Eating disorders
- And others

The five axes form a structuring and orienting model for a systematized diagnostic procedure based on the ICD-11. This is intended to facilitate, for example, treatment planning (with therapeutic prioritization and choice of method) and assessment of prognosis and ability to work.

In this book, the main focus lies on the *diagnosis* of trauma sequelae. Recommendations for therapy are given only sporadically. The model is not based on any school of therapy or specific psychological models (e.g., psychoanalysis, cognitive behavioural therapy, humanistic psychology or others).

In this introductory chapter, first some basics about different types of traumatic events are summarized. To facilitate the overview for the diagnosis of trauma sequelae, a multiaxial diagnosis in five trauma-dissociation axes is presented in the second part.

1.2 Trauma

The term "trauma" comes from Greek (Greek: wound, τραύμα) and means injury or wound of a physical or psychological nature (Van der Kolk, 2014).

Psychological and physical reactions to stressful experiences have been known since ancient times. They have been studied in more detail since around the middle of the 19th century, at times with heated social and scientific debates on how distressing events affect the body and mind (Herman, 2015; Nijenhuis, 2015; Jongedijk et al., 2019).

Note

Trauma sequelae are mental and physical illnesses that occur as a result of stressful or traumatic experiences.

1.2.1 Adverse Experiences Versus Trauma

Before focusing on traumatic events, it may be useful to reflect on the possibilities and the limitations of the term "trauma." The expression "trauma" has become more prevalent and widely used in recent years, sometimes leading to a broad or colloquial application that may dilute its clinical meaning. It is therefore meaningful to differentiate between everyday stressors, adverse (e.g., childhood) experiences and significant traumatic events that can have a profound impact on an individual's well-being (Herman, 2015).

In clinical and psychological contexts, trauma refers to an event or series of events that are extremely distressing or disturbing, often involving actual or threatened harm or violence. These experiences can overwhelm an individual's ability to cope and may result in long-lasting psychological, emotional and physiological effects (Maercker, 2022; Herman, 2015).

However, it is essential to exercise caution when using the term "trauma" to describe routine life challenges or stressors. While everyone faces difficulties and hardships, not all experiences rise to the level of trauma. Misusing or overusing the term can minimize the experiences of individuals who have genuinely experienced trauma, and may contribute to a less precise understanding of the concept (Bath, 2017).

It is therefore advisable to use the term "trauma" judiciously and accurately, reserving it for situations where a person has undergone significant psychological distress or is diagnosed with conditions such as *post traumatic stress disorder* (PTSD) following a genuinely traumatic event (Alisic et al., 2014). This helps maintain the integrity of the term and ensures that appropriate support and interventions are directed toward those who truly need them.

In contrast to the term "traumatic life events," the term "adverse childhood experiences" (ACEs) refers to potentially traumatic events or experiences in childhood that may have the potential to negatively impact a person's physical, emotional and psychological well-being throughout their life (Felitti et al., 1998).

In addition, the term "adverse experiences in adulthood" can encompass a wide range of challenging or negative events that individuals may encounter during their adult lives (Brewin et al., 2000). These experiences can have significant impacts on a person's well-being, mental health, relationships and overall quality of life. They may be traumatic, but do not necessarily lead to post traumatic disorders in childhood or later in adult life, like the chronic or severe deprivation of children of essential physical, emotional, educational and medical needs that are necessary for their healthy development and well-being; physical or sexual assault, accidents, natural disasters, witnessing violence, loss and grief, relationship difficulties and betrayal, job loss and financial hardships, chronic illness or disability, substance abuse and addiction, and mental health challenges, as well as discrimination and

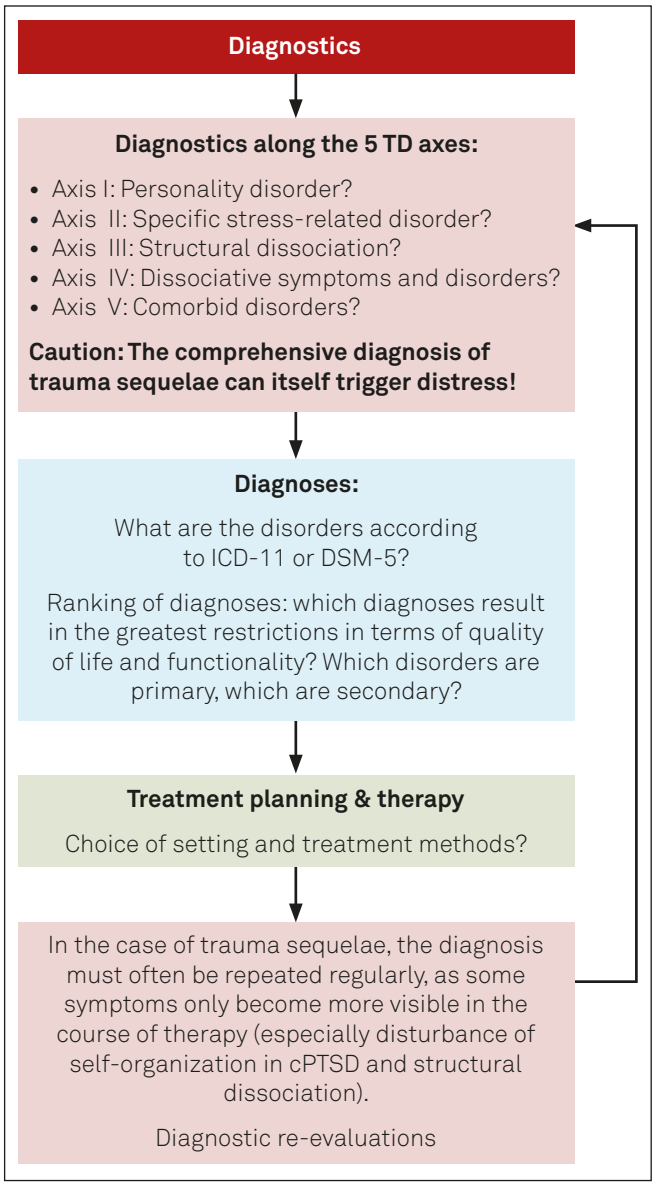

Figure 1.2. Diagnostics and treatment planning.

Further Research and Advancements

Post traumatic stress syndromes exhibit considerable diversity in the manifestation of symptoms and syndromes, the definitions and symptoms of which have evolved over the centuries (Jongedijk et al., 2023). Throughout history, there has been an ongoing quest to discover a universal and timeless framework for describing the psychological response to a wide array of adverse events, ranging from singular traumatic incidents such as motor vehicle accidents, to experiences of torture, being incarcerated in a concentration camp or enduring abuse. However, achieving such a universal framework appears to be unattainable. As mentioned in this chapter, the consequences of traumatic events are influenced by numerous factors, including the nature of the event itself; the characteristics of those affected; and the circumstances preceding, during and following the event; as well as the evolving social, cultural and professional contexts of different time periods. This understanding highlights the complexity and variability of the mental and somatic effects stemming from traumatic experiences (Jongedijk et al., 2023). Consequently, it is challenging to develop diagnostic models that can accommodate the diverse and evolving symptom profiles (Olff et al., 2023).

In response to these challenges, the TD model in this book, with its five axes, suggests a structured exploration for assessing post traumatic stress syndromes, introducing a broader perspective when evaluating post traumatic symptomatology. Clinicians should consider all possible diagnostic options, to provide patients with a sense of recognition for their mental conditions, to facilitate understanding and reconstruction of their life histories and to enable personalized treatment approaches.

However, this model is far from being complete and needs further research. Additional elaboration could, for example, incorporate both *subtyping* and *staging*, as has been proposed by several authors in the past for PTSD (Jongedijk et al., 2023).

As our understanding of PTSD becomes more intricate and diverse, evidence has emerged that supports various subtypes of the disorder, reflecting the wide range of symptom presentations (Dalenberg et al., 2012; Jongedijk et al., 2023): for example, on the dimension of internalizing versus externalizing symptomatology (Forbes et al., 2010), immediate versus late-onset PTSD (Bonde et al. 2021), somatic comorbidity (McFarlane et al., 2017), subthreshold versus full PTSD (Morgan-López et al., 2020), symptom complexity (Cloitre, 2015) or symptom severity (Jongedijk et al., 2019).

An alternative approach to subtyping is the concept of *staging*, which draws inspiration from diagnostic models used in somatic diseases such as cancer and diabetes (Jongedijk et al., 2019). According to this model, PTSD should not be regarded solely as a singular entity but rather as a disorder that evolves over time through a series of stages. Some authors contend that a longitudinal perspective, encompassing these stages, should be considered to fully understand and diagnose PTSD (McFarlane et al., 2017; Nijdam, Vermetten & McFarlane, 2022). They propose a model with, in short, four stages defined as (Jongedijk et al., 2023) follows:

(0) Asymptomatic but at risk
(1a) Undifferentiated symptoms of mild anxiety and distress

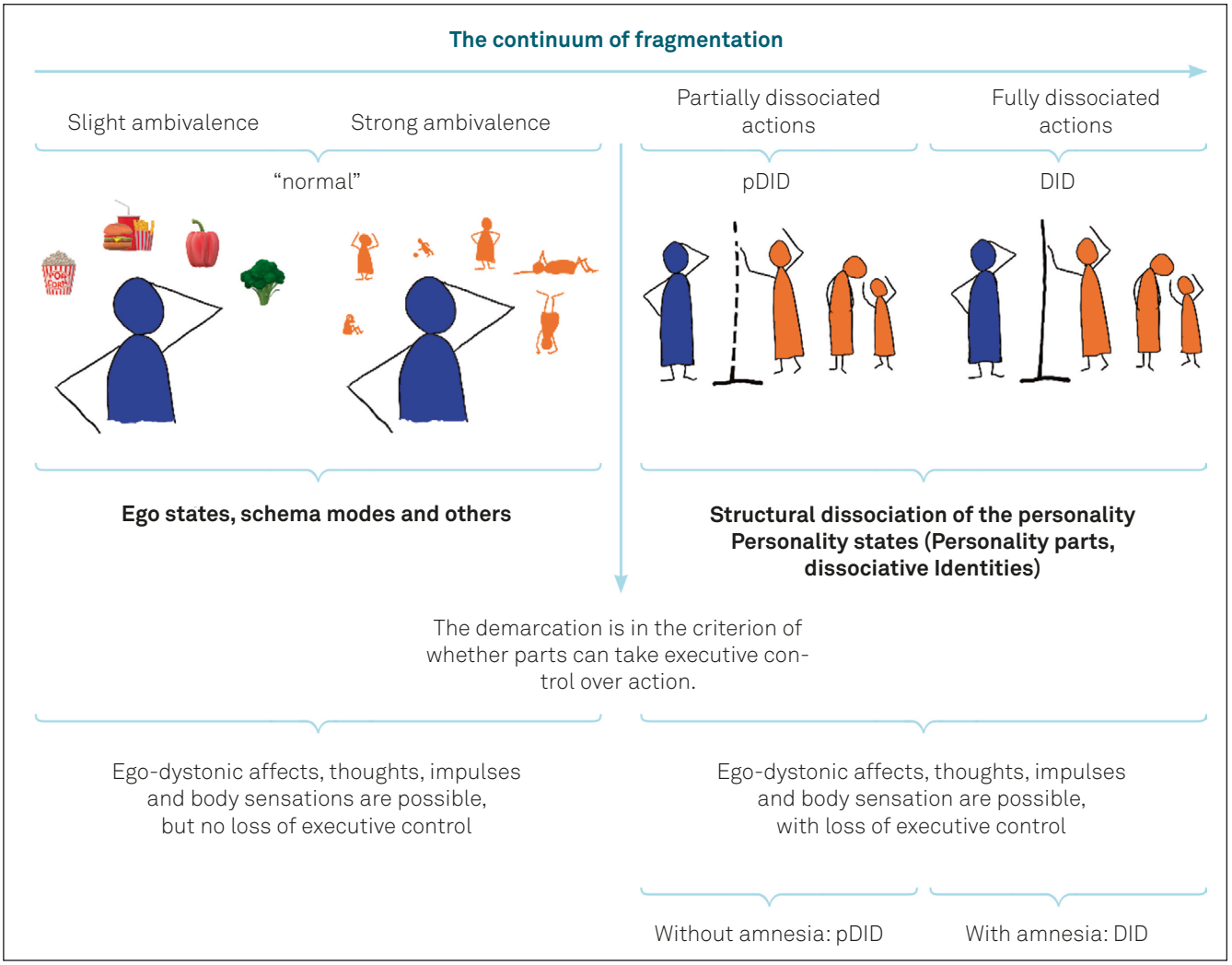

Figure 4.4. The continuum from normal ambivalence to dissociative personality states. DID = dissociative identity disorder; pDID = partially dissociative identity disorder.

regulate unpleasant affects. Later, when the "everyday personality" takes over again, it feels strong feelings of shame and guilt about taking the chocolate; moreover, it is now significantly judged by the "chocolate forbidding dissociative identity." If this pattern is repeated several times a day or week, then this can lead to weight problems. The "everyday personality" then knows quite well that the ingestion of too much chocolate is harmful to health, but it does not have the ingestion of chocolate under control due to the partly dissociated action. In this case, it is not nutritional counselling that is indicated, but rather therapy in which all involved dissociative identities are worked with.

This example is very oversimplified, but is intended to give an idea of how "normal" ambivalence can differ from structural dissociation of personality.

4.5.3 Ego States and Personality States

By describing *personality states* and *dissociative identities*, the WHO introduced new terms in ICD-11 in 2019. However, the idea of different *ego parts* is in no way new. Psychology has long used a variety of concepts for internal instances, states and parts. Some concepts are based on theoretical constructs that have nothing to do with the dissociative identities of ICD-11, and there may be overlap in other models. Clarification is needed here in light of the changes in ICD-11. Some of the concepts and possible names for states or parts are, for example:

- Psychoanalytic concepts with the three agents (ego, id and superego; Freud, 1925)
- Psychodynamic concepts of internalized objects or self-objects (Fairbairn, 1954; Kohut, 2009; Winnicott, 1974).

According to ICD-11 each personality state will contain its own pattern of experiencing, perceiving, grasping and interacting with oneself, one's body, and the environment. It follows that personality states have their own patterns of emotions and cognitions – for example, each with a common intersection. This intersection can vary from almost overlapping, to almost entirely diverging, emotions and cognitions. For example, *dissociative identity A* may deny any feelings of anger, while *dissociative identity B* may experience strong feelings of anger. However, both dissociative identity A and dissociative identity B can feel fear – that is, fear can be a shared emotion (Figure 4.7).

Seen from the perspective of a state, there are different degrees of gradation of self-reference, from ego-syntonic, to partially dissociated (ego-dystonic) and finally to fully dissociated (completely split off). Diagnostically, on the one hand, it is a matter of demonstrating the different patterns of the various personality states, and on the other hand, in-depth diagnostics means clarifying the various forms of ego-relatedness. For example, dissociative identity A can deny feelings of anger, but is flooded from time to time by ego-dystonic feelings of anger (from dissociative identity B). However, A cannot know anything at all about hate feelings from dissociative identity B – that is, the hate feelings are completely split off (Figure 4.8).

According to Nijenhuis, following Northoff (2004), the different personality states "engage in the mental acts of experiencing, perceiving, and generating a self" (Nijenhuis, 2015). He refers to the four perspectives involved as the *first-person perspective*, *quasi-second-person perspective*,

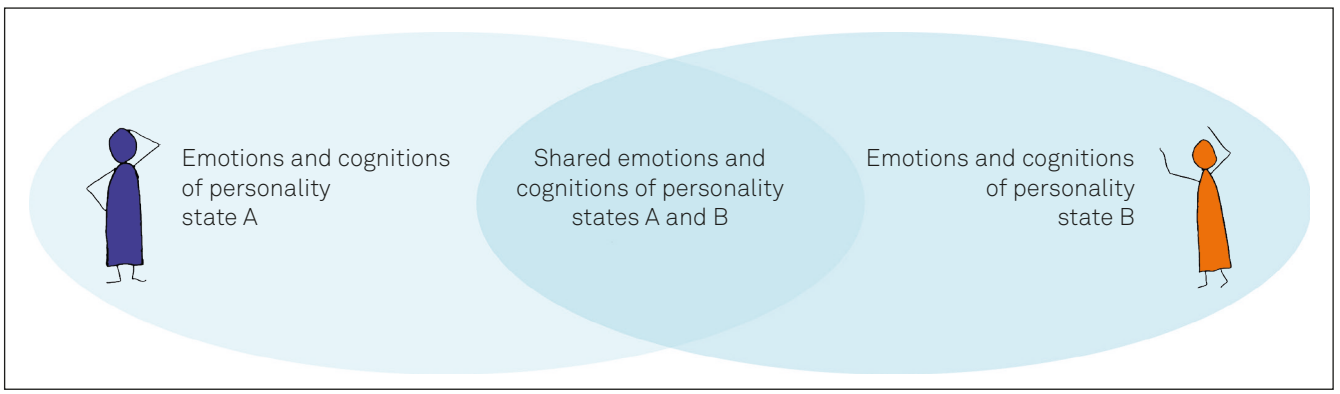

Figure 4.7. Distinction between emotions and cognitions of dissociative identities A and B with an intersection of shared emotions and cognitions. This applies analogously to perception, conceiving and interacting as well.

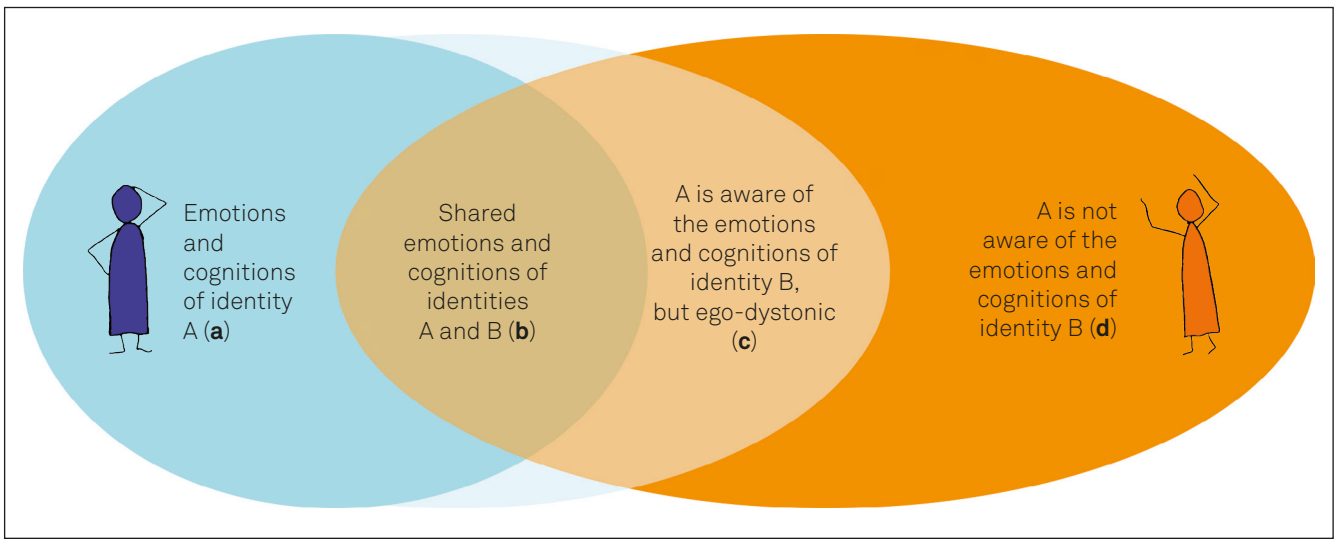

Figure 4.8. Distinction between emotions and cognitions from the perspective of dissociative identity A. This applies analogously to perception, grasping and interacting. **a** Identity A has its own emotions and cognitions, which are not shared by Identity B. **b** Identities A and B have common emotions and cognitions, which are shared by B as well. For dissociative identity A: ego-syntonic emotions and cognitions. **c** Identity A knows about emotions and cognitions, but experiences them as not belonging to them and has no personal relation to them – that is, they are ego-dystonic or partially dissociated. **d** Identity B has emotions and cognitions that A does not know about. For identity A, these are fully dissociated emotions and cognitions; for A, they are completely split off.

Note

In dissociative identity disorder, both partially and fully dissociated acts can occur – that is, both situation a and b in Figure 4.16 are possible.

Typically, the blue dissociative identity feels severe shame after such an act, on the one hand for the self-injury, and on the other hand, for the partially or fully dissociated act per se. Post traumatic intrusions may temporarily decrease after self-injury (making the orange dissociative identity calmer) until a next trigger leads to a renewed escalation.

In this example, the self-injury impulse originates from an *inner dissociative identity* (orange). It is also possible that a dissociative identity functioning in daily life (blue) performs self-injury (or other self-harming actions such as vomiting, taking laxatives, acting at high risk) in order to regulate other dissociative identities (orange).

In a disorder-specific therapy, the problem behaviour is worked through with both the blue and orange dissociative identities.

Behavioral analysis (Abbruzzese & Kübler, 2013; Grawe & Caspar, 1984) provides the basis for detailed reappraisal of problem behaviour, but requires disorder-specific adaptation in the case of structural dissociation. Partially and fully dissociated acting out most often occur in

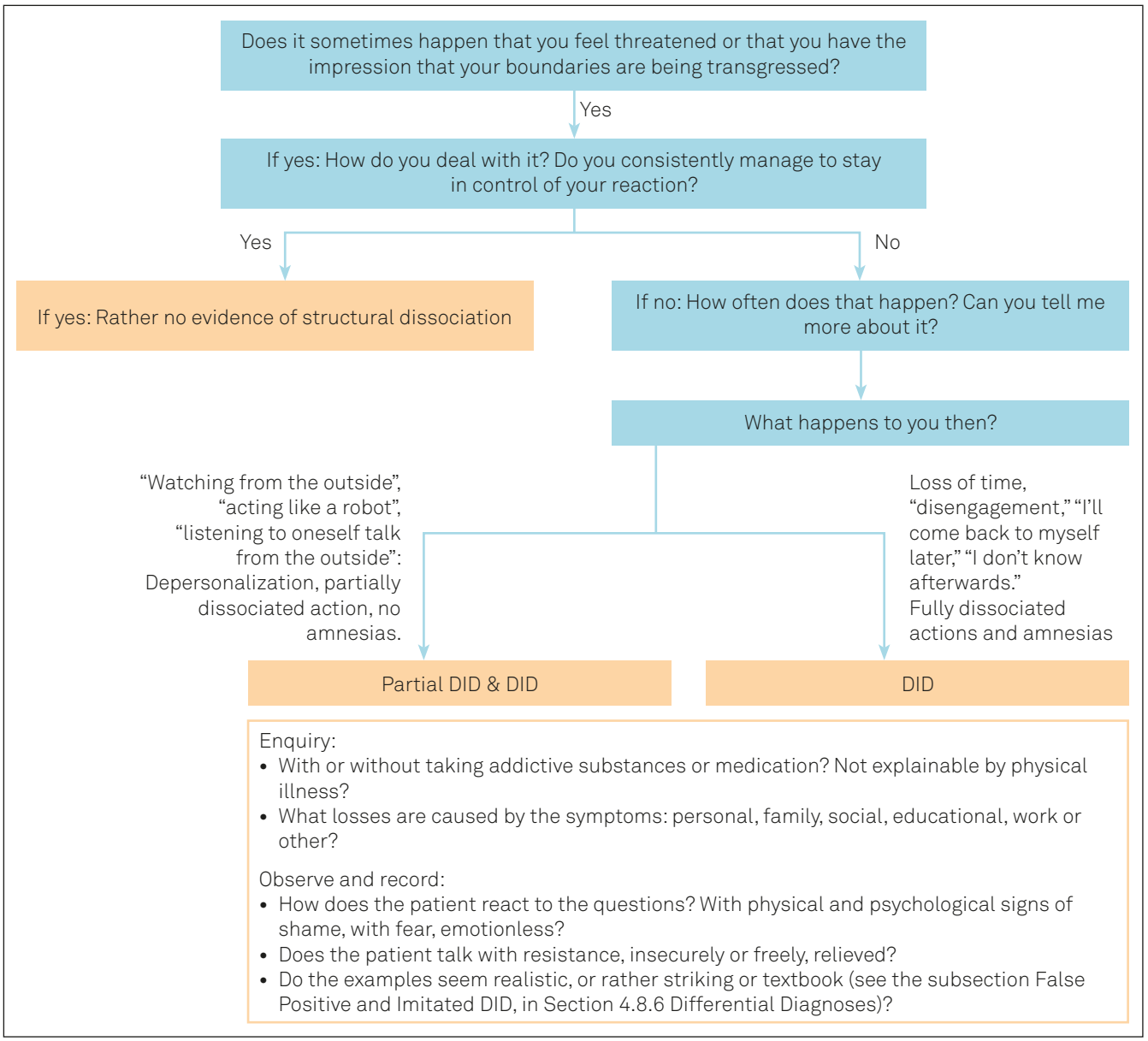

Figure 4.17. Algorithm for clarifying strategies for dealing with critical situations.

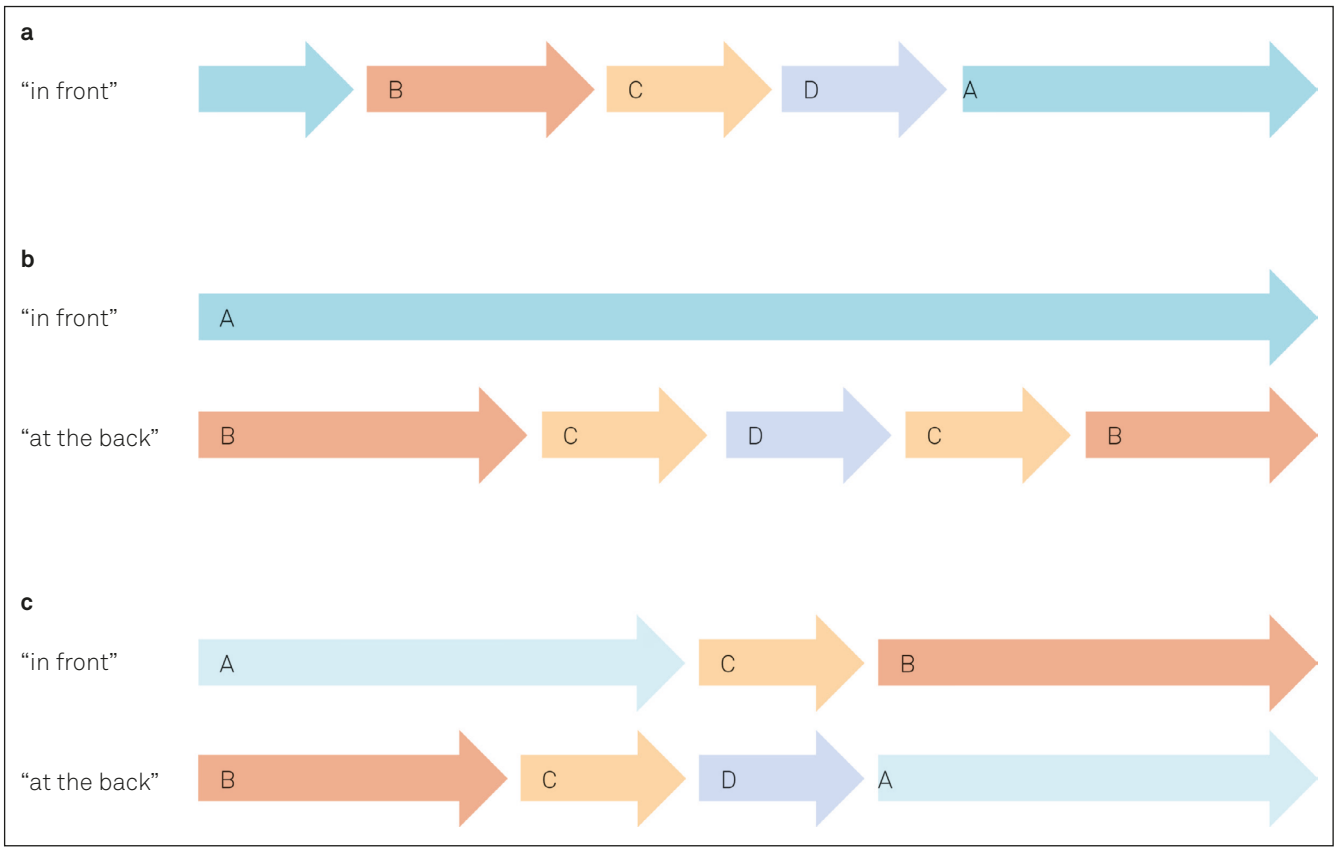

Figure 4.19. Sequential and parallel alternations. **a** Sequential alternation (no co-awareness). The dissociative identities switch sequentially. All dissociative identities have amnesia for each other's actions and experiences. Diagnosis: dissociative identity disorder (DID). **b** Parallel internal alternations (with co-consciousness). Dissociative identity A has a continuous time experience – that is, no amnesias. Dissociative identities B, C and D are sequentially present – for example, each in different dissociative identities of the body with partial motor control (in partial DID) or sensory control (e.g., in complex post traumatic stress disorder [cPTSD]); they "watch from behind." These are internal switches. A sign can be that dissociative identity A notices that their abilities and competences can suddenly change (see questions about "inner changes", evaluation of partially and fully dissociated actions). Diagnosis: partial dissociative identity disorder (or DID if external switches occur at other times). **c** Parallel external switches. All dissociative identities are conscious for a limited time – that is, all dissociative identities have amnesia. However, at least two dissociative identities are always conscious – that is, co-consciousness between dissociative identities is possible. Here: Dissociative identity A has full memory at the beginning, then a short amnesia (as dissociative identity C takes over) and partially reduced memory with depersonalization experience toward the end of the time period (B is "in front" and A "at the back"). Diagnosis: DID

the transition between two dissociative identities, the voice may change significantly in terms of volume, basic frequency of the voice, intonation, speech melody, tempo and other features. In the transition between dissociative identities, there may be mimic and gestural signs – for example, with grimaces, squinting of the eyes, physical wincing, a brief cry or exclamation or movements of the pupils. In some patients, however, the changes are very subtle and barely visible. Sometimes only a brief eye blink is apparent, with no mimic or gestural signs. Most commonly, switches are not visible (Brown & Scheflin, 1999).

In many people with DID, both forms can occur, depending on the dissociative identities involved in a switch. For example, the change between adult dissociative identities may be almost invisible, while the transition to child dissociative identities is clearly visible from the outside.

4.7.3 Dissociated Memories: Amnesias

Dissociative amnesia involves disturbances in temporal and content-related memory within the context of dissociative and/or post-traumatic disorders (see also page 232). A fundamental distinction must be made between amnesia affecting present experiences and retrograde amnesia concerning past events, including childhood, adolescence, or parts of adulthood.

Individuals with DID frequently report an inability to access memories associated with other identities, a phenomenon referred to as inter-identity amnesia (IIA) (Dimitrova et al., 2024). While accumulating research has explored IIA, a key question remains: Do objective deficits in memory retrieval mechanisms necessarily underlie this

Table 4.4. Differential diagnostic considerations in the diagnosis of DID and pDID

	Various disorders (cPTSD, borderline pattern and others), "normal ambivalences"	Partial dissociative identity disorder	Dissociative identity disorder
Partially dissociated (ego-dystonic) emotions and cognitions	Frequent	Always present	Always present
Partially dissociated (ego-dystonic) perception	Frequent	Always present	Always present
Partially dissociated (ego-dystonic) patterns of conceiving	Possible	Always present	Always present
Partially dissociated (ego-dystonic) patterns of interaction	Possible	Always present	Always present
Partially dissociated (ego-dystonic) impulses	Possible	Always present	Always present
Partially dissociated actions	No	Always present	Always present
Fully dissociated actions	No	No	Always present
Dissociative fugue	No	No	Possible
Amnesias regarding childhood and adolescence	Possible	Possible	Possible
Amnesias in crises or in everyday life today	No	No	Always present

Note. cPTSD = complex post traumatic stress disorder; DID = dissociative identity disorder; pDID = partially dissociated identity disorder.

c. In pDID, one personality state is dominant and functions in daily life (e.g., parenting and/or work), but is intruded upon by one or more nondominant personality states (dissociative intrusions). These intrusions may be cognitive (intruding thoughts), affective (intruding affects such as fear, anger or shame), perceptual (e.g., intruding voices, fleeting visual perceptions, sensations such as being touched), motor (e.g., involuntary movements of an arm) or behavioural (e.g., an action that lacks a sense of agency or ownership).
d. These intrusions are experienced as interfering with the functioning of the dominant personality state and are typically aversive.

2. Loss of executive control (WHO, 2019/2021):
   a. In DID, at least two distinct personality states recurrently take executive control of the individual's consciousness and functioning, in interacting with others or with their environment, such as in the performance of specific aspects of daily life (e.g., parenting and/or work) or in response to specific situations (e.g., those that are perceived as threatening). Changes in personality state are accompanied by related alterations in sensation, perception, affect, cognition, memory, motor control and behaviour.
   b. In pDID, the nondominant personality states do not recurrently take executive control of the individual's consciousness and functioning to the extent that they perform in specific aspects of daily life (e.g., parenting and/or work). However, there may be occasional, limited and transient episodes in which a distinct personality state assumes executive control to engage in circumscribed behaviours (e.g., in response to extreme emotional states or during episodes of self-harm or the reenactment of traumatic memories; WHO, 2019/2021).
3. The experience of intrusions (WHO, 2019/2021):
   a. In individuals with DID, it is common for one personality state to be "intruded upon" by aspects of other nondominant, alternate personality states without their taking executive control.
   b. In DID, these intrusions may involve a range of features, including cognitive (intruding thoughts), affective (intruding affects such as fear, anger or shame), perceptual (e.g., intruding voices or fleeting

Table 4.14 Characteristics and therapeutic approach in therapy Phase 1

Features	Therapy
• Suspicion of trauma spectrum disorder; start with diagnostic of attachment trauma, PTSD, cPTSD and eventually structural dissociation • Often severe instability: in situations with stress: regression, isolation, and self-injury occur, sometimes with severe crises (with self-injury), and/or marked comorbid illnesses • Often strong anosognosia, reduced mentalization, reduced affect regulation, impulse control and narrow windows of tolerance • Communication of the entire system primarily via dissociative and post traumatic symptoms • Comorbid disorders complicate diagnosis and therapy: addiction, eating disorder, depression and anxiety disorders • Incorrect or incomplete diagnoses prevent diagnosis and therapy: schizophrenia spectrum disorders, borderline pattern, bipolar disorders, epilepsy (in dissociative non-epileptic seizures), etc.	Work on therapeutic alliance • Diagnostics, psychoeducation • Psychosocial stabilization • Work on increased mentalization, awareness, and developing coping skills • Trauma confrontation contraindicated, may lead to severe suicidal crises or provoke self-injury, addiction and other dysfunctional strategies

Note. cPTSD = complex post traumatic stress disorder.

therapy is for the ANP to learn to communicate with EPs and regulate feelings, thoughts, impulses and body sensations themselves.

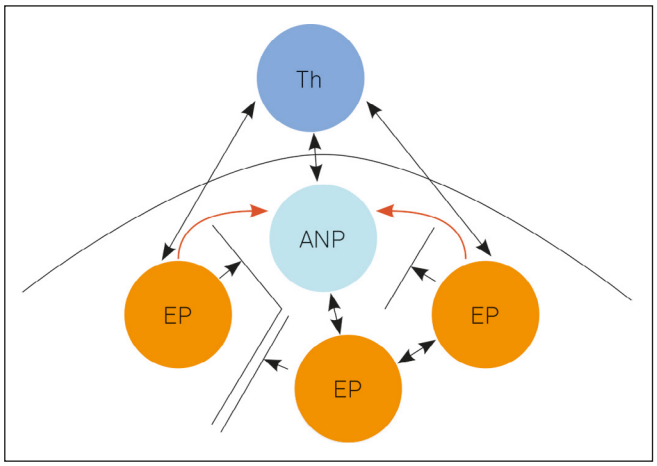

Figure 4.23. Scheme of therapy Phase 2. Th = therapist; ANP = apparently normal part of the personality; EP = emotional part of the personality.

The question about retraumatization in therapy Phase 2 is shown in Table 4.15. The characteristics of therapy Phase 2 and the therapeutic procedure are summarized in Table 4.16.

Therapy Phase 3: ANP (Mostly) Engaged, Exploration of all Dissociative Identities

At this stage, ANP and many key EPs become more accepting of the diagnosis (Figure 4.24). The therapist's communication with the patient increasingly takes place only through the ANP. In this phase, not all dissociative identities are yet known – that is, previously unaware dissociative identities may be realized by the ANP through therapy. When new dissociative identities are uncovered, new memories also may come to awareness. In this process, a temporary regression back to Phase 2 is possible, in that the ANP again no longer wants to cooperate with dissociative identities and even again questions the diagnosis.

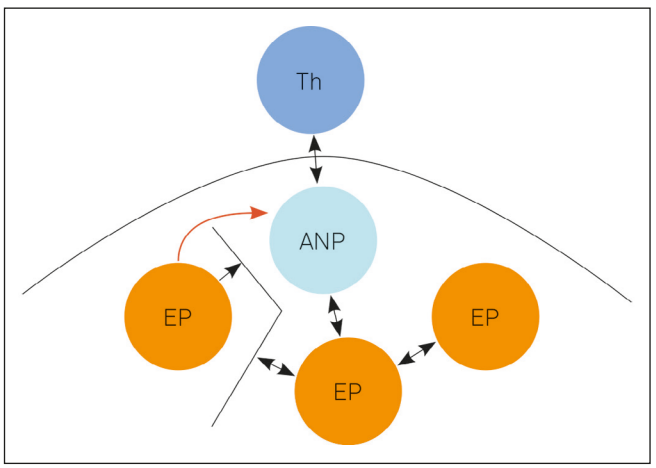

Figure 4.24. Scheme of therapy Phase 3. Th = therapist; ANP = apparently normal part of the personality; EP = emotional part of the personality.

With continued offender contact, it is almost impossible to reach this stage of therapy. The characteristics of therapy Phase 3 and the therapeutic procedure are summarized in Table 4.17.

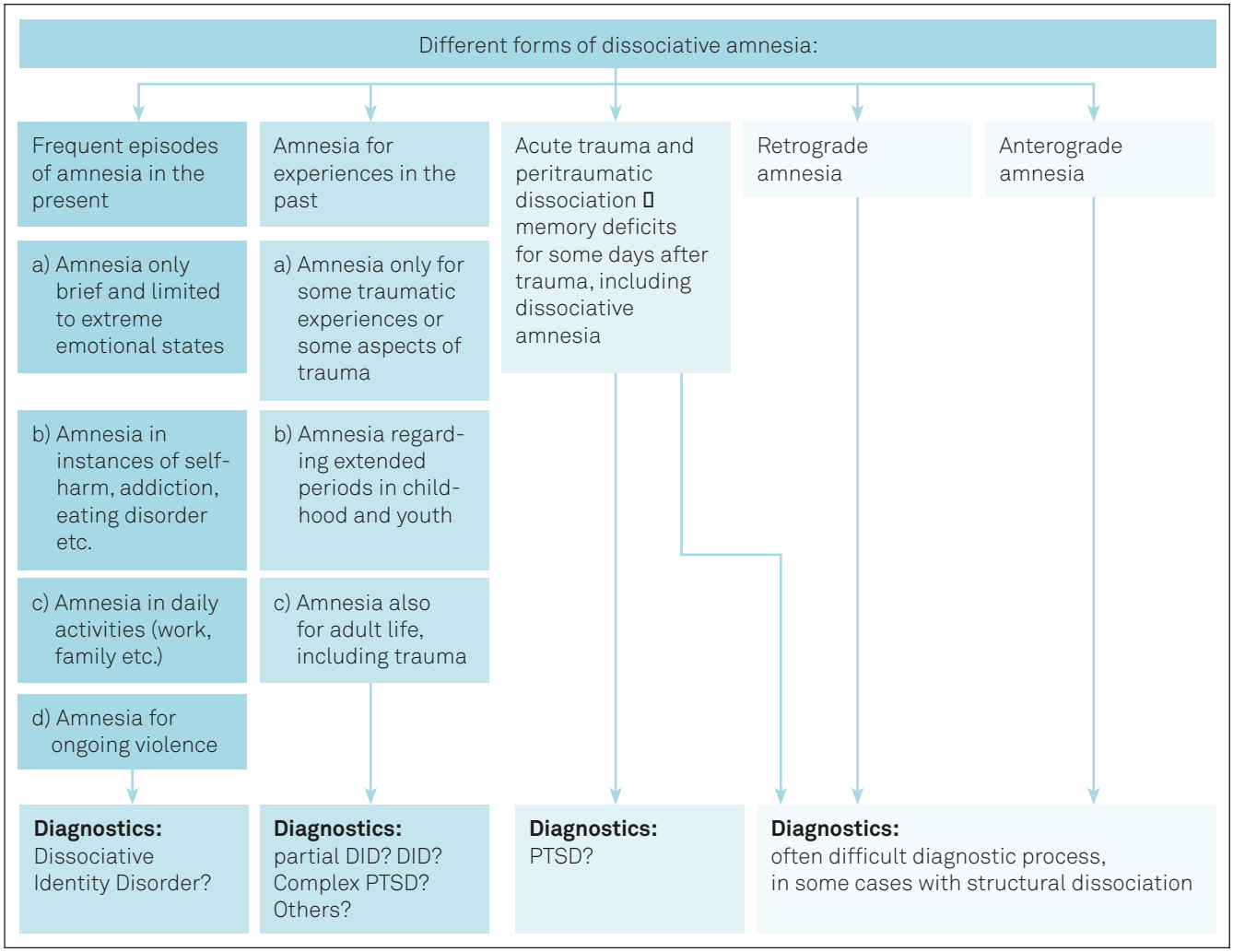

Figure 5.3. Different forms of dissociative amnesia. 1 = individual traumatic experiences are sometimes remembered, but not all. These memories may flare up later. DID = dissociative identity disorder; pDID = partially dissociative identity disorder; PTSD = post traumatic stress disorder.

- The duration of amnesias can vary from a few seconds to several days to weeks.
- Amnesias in DID can be complete – that is, all memories are missing. Sometimes, however, affected persons can remember individual fragments with isolated short images and then have an "idea" of what might have happened.
- Amnesias may include everyday actions (e.g., household, occupation or travel) as well as dysfunctional actions (e.g., self-injury, binge eating, high-risk actions or violent actions).
- Typically, amnesia in DID is associated with experiences of shame (Boon, 2023), as patients often encounter negative reactions by others due to amnestic behaviour.
- Therefore, most individuals with DID develop inventive strategies to hide the amnesias from the environment. For example, they may claim that they are forgetful or scatterbrained and therefore have trouble remembering, or that they are under too much stress to remember all the details of their life. Many affected individuals also have a mastery of steering conversations to deflect questions about amnesias.
- Typically, people with DID mistakenly interpret the amnesias as a character defect and not as part of a structural dissociation. They often think that they can get the amnesias under control with great efforts of will and rigid control.
- However, the level of suffering in dissociative amnesia is usually very high. In rare cases, affected persons seek therapy to request a dementia assessment, or they think of themselves as suffering from dementia. However, a dementia workup does not reveal any limitations in the clinical-neurological assessment. Affected individuals may live in constant fear of "waking up" and realizing they have done embarrassing things. This

8
Question Overview

The questions presented in this book are summarized again here, each with a reference to the corresponding pages in the book where the questions are explained. This summary is not a separate questionnaire. This summary does not replace assessments with standardized and scientifically verified diagnostic instruments.

8.1
TD Axis I: Personality Disorder Assessments

General questions about personality disorders.

8.2
TD Axis II: Clarification of Specific Stress-Related Disorders

8.2.1
Post Traumatic Stress Disorder (6B40)

Trauma Criteria

"An event or series of events of extraordinary threat or catastrophic magnitude" (WHO: ICD-11).

Reliving

For more detailed questions, see page 58

Intrusions
- Page 59
- Does it sometimes happen that you have intense (scary) images or thoughts from the past that keep coming back to mind (more than you would like) and that you cannot control, or can barely control?
  - If yes: How often? In which situations?
  - What are the triggers?
  - How do you react emotionally and physically?
  - How do you deal with it? How do you try to stop the memories that intrude?

Flashbacks
- Page 59
- Does it sometimes happen that you relive a traumatic experience so strongly that you lose contact with reality (as if you were yourself in the there and then)?
- Does it happen that you misjudge people in such situations (and mistake a person of today for a perpetrator of the past)?

Rumination
- Ruminating (repeatedly wanting to talk about trauma, circling thoughts around trauma; page 59)
- Do you ever feel a strong need to talk about trauma?
  - If yes: How often? Do you tell everything then or are there some points that might be important but you don't talk about? → Post traumatic avoidance?
- Do you sometimes have a mind spin about trauma, that you cannot stop, or have a hard time stopping?

Sleep Disorders and Nightmares
- Page 59
- Does it sometimes happen that you have nightmares?
  - If yes: how often? Can you describe the nightmares? Could there be a connection between the nightmares and previous traumatization? Does it sometimes happen that you relive unpleasant experiences at night?
  - In what physical state do you awaken?
  - Does it sometimes happen that you wake up from a nightmare and continue dreaming it while awake?
  - Does it sometimes happen that you are afraid to go to sleep for fear of nightmares?
  - Do you sometimes use medication, alcohol, cannabis, drugs or other substances to have fewer nightmares?

Subject Index