

BEGINNINGS -
THE START OF AN
INPATIENT PROGRAM
FOR DID-PATIENTS IN
A GERMAN HOSPITAL

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[Editor's Note: T47 een I had the pleasure of meeting Arne Hofmann, I asked him to share with the readers of DISSOCIATION his experience in starting a (DII) treatment program in Germany. This is his response.]

I was puzzled. When I had been called for an emergency I had not expected this: There was a twenty-year-old woman lying fearfully with closed eyes on her bed, not reacting to any word or helpful gesture the nurse made. After another effort to speak with her, another nurse brought the patient's file. It was there that we found a remark that she had made to her therapist: "I believe there are others in me. Their names are..." It was then that I remembered things that I had heard not long ago. I had not expected, however, that I would come across a dissociative disorder that was considered "extremely rare" so quickly. It had only been a year previously, in 1991, when I had been resident at the Mental Research Institute in Palo Alto and heard about dissociative identity disorder (DID). It was there that an experienced psychologist had told me about his treatments of DID patients, had given me more to read on the subject, and had brought me in contact with a study group and the ISSD. So here I was, a continent away from the experts I knew and was faced with my first DID patient. In the following diagnostic interview, a "protector" personality was contacted, the diagnosis DID was confirmed, and treatment was begun. As it turned out, the initial state in which we had seen the patient had been a fearful child that had not known where it had been.

Fortunately, the understandable skepticism at the institute where I work, the "Hohe Mark" Hospital, a 260-bed psychiatric/psychotherapeutic hospital, was benevolent and open-minded. So the treatment could progress even if the patient proved to be a complex multi-layered multiple who kept us struggling with her Axis II traits, her "special role" on the ward, and our counter-transference experiences. After long months of inpatient therapy, however, she slowly stabilized and could be released to continue on outpatient therapy.

A year later, we diagnosed our second DID patient, a woman we had seen already some months before but who had been reluctant to be treated at that time. She had had a successful professional life but had suddenly started to "lose time" and had lost several jobs. With a DES score of around 40 and a subsequent psychiatric interview, the diagnosis

was made.

In Summer 1994 the hospital leadership decided to transform a 14-bed psychiatric ward into an open psychotherapy unit that had a main emphasis on treating patients with psychotraumatic and dissociative disorders. I was assigned to that unit, and a gynecologist and psychotherapist joined the team in the same month. There was a great diversity of patients when we took the ward over and started to build the program. There were depressive patients, patients with borderline personalities and anxiety disorders, some psychotic patients, and even a few patients with traumatic disorders? As a start, we decided to give the DES to all fourteen patients and were puzzled by the outcome. Two patients scored 66% and 55%, respectively. One had been labeled "borderline schizophrenic" and had been in psychiatric hospitals for years. The other had never been in treatment before, but was very depressed and suicidal. In the diagnostic interview the first patient soon started to show alter personalities, but the other patient's diagnostic picture stayed vague. It was only after almost three months of treatment, a week before her dismissal, that some alters showed up in therapy sessions. As it turned out, she had had an experience several years ago in which she was misdiagnosed as "demon-possessed" and an exorcism had been tried with her.

It was autumn when - parallel to a first congress in Bielefeld, Germany, about DID - I was invited to present DID in a symposium at a national conference for psychiatrists. It was then when the networking among German-speaking therapists who treated DID patients increased significantly. Our places in the DID program filled quickly, and our waiting list began to grow.

In developing our program we decided after a short time to keep individual psycho-dynamic psychotherapy - implemented with additional techniques -- as the cornerstone of our treatment. A dance and body therapy group was included in the program as well as a modified art therapy group (the classic "uncovering" approach turned out to strengthen negative impulses among the patients). An attempt to mix an open psychotherapy-group with DID and non-DID patients showed the two types of patients had such different needs that we started a group for multiples only. Not long after we started we had to admit our limitations. After a month with five suicidal DID patients simultaneously on the ward

and some hard team stress, we limited the number of places in the program for our DID patients to four. We also started to build a stronger internal supervision system and tried to strengthen our external supervision also.

To date we have seen eighteen DID patients. Some of them came only for a diagnostic interview. Nine of them had been previously diagnosed with DID or the possibility of DID had been considered. The average age of the patients was 32 years (with a range from 21 to 49 years) . On the average, the patients had been in psychiatric or psychotherapy treatments for the previous six years. The previous diagnoses included: borderline personality disorder, schizophrenia, anxiety neurosis, obsessive-compulsive disorder, and anorexia. In two cases, the previous diagnosis seemed to reflect the German situation: "severe neurotic development after sexual abuse in childhood." It showed the growing awareness of traumatic disorders and the sequelae of childhood sexual abuse, but it also showed the need for more information on the diagnostic procedures for severe dissociative disorders.

One of the most serious problems for our ward is that we find so many DID patients that arranging for their follow-up therapies is a serious challenge. Seven of our DID patients do not have a follow-up psychotherapy with somebody willing to work with the diagnosis. The therapists of the others are mostly open-minded and motivated so that we can encourage them to treat their "first DID case." Few patients have therapists with experience in trauma therapies. But fortunately, their number grows. And so does the number of supervision groups and DID-specific trainings for interested therapists.

It was only in the last months that the first two DID patients were diagnosed in the psychiatry department of our hospital. One had become very depressed and suicidal until personality switches were recognized by the therapist. The other was a "chronic schizophrenic" patient who had never responded to neuroleptic medication, so that medication treatment had been terminated some years before. She had developed a close relationship with a therapist and told her some weeks before about "time losses." A short time after that, a twelve-year-old child alter appeared in a therapy session.

There are still far too few therapists to treat even the few diagnosed DID patients appropriately in outpatient settings. However, it is our hope that the growing scientific data on dissociative disorders and the knowledge of the possibilities to treat them will open more and more private practices and hospital settings here in Germany for work with this often-overlooked patient group. ■