

Research

The History of Dissociation and Trauma in the UK and Its Impact on Treatment

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SUMMARY

The road to recovery from trauma cannot be seen in isolation. Isolation from self (self identity as well as self in the body) and from the world outside (family and society) is the tragedy of a survival system that kept hope and potential alive but extracts a heavy toll on living. In much the same way we, as facilitators on this journey of recovery, can no longer isolate ourselves as therapists from a world outside the consulting room. We have to take account of the real world outside, its particular culture as well as the reality of multi-professional involvement. Our Clients/patients need encouragement to engage in the world of work, responsibilities and relationships alongside the therapeutic process. This piece examines the evolution of psychoanalysis and psychotherapy in the UK and the historic tensions between the National Health Service (NHS) and the private sector. It outlines a practice protocol that requires a diplomatic sensitivity to cultural differences within these two sectors. The approach mirrors the early dynamics between therapist and client/patient: developing a working alliance, recognising the power hierarchy, mapping the system. Thus, an audit (survey) of the acute wards in the locality was undertaken as a means of identifying levels of dissociative symptoms and potential for saving on unnecessary admissions. Finally the piece suggests that the Pottergate Model, as a practice protocol, aims to bridge the gap between these two vital sectors of the mental health system and at the same time keep the focus on the client/patient's need for both appropriate dependency and self responsibility throughout.

ARTICLE

Psychoanalysis and psychotherapy has followed a specific path in the United Kingdom (UK) that may well differ from many other countries. Its evolution needs to be understood if we are to comprehend the specific dynamics of the processes involved in working with trauma and dissociative clients.

Many of the early analysts and training analysts were people from non-medical backgrounds. The psycho-analytic training schools were, and have continued to be, virtually all in the private non-medical sector (The Institute of Psychoanalysis and the British Association of Psychotherapists, to name just two). The same has been true of other psychotherapy and counselling disciplines. Furthermore, there is still no statutory registration required in order to practice psychotherapy or counselling. Anyone can still call themselves a therapist and practice psychotherapy. This is fast changing as there are now three umbrella organisations that have been formed to regulate these practices within the private sector.

In the public sector, until very recently, consultant psychiatrists, clinical psychologists, occupational therapists and psychiatric nurses have gained their expertise without the need to undergo more specific training in psychotherapy or undergo personal therapy. So historically we have had a split between the psychotherapy and counselling mostly undertaken by the private non-medical sector

(where adults are seen as clients) and the professional medical model within the public sector (where adults are seen as patients).

Twenty years ago, when dissociation was beginning to be encountered, the division between these two sections of the mental health field were well established. As knowledge and experience of dissociation and trauma began to grow in this country, it became clear that (with some worthy exceptions) virtually all the therapeutic work with dissociative clients was being undertaken by psychotherapists, counsellors, the clergy, rape crisis organisations and other voluntary organisations far removed from the public sector. These courageous people had to learn on their feet, were geographically fragmented, and exposed to attacks from the False Memory Syndrome Foundation (FMSF) and in some cases from individual psychiatric services. Those working with dissociative clients were generally unsupported but desperately sought to support their clients.

It became clear how alien the two languages were (public and private), with no attempt by either side to understand each other. Professionals within the public sector saw therapists in the private sector as “having the luxury of listening to middle-class neurotics who are able to afford this self-indulgence of hours of therapy, while managing adequately enough in the world outside.” Meanwhile, medical professionals were under continual pressure to deal with the latest crisis, acting out or suicide with no adequate professional support or supervision. They were themselves struggling to survive and had to use dissociative mechanisms to make that possible. At the same time therapists working privately, in their own dissociative bubble protected from the real world, could moralise about the evils of medication and electroconvulsive therapy (ECT). The private therapists were also working alone, isolated and unconnected to the world outside.

TYPICAL NATIONAL HEALTH SERVICE (NHS) STRUCTURE

It is important to understand that when the NHS was established in 1948, the services for mental health were for the most part provided by the Asylum services, which were established during the 19th century. Some of these establishments had been started on a humane basis and some only were reluctantly provided by the County Asylum Act (Sivadon, 1952), which made a statutory order that each county in the UK provide safe and secure places for the containment of the mentally ill. Until 1948, there had been private houses set up for the mentally ill. After the NHS Act (Department of Health, 1948) all of that changed and services were provided by the medically dominated system of the NHS.

Some psychotherapy had been found to be of use in treating “shell shocked” or as we would know them Posttraumatic Stress Disorder (PTSD) sufferers from the Second World War. In psychiatric circles, a conflict had grown between the group therapists, e.g., S.H. Foulkes and the physical therapists, e.g., William Sargent.

In the NHS it was the physical treatments that won the war over the treatment of PTSD types of disorders. Electroconvulsive therapy (ECT), medication and sedation with a kind of containment was the model that dominated and was promoted by the powerful Maudsley Hospital (in South London) as a pattern of high quality care. Psychotherapy was not an official part of provision but was represented by the Tavistock Clinic in London as a national resource and therapeutic communities such as the Cassell Hospital in London. There were other examples of psychotherapy programs/models in different parts of the country often directed by highly charismatic leaders.

Gradually during the 1960s and 70s these psychotherapy programs were divested of power and authority, leaving a standard way of training psychiatrists in a strictly medical model of practice. This medical model was needed by psychiatrists to gain membership in the elite Royal College of Psychiatrists, without which a person could not be employed as a consultant psychiatrist within the NHS. Some psychiatrists persisted in psychotherapy training and were supported by a section of the Royal College, but remained small in number. These psychotherapy trained psychiatrists were largely concentrated in and around London because that is where the training institutions (privately owned and run) were based. In addition to typically being trained in the medical model, psychiatrists were not expected to have personal analysis or psychotherapy then or even to the present time. Over the past fifty years of NHS psychiatry, clinical psychologists, occupational therapists, physiotherapists, art therapists, and psychiatric nurses have all been employed under different terms and conditions of employment and with different expectations for their work. These different groups of professionals were given no clear idea as to who should lead and direct the treatment team in any particular case except for an expectation that the consultant psychiatrist was "responsible." Different employee organisations represented the interests of the different professionals. The resulting different pay structures have created professional rivalry and enormous differences in benefits from employment when compared to the work actually undertaken. Until the care programme approach, which is a recent innovation, there was no one plan to which everybody involved in the care of a patient should adhere. The system was in fact dissociative in structure and in function. Private psychotherapists had a vast body of information which was never incorporated in the training of future psychotherapists. Individuals had to seek personal analysis and psychotherapy training, paid for largely from their own pockets. A powerful example was the senior author's former teacher, Dr. J oe Redfearn. Dr. Redfearn published in 1985 (republished in 1994) a book with the title *My Self, My Many Selves*-a most helpful and straightforward account of the effects of trauma and dissociation in relation to subpersonality formation. It is doubtful that many health professionals in the UK or for that matter anywhere in the world have read this book, as he works in the private sector. A much better received book was published in 1996 by Dr. Phil Mollon as he was both a NHS psychologist and privately trained psychoanalyst. The book was entitled *Multiple Selves, Multiple Voices: Working with Trauma, Violation and Dissociation*.

Structurally, the health professions have been slowly growing together and can perhaps now begin to bring the wealth of experience of observed behaviour and patterns of dysfunctional thinking processes together with the feeling and meaning which has come from a split off private sector. The qualities of control, restraint, and public protection have come from a politically driven NHS; while containment, understanding, and interpretation with integration in the mind seem to come from the private sector.

In the last ten years, we have seen the development of hybrid clinics; Dr. Stuart Turner, for example, obtained funding from the NHS to set up a trauma centre in London, which also had an income derived from private earnings. Dr. Turner is a past president of the European Society for Study of Trauma. Dr. Valerie Sinason, a psychoanalyst, has established also in London a Clinic for the Study of Dissociation, again with public (NHS) and private money involved.

Where psychological therapy services are still viable in NHS mental health provision, some appointments of clinical psychologists have been dedicated to PTSD, but this is patchy and follows no set national pattern. There are no Statutory Guidelines except for those in connection with

emergency services connected with large scale disasters and those are only short term services. It is as though all of the information from individual and group psychotherapy painfully gained and recorded largely in relation to large and small scale traumatic events has been ignored as far as mainstream psychiatry is concerned, within a State run NHS. A blind eye has been turned in favour of medications, ECT and social behavioural readjustment to fit in with a society that probably gave rise to the traumatic experiences in the first place. It would seem that the future opportunities for the treatment of PTSD and dissociative disorders in the UK are with voluntary and private institutions willing to negotiate for funding for services from the NHS and Insurance.

LEARNING THE LANGUAGE

The first author noted that after eight years of supervising a number of multi-disciplinary professional groups within the local psychiatric services, the level of projections, fragmentation, lack of containment and obvious presence of dissociative patients (though unrecognised) at both inpatient and outpatient level was revealed. For example, on several occasions two members of the same supervision group (sometimes from different professions) would find themselves presenting, over a period of time, the same patient but with no recognition of this. This was because the same patient would be experienced by each in a radically different way. It was only after a while that it became clear that both professionals were talking about the same person. One might see Patient A as strong, manipulative, acting out, provocative, a waste of space and deserving of being discharged; the other would talk of Patient A's vulnerability, terror and aloneness. Among the professionals involved, this could very easily lead to clashes, reinforcing patients' fear of their own destructiveness as well as lack of containment (reminiscent of the model of a dysfunctional family). The eventual containment and sense of self-worth and power within the supervision groups led to a diminishing of this acting out by both professionals and, eventually, by patients. To use dissociative language, you could say that the pro-bonding professionals began to outweigh the anti-bonding professionals within the institution and this inevitably began to improve the containment of these patients.

Though the examples quoted above were clearly triggered by dissociative patients, up to this point (about 12 years ago), no specific mention of dissociation had been used in exploring the dynamics of the group and the specific patients. It was too soon to bring in yet another consideration. It was felt that the work until then had been to consolidate a strong 'working alliance' (as with very fragmented clients) and incorporate an educational cognitive approach to the dynamics involved.

Some worthy professionals in the public sector were finding their own position hard to keep safe because of the climate that existed within the public sector and because they were in the minority. In much the same way, dissociative clients can only start to talk about the untellable when the inner system is co-operating and the therapeutic environment is sufficiently contained. The outcome of our experiences was to use the language of research to try to identify levels of dissociative symptoms among the local inpatient population and to use this as a tool to begin to educate the professionals in a less threatening way.

AUDIT

An audit or survey was conducted at a psychiatric hospital in Norfolk under the supervision of the second author and will be presented here to better understand the status of dissociation in the UK

and demonstrate the effectiveness of an educational approach to complex trauma as far as the NHS is concerned.

Patients admitted to acute psychiatric units have clearly presented dissociative behaviours but, within a culture unaware of this phenomenon, they remain diagnosed. A point prevalence estimation using the Dissociative Experiences Scale-2 (DES-2, Carlson & Putnam, 1983; Carlson et al., 1993) and DES Taxon was undertaken in an acute psychiatric unit.

It was not possible to incorporate a diagnostic instrument (such as the Structured Clinical Interview for DSM-N Dissociative Disorders, SCID-D [Steinburg, 1994]) into this study. The aim therefore of this audit was to raise awareness and interest in dissociation among the psychiatric professionals and identify possible links between undetected dissociation (both dissociative symptoms and dissociative disorders) and repeated hospital admissions. This would be a first step towards formulating a more appropriate treatment model at the outpatient level. The results of the audit have revealed a significant percentage of patients scoring over 30 on the DES with clear indications that some are likely to suffer from a dissociative disorder. Furthermore, some correlation has been demonstrated between the presence of dissociation and repeated hospital stays. This has helped staff to have a better understanding of slow responders or non-responders to standard biological treatment regimes.

Group supervision over a number of years at a local psychiatric hospital has highlighted clusters of patients clearly demonstrating dissociative symptoms, but within a culture unaware of this phenomenon. No study to date has been undertaken in the UK on the frequency of dissociation among the inpatient population. Our objective was to identify dissociative disorders among the acute wards of this hospital and compare results from similar research in the United States of America (USA) and abroad.

It became clear that no research protocol involving a full diagnostic assessment (e.g., SCID-D) could be ethically undertaken without a treatment plan in place, if the postulated outcome of the research identified patients as having a dissociative disorder. The staff needed to implement such a treatment programme would have to be resourced within the psychiatric services. The type of staff needed for such a program was not available at the time of the audit. Furthermore, the proposal of such a research project had caused a dissociative reaction within the hospital. For instance, despite invitations to attend these early discussions, some of the key psychologists involved in work with abused patients were resisting any initiative outside their area of knowledge and authority. The compromise was to undertake a point prevalent audit on a specific day using the DES for which no outcome treatment plan was required and no ethical approval needed.

Our secondary objective was to look at possible links between multiple admissions and high dissociate symptoms. Strumwasser, Paranjpe and Udow (1991), when studying psychiatric admissions, found that a significant proportion of bed days (40%) utilised by general psychiatric patients were deemed to be inappropriate. In most UK acute psychiatric admissions units, routine evaluation of dissociate symptoms is not carried out. Our secondary objective was to find a marker that would correlate with poor response to conventional treatment and multiple admissions with the aim to undertake further research using a recognised alternative treatment model. We wanted to find

out the number of patients with dissociate symptoms at a point in time on the acute admission unit and to correlate this with features that suggest that they may be inappropriately placed.

Dissociation

Dissociation, unlike many other mental processes, occurs in both minor non-pathological and major pathological forms. The creation of the dissociative disorders category in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III, American Psychiatric Association [APA], 1980), followed by the DSM-III-R (APA, 1987) and DSM-IV (APA, 1994) has led to an increased interest in the nature of dissociation and its role in specific symptoms and syndromes. DSM-IV identified five “dissociative disorders,” namely Dissociative Amnesia, Dissociative Fugue, Dissociative Identity Disorder [DID], Depersonalisation Disorder and Dissociative Disorder Not Otherwise Specified [DDNOS].

Pathological dissociation is a post-traumatic defence mobilized by the patient as protection from overwhelming pain and trauma (Braun, 1990; Coons, Cole, Pellow & Milstein, 1990; Fine, 1990; Kluft, 1985; 1988; Kluft, Braun & Sachs, 1984; Putnam, 1985; Ross, Norton & Wozney, 1989; Spiegel, 1984, 1991; Spiegel & Cardena, 1991; Terr, 1991).

Dissociative symptoms occur within a variety of psychiatric diagnoses including personality disorders (such as Borderline Personality Disorder), eating disorders, anxiety disorders, depression and schizophrenia (Clary, Burstin & Carpenter, 1984; Fine, 1990; Fink & Goldinkoff 1990; Goff, Olin, Jenlike, Baer & Buttolph 1992; Havenaar, Boon & Tordoir, 1992; Kluft, 1988; Marcum, Wright & Bissell, 1985; Roth, 1959; Schultz, Braun & Kluft, 1989; Torem, 1986).

Recurrent to persistent dissociative symptoms occur in the dissociative disorders and may also be seen in PTSD (Blank, 1985; Bliss, 1983; Gelinias, 1984), and phobic disorders (Frankel & Orne, 1976).

METHOD

Participants

The study was carried out in an acute psychiatric unit in Norfolk. The unit has five wards with 20 patients in each, making a total of 100. There are ten consultant-led community mental health teams that have access to the acute admission unit. We decided to use the DES-2 as the screening instrument.

The Instrument

The DES is a 28-item self-report instrument that can be completed in 10 minutes, and scored in less than 5 minutes. It is easy to understand, and the questions are framed in a normative way that does not stigmatize the respondent for positive responses. A typical DES question is: “some people have the experience of finding new things among their belongings that they do not remember buying. Circle the number to show what percentage of the time this happens to you.” The respondent circles a percentage ranging from 0% to 100%, at 10% intervals. Only one alteration was made to DES 2. In question 1, the word ‘subway’ was replaced by the word ‘underground’ to make the test more culturally appropriate.

The DES has very good validity and reliability, and good overall psychometric properties, as reviewed by its original developers (Carlson & Putnam, 1983; Carlson et al., 1993). It has excellent

construct validity, which means it is internally consistent and hangs together well, as reflected in highly significant Spearman correlations of all items with the overall DES score. The scale is derived from extensive clinical experience with an understanding of DID. In the initial studies during its development and in all subsequent studies, the DES has discriminated DID from other diagnostic groups and controls at high levels of significance (Ross, 1997).

Scoring

DES scores over 30 are indicative of some dissociative symptoms and the possibility of a dissociative disorder (Ross, 1997). Follow up studies (Carlson et al., 1993) using a structured clinical interview (such as the SCID-D) generally confirm that 50% of such patients turn out to have a dissociative disorder. The DES Taxon consists of 8 of the DES questions: 3, 5, 7, 8, 12, 13, 22, and 27. These questions are familiar to clinicians who use the SCID-D (Steinberg, 1993, 1994) to evaluate the presence of a dissociative disorder. Steinberg's formulation is based upon 5 factors: depersonalization, derealization, amnesia, identity confusion, and identity alteration. The DES Taxon correlates roughly to these areas of inquiry, based on a spreadsheet by Waller and Ross, 1997. Calculations based on the article by Waller and Ross (1997).

Procedure

Six researchers were found among the psychiatric professionals, one for each of the six wards. On the day decided to conduct the point prevalence (Thursday, the 11th of December, 1997) all current inpatients were listed and allocated to a random number. The nurse in charge of each ward knew which patient had been allocated each number but referred to them only by number to the researcher who did not know the name of the patient. The questionnaire was administered on all six wards during the same day, collected and analysed.

RESULTS

Of 122 patients surveyed, 28 had been discharged on the day of the study and 19 were on leave. Ten patients were not well enough to take part, which gave us 59 completed questionnaires. Of the 59 questionnaires, 18 (30.5%) scored over 30. It should be noted that none of the patients had been assessed for dissociative symptoms prior to this study. We also found in the study (Table 1) that frequent re-admission correlated with high dissociation scores. The results demonstrated that a third or more of patients with high numbers of admissions also has positive dissociation scores.

DISCUSSION

A paper published in the Psychiatric Bulletin by Peter Ellwood (1999) identified medical and socio-demographic characteristics of admissions considered inappropriate (25%) by psychiatrists. Ellwood's "twenty-five percent" of the admissions are approaching the fairly consistent one-third to two-thirds ratio found in this study. It would have been interesting to have had in Ellwood's study the dissociation scores of the patients found to be "inappropriate for admission."

This study revealed that a significant proportion of acute inpatients could be identified as having a possible dissociative disorder using a relatively simple dissociation test. It has also been presented that significant proportions of acute inpatients are reportedly inappropriately admitted. When we add to this mix the difficulty of multiple diagnosis and predictable responses to conventional (medication) treatment, serious questions are raised. The study supports the need for a research trial designed to

test first, in a more detailed way, the precise nature of the dissociative symptoms recognised by the screening instrument. Further research using structured interviews such as the SCID- Dare required, and the more accurate identification of dissociative disorder patients might result in differential treatment planning with behavioural management indices as treatment outcome variables, e.g., readmission/length of stay.

TABLE 1. Relationship of number of hospitalizations to mean DES score

Number of Patients	Number of Admissions	Number with a DES Score over 30
42	2	16 (38%)
28	3 or more	9 (32%)
18	4 or more	6 (33%)

There are a high number of dissociators among inpatients in acute psychiatric units. Basic appropriate therapeutic principles are difficult to provide on a modern, acute psychiatric inpatient unit where bed occupancy rates are in excess of 100%. These raise challenges for those with responsibility for planning and maintaining services. This study suggests, however, that if more appropriate outpatient based “holding therapies” are provided, then at least a quarter and, perhaps, a third of inappropriate admissions could be reduced while, at the same time, providing more appropriate treatment with better outcomes. This, however, remains to be tested and there is an urgent need for such a project.

POSITIVE FAMILY MODEL

There is a growing awareness of the dynamics of the two very different worlds of mental health in the UK and confirmation that the levels of dissociative symptoms and likely dissociative disorders were very similar to levels experienced in other countries (The Ross Institute). The question remains as to how we could begin to address these splits and help bring about a more integrated approach to treatment and positive outcomes.

The first task was to identify the differences between the roles, the advantages and disadvantages of the two worlds of mental health. The advantages of working in the private sector involve being able to tackle dissociation and having a contained environment. The disadvantages of working in the private sector are that you tend to work in a “bubble” unrelated to the outside world and you may function as the client’s “rescuer” in regards to the client’s family, psychiatric or social services, or in court appearances.

The advantages of working in the public sector may include having a safe haven in times of emergency and having a range of therapies offered “in-house.” The disadvantages include having no link with a private therapist and having an over reliance on medication for patients.

The first step in healing this split between the private and public sector of mental health is to learn the language of the dissociative patient. The first author was taught in his analytical training that it

was up to the patient to learn the language of psychoanalysis. If they didn't they were either resisting or their condition was not suitable for therapy! When confronted with what turned out to be his first MPD client (as it was called in those days), the author had to radically change this prosaic attitude. It was up to the therapist to learn her language, not the other way around. The author's language of interpretations of fantasies was completely out of place at a starting point. A grounding into reality became the cornerstone of an early working alliance. In the same way, if a productive relationship was going to be developed with psychiatry then we would need to learn their language, the language of screening instruments and assessments and the DSM IV.

There are strong parallels between the work we do with individual clients at a micro level, and its mirroring within the UK psychiatric system. Dissociation, when no longer needed as a survival defensive mechanism, can become an enslaving entanglement within the interior world of the client whose default position is the "entrapment and infantilisation" of the individual's capacity to be a self-regulating independent and creative individual.

A second step in bridging the gap between the two mental health systems in the UK is to better understand a patient's behaviour when they are needing an emergency admission to the acute ward of a psychiatric hospital. There are at least three patterns of behaviour to be aware of. First, the new patient may lose "a sense of self." This loss of a sense of self leads to either a negative attention or compliant victim role. It doesn't take that much for any of us to lose a sense of self when we are away from our own environment. We generally revert to one of two primitive responses, to become compliant or to fight. It makes it understandable why some people taken hostage choose to make trouble for themselves, as it prevents their loss of self.

The second pattern of behaviour is that of a loss/abdication of responsibility for decisions taken. If you fight, decisions can be taken for you in actions that can lead to sectioning (compulsory admission to hospital under Mental Health Act). If you act in a compliant mode, you give over responsibility to authority and look to them to tell you what to do and behave in a childlike way. The third pattern of behaviour is illustrated by patients having their "antennae finely tuned" to splits/discords within the system and capitalising on these opportunities. This is such familiar territory for someone from a dysfunctional family.

The following is an example of a typical pathway for someone with DID when admitted to hospital: (1) crisis leads to hospital admission; (2) diagnosis is given which naturally can contradict an earlier diagnosis (in DID, etc.); (3) CPA (Care Plan Assessment) team is set up which can encourage splits in both the team and the patient; and (4) in general circumstances changes are made, often unilaterally by individual professionals involved, according to the patient's perceived behaviour and interpretation according to the professional involved. The patient will on the one hand quickly adapt to fit into the perceived role but then change behaviour according to the next professional or peer person they come in contact with.

This typical pathway for the DID patient in hospital admission can lead the patient to having difficult behaviour/acting out in the wards, self harm, and regression. This typically produces a "them/us culture" by both patient and professional. The patient can end up being discussed in either a derogatory or combative way.

With an understanding of the patient's language, the aforementioned possible patient behaviours at admission and the typical pathway for an admission, the authors offer an alternative, the "Positive Family Model." Appropriate responsibility by parental authority (professionals) and patient is encouraged in this model. All discussions and decisions should be taken at CPA meetings with the patient present. The views of the patient should be elicited respectfully as they know themselves at some level better than you do. When things "go wrong," view it as a group problem: "We have a problem." The more the patient is brought into solutions, problems, etc., the less likely acting out or self harm will take place. The hospital is not to become the equivalent of a child minder, wherein the children are dumped to be picked up again at the end of admissions. So right from the start we are encouraging the adult patient to take responsibility for the child within. It is a creative flow between dependency and independency.

POTTERGATE MODEL FOR LOCALITY MANAGEMENT SUPPORTIVE CONSULTATION

What steps have we taken, at the Pottergate Centre, to facilitate internal dialogue between professionals both in the private and public sector and dissociative clients, to get this condition treated seriously and to get the right help? We started by focusing just in our own locality but have broadened this in the last three years to offer this evolving model nationally. There are now broadly speaking two pathways through which the Centre gets referrals: first, professional referrals for an assessment and recommendation for treatment. The second is where the client self-refers and self-funds as a first step to getting appropriate help.

Such referrals to our Centre via this route were unknown as of four years ago. It has begun to change in a significant way. Some of this is down to survivors (trauma patients) fighting to get recognition of their plight. Right from the start, the person referred is included in all correspondence and invited to contact us regarding any worries, etc. If a screening instrument has not previously been completed, then this is sent to them for completion if they are able to. Two assessments are undertaken: the SCID-D with myself and the psychiatric assessment with my colleague, William Hughes, who is a consultant psychiatrist. He will have received all the relevant medical notes from the services as his role is to identify the primary diagnosis. Very often people have been diagnosed with Borderline Personality Disorder and immediately any question of effective help had been dismissed in the past.

These two extensive reports are sent (including details of the results of the screening instruments unless insignificant) along with a recommended treatment plan which will include several elements if the person was diagnosed with a dissociative disorder. The recommendation of individual psychotherapy is first given with the understanding that it will be intensive individual therapy (2/week) with a therapist trained in working with dissociation. The prognosis is given as generally good, but requiring long term work. The advantages of providing treatment locally rather than from a specialised unit in another area is given to avoid further splits and the effectiveness of having a strong and contained multi-disciplinary team in place at the outpatient level. We offer to select/train either an in-house therapist or someone from the private sector, supervision for the therapist and consultancy for the team and we encourage the therapist's involvement in CPA meetings.

With a strong CPA team in place, Multi-agency involvement can be reduced (reduction in costs), and positive moves can take place to outpatient treatment (cost reduction). With a strong plan in place “in case” of a future admission, there less likelihood that this will restart the diagnostic roller coaster noted before. All along the patient is encouraged to take appropriate responsibility and appropriate use of help. All of this in our experience helps reduce self-harm, the over use of services (an inappropriate search for parenting) and an increase in self worth.

FUTURE LINKS

Through the development of the United Kingdom Society for the Study of Dissociation (UKSSD), with support from the International Society for the Study of Dissociation (ISSD), it has been possible over the past five years to establish a growing body of professionals willing to undertake further training to give a secure base to treating and supporting people with a variety of trauma based disorders including specifically dissociative disorders as defined within DSM IV. We have found people willing to give up their time for supervision and case discussion to keep standards high. It is exciting that NHS Primary Care (OP) practices may soon have “purchasing power” to buy services for their patients because very often it is at the OP level that the most priority is given because outpatients turn up week after week with undiagnosed somatic and or psychological symptoms. Patient self-help groups such as First Person Plural are arranging national level interest and, as a recent conference demonstrated, are a voice that is reaching throughout the UK to unify understanding. European colleagues are increasingly interested to join with us in the UK to understand our own dissociation, as we come to a better understanding about our own divisions and chaotically organised services so we grow closer to helping the disorganised and fragmented inner world that we are striving to heal. It is difficult to find other than a powerful reflection that the divisions within Europe and within our UK NHS give us an incentive to work very hard to create a container that is worth internalising.