

Mental Health Outpatient Treatment for Dissociative Disorders

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Developed By: Medical Necessity Criteria Committee

I. Description

Dissociative Disorders are psychiatric syndromes characterized by disruptions of aspects of consciousness, identity, memory, motor behavior or environmental awareness. They are considered protective reactions to overwhelming psychological trauma. Children who experience chronic physical, sexual or emotional abuse are at greatest risk of developing dissociative disorders. Children and more rarely, adults, who experience other traumatic events such as war, natural disasters, kidnapping, torture and invasive medical procedures may also develop these conditions. The American Psychiatric Association defines five dissociative disorders including: Dissociative amnesia, dissociative fugue, dissociative identity disorder, dissociative depersonalization disorder, and dissociative disorder not otherwise specified.

Assessment and Diagnosis:

Appropriate diagnosis is made according to diagnostic criteria in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*. The diagnosis of dissociative disorder, and in particular, Dissociative Identity Disorder and Dissociative Disorder Not Otherwise Specified, has been surrounded by significant controversy. Clinicians should be alert to the possibility of false positives in diagnosing these disorders. Patients may have dissociative experiences that do not meet criteria; patients, particularly those with Cluster B personality disorders, may inaccurately identify themselves as having DID; and symptoms of other psychiatric disorders may mimic symptoms of dissociative disorders. Differential diagnosis should include consideration of the following:

- Other dissociative disorders
- Substance use disorders
- Posttraumatic Stress Disorder or Acute Stress Disorder
- Personality Disorders
- Psychotic disorders

Additionally, clinicians must assess the patient's psychosocial functioning, ego strength and resiliency, motivation, and external resources including social support; and tailor treatment to the patient's needs as they relate to these internal and external resources.

Treatment Goals and Interventions:

Empirical research regarding treatment remains scant and available guidelines appear to be based largely on clinical consensus rather than research. According to ISSD guidelines, “Treatment for DID should adhere to the basic principles of psychotherapy and psychiatric medical management, and therapists should use specialized techniques only as needed to address specific dissociative symptomatology” (p. 117). Establishing appropriate expectations for treatment is of utmost importance in treating individuals with dissociative disorder. Goals and interventions should focus on achieving integrated and adaptive functioning and need to be tailored to the patient’s resources and abilities. Available evidence suggests that for a large number of patients with dissociative identity disorder, improvement rather than cure is an appropriate treatment goal.

II. Criteria: CWQI BHC-0003

A. Continued authorization:

Continued authorization is indicated by **ALL** of the following:

1. The treatment plan establishes achievable recovery goals appropriate to the patient’s symptoms, resources, and functioning.
2. Treatment is provided at the lowest level of intensity (including frequency and duration of outpatient sessions and duration of the treatment episode) necessary to maintain the patient’s stability and achieve progress toward appropriate treatment goals.
3. The treatment plan includes a realistic plan for termination and promotes the patient’s ability to independently manage symptoms and resolve problems.

Plus 1 or more of the following:

4. Continued measurable improvement in symptoms and/or functioning as evidenced by improvement in behavioral outcome measures.
5. Continued progress toward development of skills to prevent relapse.
6. Treatment plan revision to address lack of progress. If no improvement is noted, the treatment plan should be modified to include the consideration of:
 - a. Need for medication evaluation
 - b. Possibility of underlying Personality Disorder
 - c. Need for psychosocial interventions (e.g., support groups)
 - d. Possibility of co-occurring conditions that need attention (e.g. medical conditions, substance abuse)
 - e. Referral to a different provider or different type of treatment
7. If there is a clear risk of deterioration with no further treatment, appropriate maintenance treatment is covered. If continued treatment is intended primarily to prevent deterioration, and significant improvement in symptoms is not expected, treatment should be provided at the least intensive level required to prevent deterioration.

B. Termination Criteria:

Termination of continued authorization is indicated by **1 or more** of the following:

1. Patient has demonstrated stabilization of symptoms and appropriate relapse prevention skills have been established.
2. Patient is not improving, despite amendments to the treatment plan (consider referral to another therapist or another form of treatment)
3. Patient has achieved a stable level of functioning and further treatment is not expected to produce significant improvement.

III. Information Submitted with the Prior Authorization Request:

1. Diagnosis and presenting symptoms
2. Relevant psycho-social and treatment history
3. Assessment of both substance abuse and mental health concerns
4. Measurable treatment goals
5. Scope and duration of planned treatment interventions
6. Response to treatment, including measurable change in symptom presentation, outcomes measures used, and results of outcomes measures
7. Medical conditions affecting treatment and coordination with medical providers

IV. Annual Review History

Review Date	Revisions	Effective Date
05/2013	Annual Review. Added table with review date, revisions, and effective date. Refined termination criteria 1.	05/2013
05/2014	Annual Review.	05/2014
05/2015	Annual Review. Clarification in Subject line.	05/2015
07/2016	Annual Review. Minor clarifications.	07/2016
07/2017	Annual Review. Updated to new template	09/2017
07/2018	Annual Review. No changes	09/2018

V. References

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3. *Dissociative Disorders*. Dr. Idan Sharon, Consulting Staff, Department of Neurology and Psychiatry, Cornell New York Methodist Hospital. 2007.
4. *Guidelines for Treating Dissociative Identity Disorder in Adults, Third Revision*. International Society for Study of Dissociation. 2011. Available at http://www.isst-d.org/downloads/GUIDELINES_REVISED2011.pdf.

5. *Guidelines for the Evaluation and Treatment of Dissociative Symptoms in Children and Adolescents*. International Society for Study of Dissociation. 2004. Available at <http://www.isstd.org/education/treatmentguidelines-index.htm>.
6. *Owning the past, claiming the present: perspectives on the treatment of dissociative patients*. Australian Psychiatry. 2005.
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9. Gentile, J.P.; Dillon, S.S.; and Gillig, P.M (2013). Psychotherapy and Pharmacotherapy for Patients with Dissociative Identity Disorder. *Innovations in Clinical Neuroscience*, 10(2): 22-29. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3615506/pdf/icns_10_2_22.pdf