DISSOCIATION and PTSD

Fiona Kennedy
GreenWood Mentors Ltd
drkennedy@greenwoodmentors.com

copyright Fiona C Kennedy 2010
Workshop Structure

What
- Definition
- History

Model
- CBT
- Formulation

How
- Case vignettes
- Your cases
What is dissociation?

- A failure to integrate experiences (memories, perceptions, etc.) that are normally associated (e.g. Janet, 1889)

- Symptoms such as amnesia, depersonalisation, derealisation & identity confusion result from ‘emergency’ biological responses and may serve to REDUCE AWARENESS of intolerable information
DSM-IV definition

- disruption of the usually integrated functions of consciousness, memory, identity or perception of the environment

- E.g. Mother sees a wasp
Dissociation is not always pathological

E.g. Mother daydreams in park
Why is dissociation important?

- Characteristic of complex psychological disorders with poor therapeutic outcome (PTSD, BPD, DID)
- Probably is a mediator in trauma-psychopathology link
- If not addressed, seriously therapy interfering
Dissociative phenomena

- memory
- sense of self
- Consciousness/perception
- Somatic/bodily symptoms
Phenomena which have been considered dissociative

- memory
- amnesia for past events (e.g. a childhood trauma)
- amnesia for the recent past (e.g. yesterday’s therapy session)
- amnesia for important personal information (e.g. one’s address)
- fugue states (where the person lives for a time as a another person with no memory of the past)
- ‘reliving’ of traumatic events (where a memory is experienced as if here and now)
Phenomena which have been considered dissociative

- **sense of self**
- depersonalization (feeling disconnected from the body)
- derealization (feeling the environment is not real)
- age regression (experiencing oneself as a child)
- identity confusion
- Identity alteration
- multiple personalities (Dissociative Identity Disorder)
- possession states
- intermittent loss of skills (e.g. one day the individual can drive, the next day s/he cannot)
Phenomena which have been considered dissociative

- Somatic/bodily symptoms
  - non-organic pain
  - auto-anaesthesia (being unable to feel pain)
  - somatic symptoms such as gait disturbances, problems urinating
  - some unexplained medical symptoms
  - motor inhibition (e.g., being unable to perform certain actions, being rooted to the spot)
  - ‘made behaviors’ (automatic behaviors carried out without feeling in control)
  - non-epileptic seizures
Phenomena which have been considered dissociative

- other phenomena
- emotional numbness
- mental blanking (inability to think)
- inability to speak
Your examples of dissociative phenomena?
Useful reading


A quick romp through history
in 1623 it was reported that Sister Benedetta of Italy was ‘possessed’ by ‘boys’ who caused her chronic pain and spoke in different dialects. As, a nine year old boy, Splenditello, she had a sexual relationship with another nun. She also self-mutilated and suffered eating problems (van der Hart, Lierens and Goodwin, 1996).
The first ‘multiple personalities’

- Myer’s case of Louis Vivet (1886) is reported by Faure, Kersten, Koopman and van der Hart (1997) as the first explicitly described case of multiple personality.

- Vivet was born of a ‘child mother’, neglected, beaten and then abandoned at the age of seven.
He showed many personality states, ‘hysterico-epileptic seizures’, intermittent paralysis, varying food preferences (e.g. either craving or disliking wine), aggression and stealing interspersed with calm politeness.
Moreau de Tours first used the term ‘dissociation’ (‘désagrégation’) in France in 1845, to mean a lack of integration of ideas, causing a split in the personality.
Puységur, (1751-1825) Mesmer’s student, used magnetism to induce convulsions; people entered a state called ‘artificial somnambulism’ (later called hypnosis) Subjects had amnesia for events during this state and seemed to have two separate streams of consciousness divided from each other.
Charcot (1887) used artificial somnambulism/hypnotic states as a model to explain ‘hysterical’ symptoms such as paralysis, claiming that these symptoms occurred in separated-off states of consciousness.
In summary, by the late 19th Century scientists had noticed the connection between divided states of consciousness and psychopathology in terms of ‘hysteria’ and multiple personality.
The late 19th-early 20th Century: vehement emotions and repression

- Pierre Janet’s (1859-1947) theory
- ‘idées fixes’ were traumatic memories, with associated ‘vehement emotions’ and images, movements and physiological ‘phenomena’,
- They alternate with an ‘apparently normal personality state’ and cause intrusions when triggered by relevant traumatic reminders.
One personality state seemed not to experience the trauma, the other experiences nothing but the trauma (e.g., Janet, 1889, 1907, 1928).

Secondary idéées fixes: dreams, fantasies or hallucinations related to the trauma, which Janet called ‘hysterical psychosis
Breuer and Freud initially built on the idea of hypnotic or dissociated states as divisions in consciousness which underlay hysteria (1893).

Freud gave childhood trauma a central role in the development of ‘hysterical’ psychopathology (1893).
However, he changed his formulation; the concept of repression of unacceptable sexual wishes gradually replaced that of dissociation (Erdelyi 1985).
The Great Wars: shell shock

Two World Wars resulted in much military trauma, or ‘shell shock’, some of it well documented by army psychiatrists (e.g., Myers, 1940).

Overwhelming traumatic experiences could not be integrated and were held in an ‘emotional personality’ which had vivid awareness of the trauma and acted as if the trauma were re-occurring.
‘Shell shock’ has now been replaced with the terms ‘post traumatic stress disorder’ (PTSD), acute stress disorder (ASD) and complex post-traumatic stress disorder.
A re-emergence of interest: the ‘60s and ‘70s

- The case of Eve (Osgood and Luria, 1954) later made into a film ‘The Three Faces of Eve’ attracted great public and clinical attention
- Further public interest was stimulated by the publication of the case of Sybil (Schreiber, 1973)
In the academic world Hilgard (1977) published his neo-dissociation theory. Hypnotised students reported feeling no pain (with their hands in a bucket of freezing cold water). But he accessed another state of consciousness in which they could feel the pain, which he christened the ‘hidden observer’.
Central Control System

e.g. memory

e.g. perception
Personality 1

CCS

memory

perception

Personality 2

CS

memory

perception
So by the ‘70s, information-processing models were having an impact on our thinking about the self, trauma and dissociation.
In the 1970s and 1980s, there was refinement of cognitive theory and a surge in the development of cognitive therapy.

Some used a generic cognitive understanding to formulate symptoms of dissociation (e.g. Kennerley 1996)

Others took a schema based cognitive perspective (e.g. Young 1999).
Cognitive and behavioural avoidance may slow information processing (Foa & Kozak, 1986) or prevent full inspection of stimulus features (Williams, Watts, MacLeod & Mathews, 1997)

These processes have been shown to occur without conscious awareness (Dixon, 1981; Patton, 1992) and are believed to involve both classical (Nijenhuis & Vanderlinden, 1995) and operant conditioning (Kennerley, 1996).
Cognitive approaches in the 21st century

- Brewin, Dalgleish and Joseph (1996) published a ‘dual representation’ model of PTSD,
- Two levels of information processing: situationally accessed memories (SAMS) and verbally accessed memories (VAMS).
Situationally accessed memories were driven by stimulus similarity (e.g. a man with blue eyes triggers memories of a client’s abuser, who also had blue eyes);

verbally accessed memories were integrated with autobiographical memory, with a sense of location in time and perspective.

A failure to integrate SAMS into VAMS this way was held to produce flashbacks and other symptoms of PTSD.

They mentioned dissociation as an “as yet poorly understood” cognitive response that might inhibit the integration of trauma memories into the autobiographical (VAMS) memory database.
Hypnotic phenomena
Depersonalisation disorder
Dissociative amnesia
Somatisation disorder
DID
2005 Holmes et al. review: 2 categories:

**Detachment**
- Peritraumatic unreality
- Depersonalisation disorder

- Amnesia (not recoverable)

**Compartmentalisation**
- Amnesia (recoverable)
- Hypnotic trance
- Medically unexplained symptoms
- Identity alteration
- DID
Detachment

- incorporates depersonalisation and derealisation, out of body experiences, ‘spacing out’ and other feelings of unreality. There is little disturbance to sense of identity.

- physiological changes prevent the encoding of information during trauma, leading to fragmented recall later. This kind of amnesia is not reversible, since it involves an encoding failure.
For example

A driver sees a lorry coming towards her on the wrong side of the road

The threat response involves ‘freezing’ with feelings of detachment

The driver cannot remember significant aspects of the accident later

‘Re-living’ does not lead to recall of all aspects of the event
‘a deficit in the ability to deliberately control processes or actions that would normally be amenable to such control’ (Holmes et al., 2005)

Includes an inability to bring normally accessible information into conscious awareness (e.g. a past experience of child abuse).

This kind of amnesia is reversible in principle, because information has been encoded in memory, in contrast with the encoding failures in detachment (Allen et al 1999).
Functions which are no longer amenable to control (e.g. walking) are said to be ‘compartmentalized’. So symptoms such as conversion disorders or non-organic pain are included in this category. Compartmentalized processes continue to operate normally and can influence emotion, cognition and action (Brown 2002a,b, 2004; Cardena, 1994; Kihlstrohm, 1992).
For example

A man has intermittent lower spinal pain, causing difficulty walking

No medical cause is found

During therapy, the man gradually recalls cruelty from his father

Finally remembering a childhood rape which caused spinal pain and walking problems at the time

On recall, the symptoms disappear
The implications of this distinction for treatment, according to Holmes et al, are that
- in compartmentalization, the therapist should work towards reactivation and reintegration of compartmentalized elements;
- in detachment the therapist needs to work towards preventing detachment being triggered, and terminating the state when it is.
In summary, the detachment-compartmentalisation distinction is helpful in that it begins to differentiate different types of dissociation. But it does not address the disturbances to identity found so often in dissociative clinical presentations.
Several cognitive theorists have used the notion of a ‘working self-concept’, one of several schemas which interpret and respond to internal and external input.

For example Conway and Pleydell-Pearce, 2000, who stressed the fundamental link between autobiographical memory and the self.
The ‘working self’ is similar to ‘working memory’ related to the self:

- From moment to moment it selects representations of the self based on past experiences and present context.

- The individual will have several working selves.
‘Simple’ Type I PTSD

- Re-experiencing
- Hyperarousal
- Avoidance
Acute Stress Disorder (DSM IV)
PTSD type symptoms < 1 month
Predicts 83% PTSD cases at 1 year (Brewin et al 1999)
Re-experiencing and hyperarousal predict chronic PTSD
Complex/Type II PTSD

- DESNOS (Van der Kolk 2002)
- regulation of affect and impulses
- attention or consciousness
- somatization
- self-perception
BPD

- Affective dysregulation
- Substance abuse/compulsive spending etc
- Emptiness or boredom
- Sense of self confused
- Self harm
- Attachment: abandonment/idealisation-devaluation
- Dissociative/psychotic states
Dissociative Identity Disorder

- Two or more personality states which repeatedly take control of behaviour
- Amnesia for important personal information
Other diagnoses

- dissociative amnesia
  - inability to recall important (traumatic) personal information

- dissociative fugue
  - sudden travel from home/work with inability to recall past (DSM-IV) or journey (ICD-10)

- depersonalisation disorder
  - experiences of feeling detached from/external observer of, own mental processes or body

- dissociative disorder not otherwise specified
Psychosis

- Dissociative psychosis (Ross 2009)
- Are psychotic symptoms traumatic in origin and dissociative in kind? (Moskowicz et al 2009)
- Evidence that dissociation mediates the pathway between trauma and positive symptoms of schizophrenia (delusions, hallucinations, disorganised speech, disorganised behaviour/catatonia)
Self-induced dissociation

- Substance misuse/self harm
- Compulsive/impulsive
- To induce dissociative state
- To escape from dissociative state

copyright Fiona C Kennedy 2010
Continuum of personality disorders

Early Trauma
- PTSD
- Attachment problems
- Regulation problems

Personality
- Sense of self
- Control problems
- Relationship problems

Functioning
- DESNOS
- BPD
- DID
- Psychosis
- Anxiety
- Depression
- Substance misuse
- Eating
- Somatoform
Personality fragmentation

- ‘Normal’
- Complex PTSD
- ‘BPD’
- ‘DID’
Structural dissociation’ theory

- e.g., Nijenhuis and Boer, 2009
- dissociation as divided consciousness with separate senses of self in all cases
- In PTSD, an ‘apparently normal person’ (ANP) remains to negotiate the outside world
- an ‘emotional personality’ (EP) holds the trauma memory separate
PTSD

ANP

EP
Kathy: long term sexual abuse by adoptive father

Mental Health Problems
- Depression
- Psychosis
- BPD features
- Flashbacks

Vulnerability alcoholism, failure to protect child lead to loss of child

Altered brain structures ‘hardware’

Conditioned responses hiding, out of body, amnesia

Reduce awareness and prevent exposure and learning

Ambivalent about whether she was abused, stayed in abusive relationship, did not see CSA threat from husband
Mental Health Problems
- Dissociative disorders
- Conversion disorders
- Psychosis
- BPD
- PTSD

Vulnerability to further real/perceived trauma

Trauma history or other vulnerability factors

Altered brain structures
- ‘hardware’

Conditioned dissociative responses to real/perceived threat
- ‘software’

Reduce awareness and prevent exposure and learning
- Prevent therapeutic change
- Prevent adaptation to new (safe) environment
- Fight/Flight/Freeze

Vulnerability to further real/perceived trauma
Take 5 minutes in pairs

- Can you use this formulation for your own case?
A Cognitive Model of Dissociation

Kennedy et al 2004
A new model

- Development of Beck’s (1996) cognitive theory of personality and psychopathology

- ‘decoupling’ of mental processes may occur at one or more of three stages of information processing
1 automatic processing: intrusive images

2 strategic processing:
   a intrusive thoughts, behaviours, affect; somatic symptoms
   b mental blanking (amnesia), inability to do things, inability to feel, paralysis

3 identity disturbance
   state switching, losing time, fugue, amnesia, DID
Beck’s theory

- Personality is construed as a collection of ‘MODES’
- A mode is a set of schemas for encoding cognitive, behavioural, affective and physiological information and for generating responses to this information
- ‘ORIENTING SCHEMAS’ encode input from the environment and activate appropriate modes
A mode: client diagram
Orienting schemas

Automatic

Strategic

behav

cog

affect

physio

MODE 3

MODE 2

copyright Fiona C Kennedy 2010
Types of dissociation

I automatic: (cf PTSD ‘data-driven/SAMs)
Decoupling of early processing because of perceived threat

II within mode: (cf PTSD autobiographical/ VAMs)
Decoupling of affective, behavioural, cognitive, physiological schemata

III between mode: Decoupling of links between modes; personality structures disconnected
Stage I dissociation

- Dissociation in response to automatic association with threatening stimulus features
- Results in failure to further integrate incoming information.
- Incomplete dissociation results in flashbacks, nightmares, hallucinations, misperceptions, non-conscious ‘triggers’ to panic response.
Stage II dissociation

- Dissociation of links between schemata within a mode
- Results in inaccessibility of thoughts/feelings/behavioural/physiological responses (e.g., flattened affect, ‘hysterical’ blindness)
- Incomplete dissociation results in intrusive responses (e.g., non-organic pain; behavioural re-enactment, intrusive thoughts).

COPYRIGHT FIONA C KENNEDY 2010
Stage III dissociation

- Dissociation of links between modes
- Results in identity disturbances ranging from dissociative identity disorder (relatively complete dissociation)
- Through borderline personality disorder to severe mood or state switching (relatively incomplete dissociation).
Based on Beck (1996) theory of personality

- Dissociation as inhibition of normal associative processing
- Such inhibition is always incomplete, resulting in ‘break through’ or ‘leakage’ of dissociated (compartmentalised) material
- Especially when strong S-S / S-R associations present.
- And in the context of a trusting relationship/therapy
Automatic Processing

Mode 1
- thoughts
- feelings
- behaviour
- somatic

Mode 2

Mode 3

Strategic processing
For example, a client with BPD
- Has olfactory, visual and somatic ‘hallucinations’ (Level 1)
- Discusses childhood abuse without feeling (Level 2)
- Switches from a kind, empathic personality to a vengeful, angry ‘mode’ (Level 3)
The Wessex Dissociation Scale (WDS) gives a profile a client according to level. Formulating the problems by level and explaining to client is beginning of treatment.
New Book 2013

- Dissociation and Trauma: New Approaches in Cognitive Therapy
- Chapters by: Van der Hart, Gilbert, Kennerley, Mansell, Brown
- And Cowdrill, Sambrooke, Newman-Taylor, Stopa

- A good read!
In summary

- Up until the late 20th century there developed considerable understanding of dissociation but little idea of how to treat it.

- Cognitive theory and neurobiological advances have allowed us to develop more specific definitions and some effective treatment approaches.
But much remains to be done!
Useful reading


