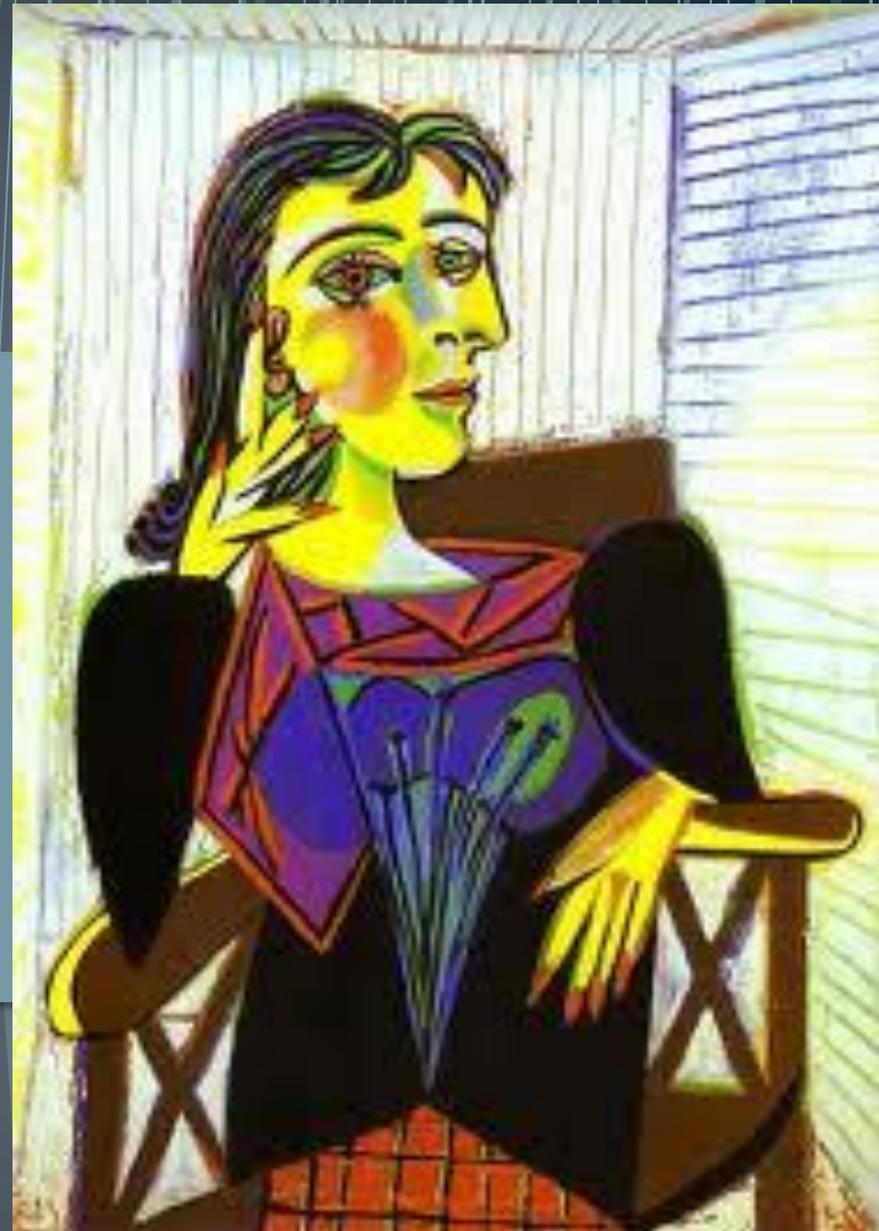


BEYOND THE FRONTIERS OF THE DISSOCIATION

DR VERONICA STANGANELLI
HOBART, RANZCP 2012



BEYOND THE FRONTIERS OF THE DISSOCIATION



- INTRODUCTION
- CHALLENGES WORKING WITH DISSOCIATIVE DISORDERS
- PREVALENCE OF DISSOCIATIVE DISORDERS IS 10 %
- CONTEXT OF MULTIPLE PARADIGMS
- IN OUR ERA OF BRAIN, CIRCUITS AND NEUROTRANSMITTERS
- THEY REMAIN FASCINATING AND MYSTERIOUS IN OUR CLINICAL PRACTICE

BEYOND THE FRONTIERS OF THE DISSOCIATION

- OBJECTIVES
- THE AIM OF THIS PAPER IS TO SHARE THE IMPACT OF WORKING WITH DISSOCIATIVE DISORDERS IN PRIVATE PRACTICE
- OUR PATIENTS
- THEIR FAMILIES
- OUR COLLEAGUES
- OUR COMMUNITY
- OURSELVES

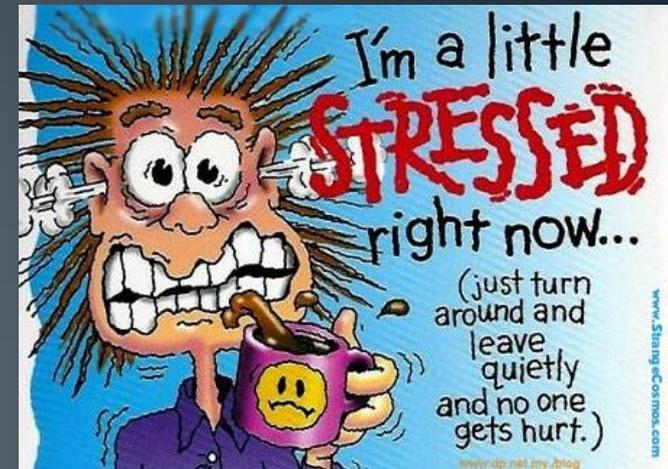


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- DEFINITION

DISSOCIATION IS DEFINED IN ACUTE STRESS DISORDER BY DSM IV TR (308.3) AS:

- A. SUBJECTIVE SENSE OF NUMBING
- B. DETACHMENT, ABSENCE OF EMOTIONAL RESPONSIVENESS
- C. REDUCTION IN THE AWARENESS OF HIS/HER SURROUNDINGS
- D. DEREALIZATION
- E. DEPERSONALIZATION
- F. DISSOCIATIVE AMNESIA (e.g. INABILITY TO RECALL AN IMPORTANT ASPECT OF THE TRAUMA)



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- DEFINITION
- DSM IV TR DEFINES DISSOCIATIVE IDENTITY DISORDER (2000) (DID)
 - A. THE PRESENCE OF TWO OR MORE DISTINCT IDENTITIES OR PERSONALITY STATES (EACH WITH ITS OWN RELATIVELY ENDURING PATTERN OF PERCEIVING, RELATING TO, AND THINKING ABOUT THE ENVIROMENT AND SELF)
 - AT LEAST TWO OF THESE IDENTITES OR PERSONALITY STATES RECURRENTLY TAKE CONTROL OF THE PERSON'S BEHAVIOUR
 - C. INABILITY TO RECALL IMPORTANT PERSONAL INFORMATION THAT IS TOO EXTENSIVE TO BE EXPLAINED BY ORDINARY FORGETFULNESS
 - D. THE DISTURBANCE IS NOT DUE TO :
 - THE DIRECT PHYSIOLOGICAL EFFECTS OF SUBSTANCES (e.g. blackouts or chaotic behaviour during alcohol intoxication)
 - OR A GENERAL MEDICAL CONDITION (e.g. complex partial seizures)

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Pathological dissociation is experienced as an involuntary disruption of the normal integration of conscious awareness and control over one's mental processes. Dissociative symptoms can manifest in every area of psychological functioning.

Dissociative symptoms are characterized by
(a) "positive" dissociative symptoms
unbidden and unpleasant intrusions into awareness and behaviour, with losses of continuity in subjective experience

(b) "negative" dissociative symptoms
an inability to access information or
to control mental functions that normally are able to access or control



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DISSOCIATION IN THE PAST ERAS

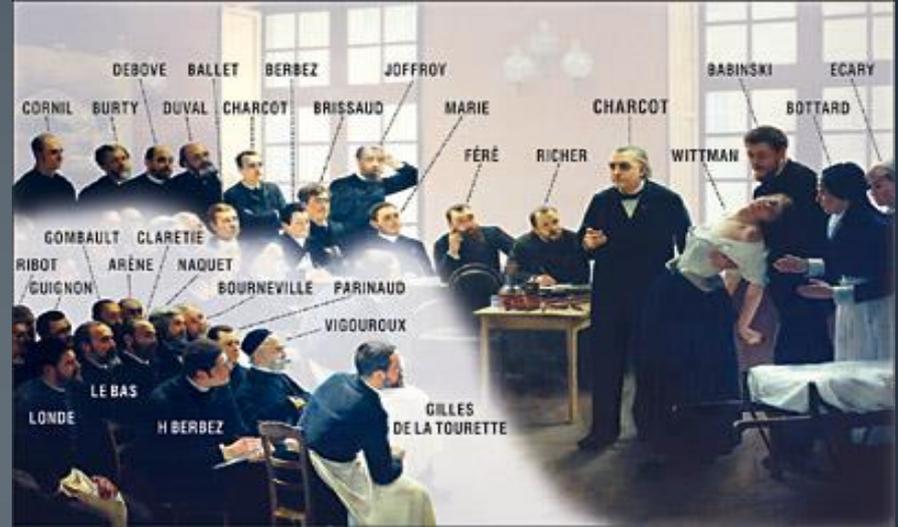


- HIPPOCRATES OF KOS (460 BC – 370 BC)
“THE BODY MUST BE TREATED AS A WHOLE AND NOT JUST A SERIES OF PARTS”
He rejected the views of his time that considered illness to be caused by superstitions and by possession of evil spirits and disfavour of the gods
- MARQUIS DU PUYSEGUR/FRANZ MESMER (1751-1825) ANIMAL MAGNETISM (MESMERISM)
Magnetic convulsive crisis by hypnosis with amnesia that they were thought as a “artificial somnambulism”
- DR BENJAMIN RUSH (1812)
He devoted a chapter in his psychiatric text named “Dissociation” : an association of un-related perceptions or ideas, with inability of the mind to perform judgement

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DISSOCIATION IN THE PAST ERAS

- MOREAU THE TOURS (1845)
He coined the term dissociation (disaggregation) isolation of ideas, dreams, under the effect of hashish
- PIERRE JANET (1859-1947)



He was a French philosopher and doctor in the Salpêtrière (Paris) at the end of the 19th century, who systematically elaborated on the concept of dissociation and trauma

Dissociation as a discontinuous phenomenon that it was only seen in individuals with mental disorders, particularly hysteria, and it was absent in healthy people. Dissociation as a division of personality or consciousness

- SIGMUND FREUD AND BREUER (1893)
Dissociation was the first mechanism of ego defence in Psychoanalysis to elaborate the Theory of neurosis. Later Freud attributed war neuroses to conflicts in ego structures (ego, id, superego) and instinctual drives (libido, destrudo)

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DISSOCIATION IN THE PAST ERAS

- F. MYERS (1873-1946) PTSD

Myers developed the term “emotional personality” in War Veterans based on Janet’s theory. The mental condition in which his patients “re-experienced” their trauma was described as a dissociated personality

- DSM AND PTSD

- WWI - “ SHELL SHOCK ”

- WWII - “ BATLLE FATIGUE ”

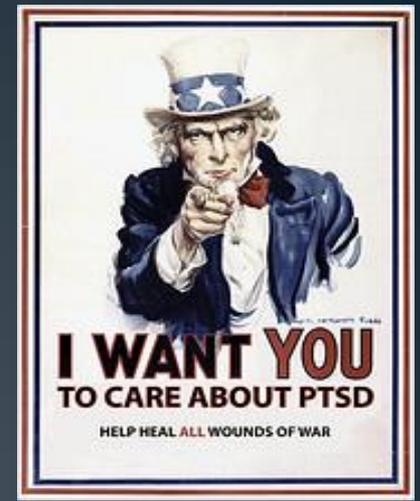
- 1952 - “ GROSS STRESS REACTION ”

- 1980 - “ POST TRAUMATIC STRESS DISORDER”

- “A normal personality may utilize established patterns of reaction to deal with overwhelming fear.”

- These were differentiated from neurosis and psychosis on the basis of “clinical history, reversibility of reaction, and its transient character”

- Appeared dissociative disorders in DSM as a broad classification, including somatoform disorders as a break-down of the normal integrated functioning



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DISSOCIATION IN THE PAST ERAS

- A. M. LUDWIG (1983) “PLAYING POSSUM” “FROZEN RESPONSE”

Altered states of conscious with a continuum from normality to dissociation

Dissociation as a specific response to overwhelming stimuli

Based on the evolutionary history of mammalian organisms

Related to the freezing response of animals confronted with a predator

Or other life endangering threat.

The psychobiological functions of dissociation include:

1. Automatization of behaviour
2. Resolution of irreconcilable conflicts
3. Escape from the constraints of reality
4. Isolation of catastrophic experiences



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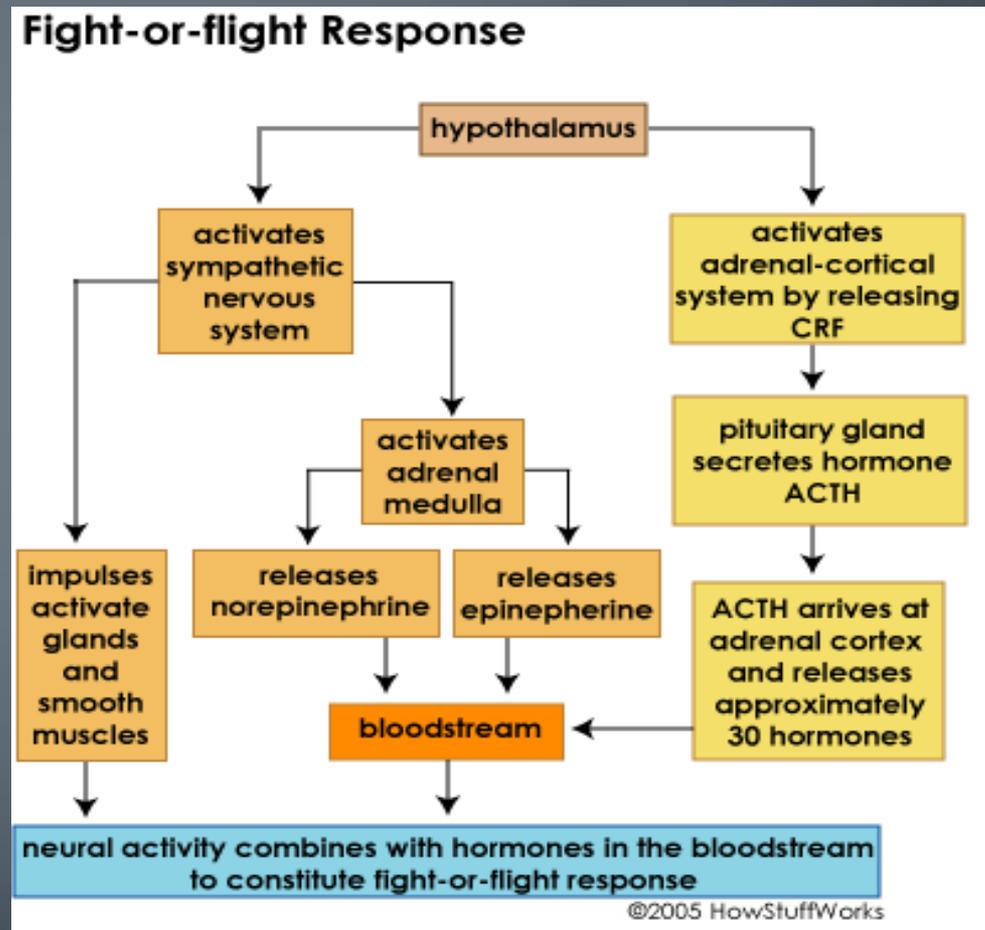
FIVE PORTRAYALS OF DISSOCIATION IN THE NEW ERA



1. DISSOCIATION AS SPLIT PERSONALITY, CONSCIOUS OR EGO ORGANIZATION
2. RE-INTERPRETED BY FREUD AS A DEFENSE OF EGO MECHANISM SUBSUMED BY CONCEPT OF REPRESSION
3. DISSOCIATION AS A PROCESS: INITIAL DIVISION OF THE PERSONALITY FOLLOWING TRAUMA AND SWITCHING BETWEEN DISSOCIATIVE PARTS OF PERSONALITY
4. DISSOCIATION AS A BROAD SET OF EXPERIENCES AND SYMPTOMS THAT ONE CHARACTERISED BY A BREAKDOWN IN AN INTEGRATED PSYCHOLOGICAL FUNCTIONING
5. DISSOCIATION AS A CONTINUUM THAT STRECHES FROM NORMAL TO PATHOLOGICAL SYMPTOMS

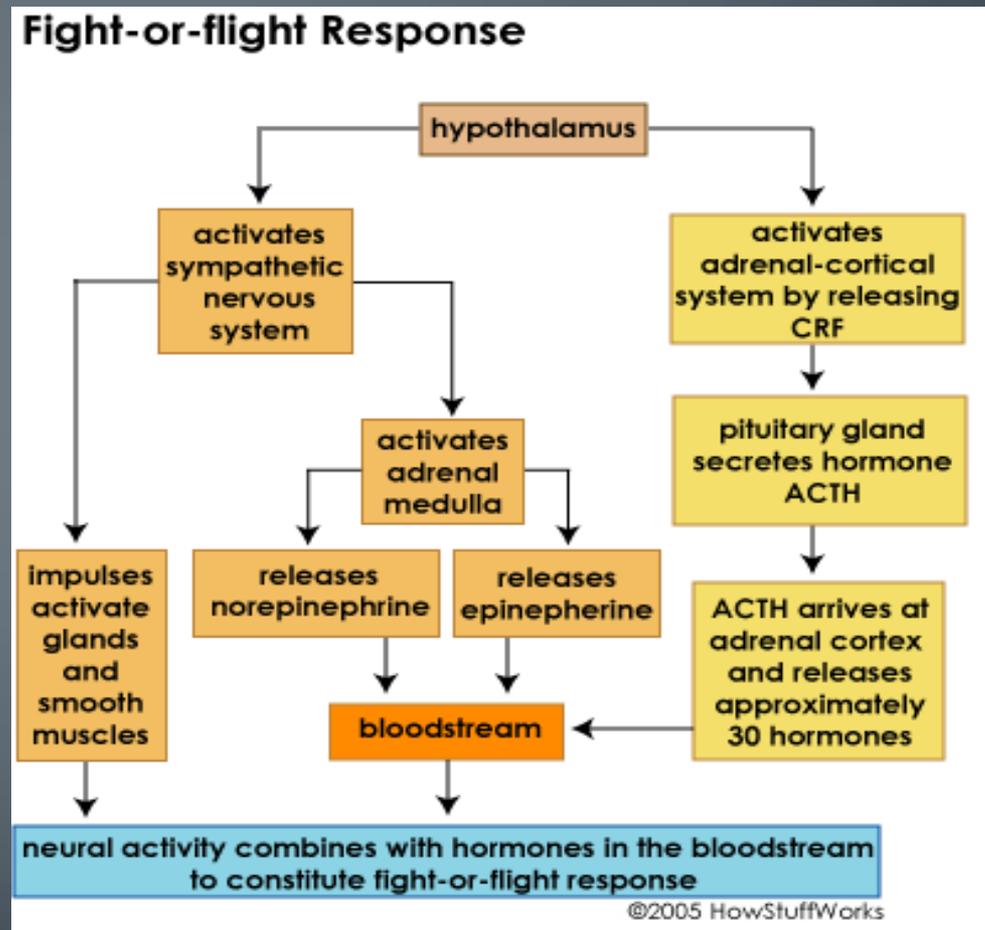
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- DISSOCIATION IN THE NEW ERA



BEYOND THE FRONTIERS OF THE DISSOCIATION

- DISSOCIATION IN THE NEW ERA



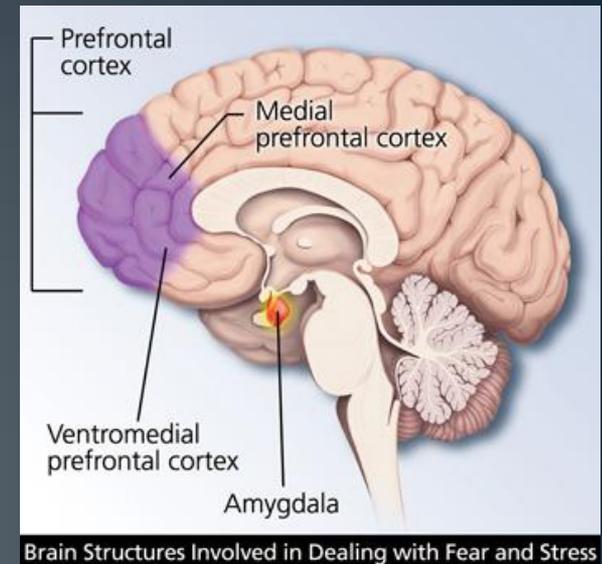
BEYOND THE FRONTIERS OF THE DISSOCIATION

- **DISSOCIATION IN THE NEW ERA**

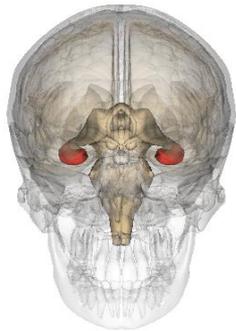
- Lanius et al. postulate a subtype of PTSD characterized by over-modulation (i.e., excessive inhibition) of emotions when exposed to traumatic memories, and a subjective disengagement from the emotional content of the traumatic memory through depersonalization or de-realization responses

They hypothesize that a hyper-inhibition of limbic regions by prefrontal areas occurs in situations of excessive emotional stimulation

In these patients, the relative detachment from the traumatic memories may be rooted in suppression of limbic regions with heightened frontal but diminished hippocampal activity

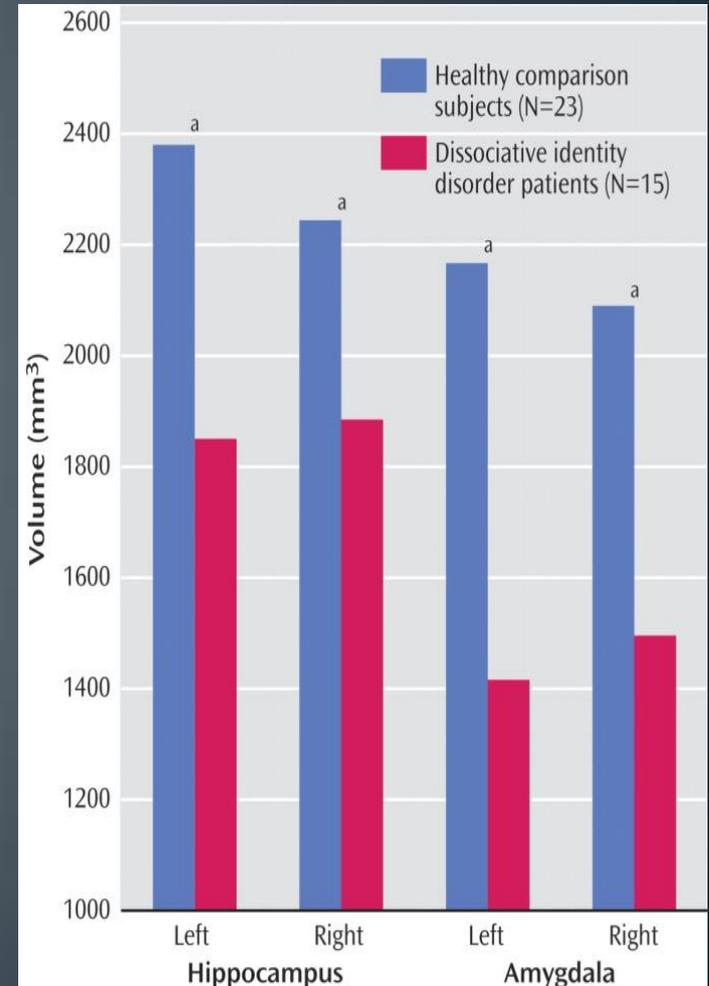


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HIPPOCAMPUS

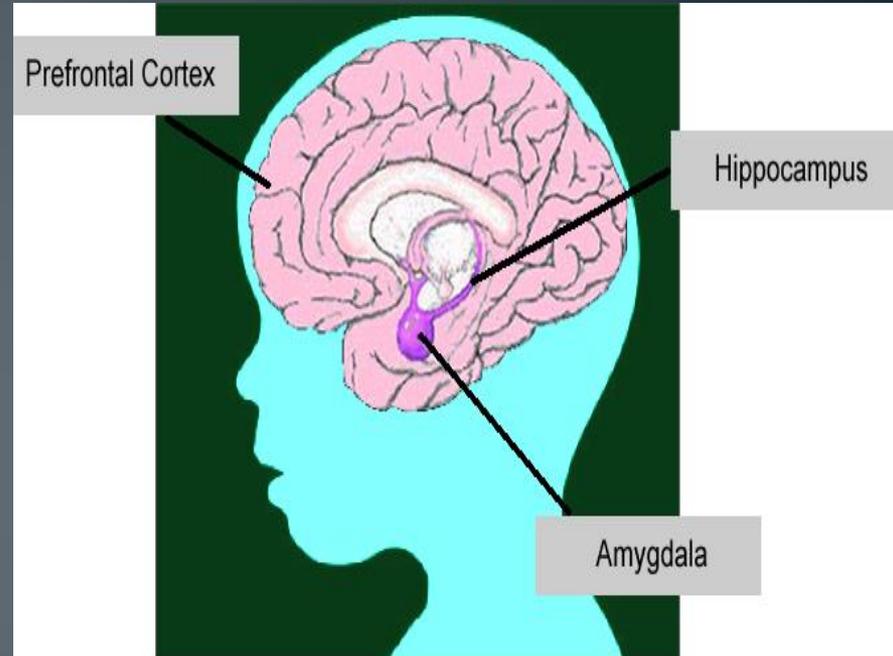
The hippocampus being an essential structure for the formation, storage, and retrieval of visual and verbal memory



José R. Maldonado, M.D., F.A.P.M., F.A.C.F.E.; David Spiegel, M.D.

DOI: 10.1176/appi.books.9781585623402.298080

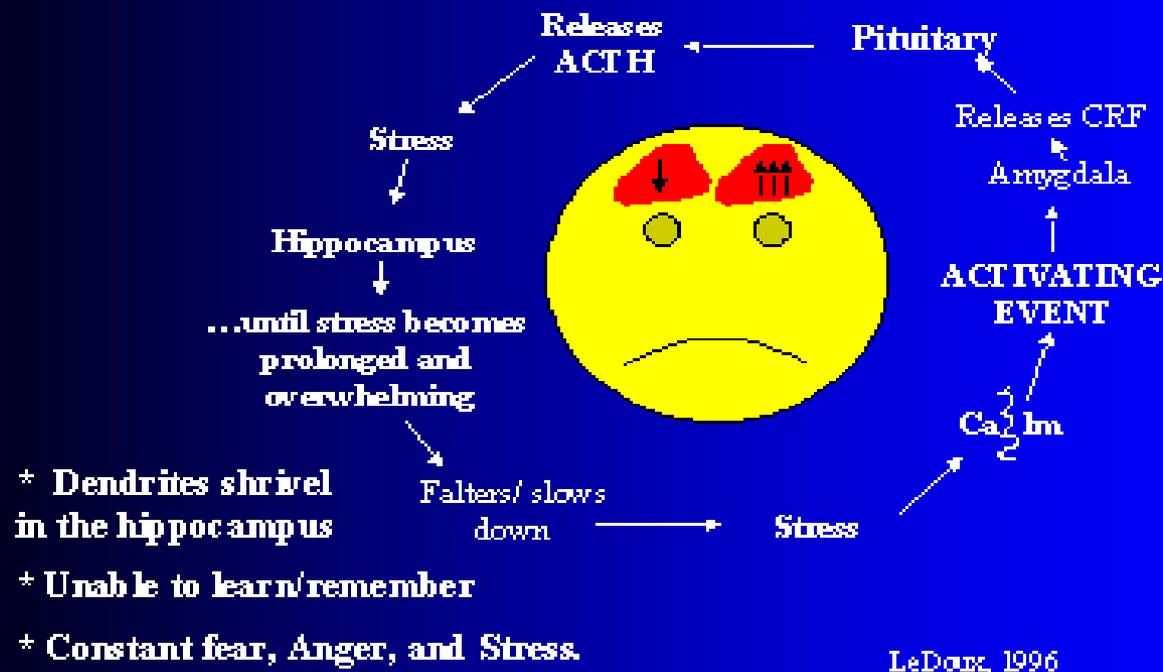
BEYOND THE FRONTIERS OF THE DISSOCIATION ATTACHMENT THEORY



Attachment disorders expressed in episodes of hyper arousal and dissociation, are imprinted into the developing limbic and autonomic nervous systems of the early maturing brain. Changes lead to the poor stress coping mechanisms that lie at the core of infant, child, and adult posttraumatic stress disorders.

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Stress and the Brain The Terrified Child



BEYOND THE FRONTIERS OF THE DISSOCIATION

TREATMENT PHASES:

1. SAFETY, STABILIZATION AND SYMPTOMS REDUCTION
2. WORKING WITH TRAUMATIC MEMORIES
3. IDENTITY INTEGRATION AND REHABILITATION

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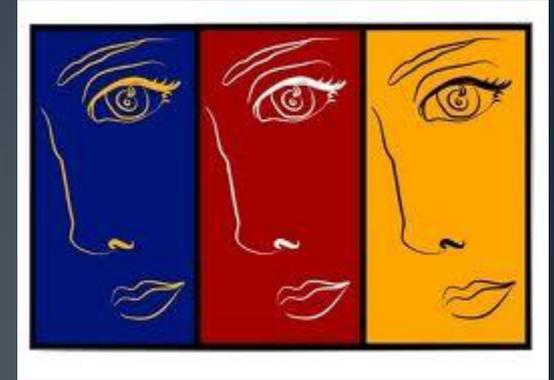


- MATERIAL AND METHODS
- THREE VIGNETTES ARE PRESENTED IN THE INITIAL PHASE OF THE TREATMENT (SAFETY, STABILIZATION AND SYMPTOM REDUCTION)
- WE WILL TALK ABOUT THE COMPLEXITIES OF THE MANAGEMENT PLAN IN PRIVATE PRACTICE SETTING
- FOR CONFIDENTIAL ISSUES, SCENARIOS, NAMES HAVE BEEN CHANGED IN ORDER TO MAINTAIN ANONIMITY AND PRIVACY

BEYOND THE FRONTIERS OF THE DISSOCIATION

First vignette

- *Julianna, 29 year-old married woman,*
- *lives with her husband (30)*
- *Referred by her GP due to anxiety disorder*
- *She had a long history of physical, emotional and sexual abuse since early childhood*
- *She has been suffering from high levels of distress with daily panic attacks*
- *Intense nightmares, flashbacks of previous abuses*
- *Avoidance of social situations*
- *Suicidal ideation in the context of starting her trauma therapy*
- *She portrayed herself as a “multiple-self” person*
- *Living with more than one hundred “alter-egos”*
- *“They” can not respond anymore for their actions*
- *“They” were afraid of one of the alter-egos: “Peter” who wanted to commit suicide*
- *“They were not ready to talk about their trauma yet”*



BEYOND THE FRONTIERS OF THE DISSOCIATION

First vignette



- *Julianna was thought as a dissociative identity disorder with PTSD symptoms*
- *She had a long history of trauma with attachment disorder and possible changes in her neurodevelopment, amygdala and hippocampus, and neurotransmitters*
- *Her tendency to dissociate started in early childhood*
- *We know that childhood maltreatment is associated with an increased risk of suicide*
- *In particular, with Julianna's cumulative traumas which included physical, sexual, emotional abuse and neglect*
- *Julianna has been re-enacting her history of abuse by her alter-egos*
- *In particular, his alter-ego " Peter " represented a part of herself who was in danger and suicidal if she tried to connect with her memories and history of trauma*

BEYOND THE FRONTIERS OF THE DISSOCIATION

First vignette

- *Julianna presented as a complex case that required to address our therapeutical alliance and her SAFETY ISSUES as priorities*
- *Safety plan with her husband and with the Crisis Team in our local public Hospital*
- *As a result of not having a private hospital in our area; Julianne and her alter-egos decided to be admitted in our local public hospital if they were severely suicidal*
- *On the other hand, we started with psycho-education to her and to her husband in order to integrate them in our plan and to support them with her alter-egos.*
- *Contract included cancelation of her driving licence*
- *Besides that, psycho-education to her GP who was monitoring her suicidality on weekly basis; helped us to avoid the splitting within the team*
- *Meetings with Julianne and her alter-egos, teaching her how to work with “Peters’ suicidality” and whether they were happy to communicate with her husband and with the crisis team if Peter needed*
- *We agreed to start with Quetiapine XR 100 mg nocte*
- *We decided to review her therapeutical approach with her psychologist*



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Second vignette



- *Mia, 26 year-old single mother of a three-year old girl*
- *Lives with her family and was referred by her GP due to anxiety*
- *Two-year history of periods of absconding from her home lasting 2 days*
- *Inability to recall those events*
- *Confused about her personal identity*
- *Her disorder started after her baby was accidentally burned with a bottle of hot milk*
- *Family history of anxiety and depression in both sides of her family*
- *Previous history of abandonment and losses in early childhood*
- *Attachment disorders since Mia was born that she re-enacted with her own child*
- *One of her presentations was a hypomanic episode whereas the others were with severe depression*
- *She was not suicidal or aggressive with her baby who was under her family's care*
- *Mia was diagnosed with bipolar type II after excluding organic causes and substance abuse. On the top of that, she was also diagnosed with dissociative disorders (dissociative amnesia and fugue)*

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Second vignette

- *Mia had history of attachment disorder, abandonments and losses in childhood with possible changes in her hippocampus axis with exaggerated ACTH release and reduced cortisol release in response to stressors*
- *Overlapping, she had an accident with her baby who was superficially burned*
- *Mia re-enacted her previous own traumas and dissociated*
- *On the top of that, she developed a mood disorder that interacted with her PTSD symptoms and anxiety*
- *This vignette highlights how the comorbidity of bipolar disorder and dissociation increases a patient's lethality risk and how both disorders may contribute to the volatile destabilization of the other.*



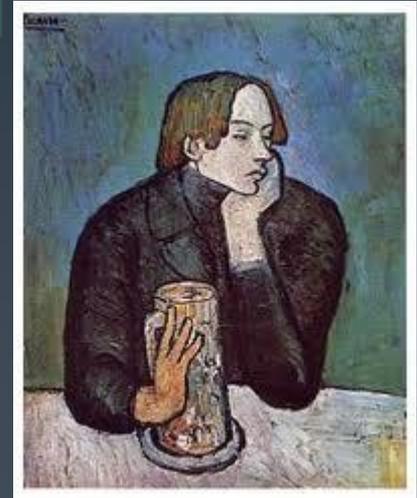
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Second vignette

- *Mia was not easy to engage but we could organize a safety plan with her family*
- *The priorities in Mia's case were her safety during her fugues*
- *The compliance with medications*
- *Organic causes and substance abuse were excluded*
- *Contraception in order to protect her from a new pregnancy with the mood stabilizer, control of STD, and substance abuse. To cancel her driver licence*
- *The meetings with her family were crucial to be compliant with mood stabilizers and to monitor her sodium valproate levels with 500 mg bd*
- *Liaison with local Police, Crisis Team at the public Hospital, NGO and GP*
- *Mia improved with medication, she started to work part-time and her fugues progressively decreased*



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Third vignette

- *Tom, 18 year-old young late adolescent*
- *Lives with his family and was referred by his GP due to Conversion disorder*
- *12 month-period of pseudo-seizures lasting up to thirty minutes and retrograde amnesia of the events. Numerous presentations with catatonia and non responsive*
- *His disorder started after he was assaulted by a gang one year ago*
- *Family thought that he was “playing possum” and afterwards “schizophrenia”*
- *Normal childhood. No family history of mental illness*
- *Important commanding auditory hallucinations running negative comments about him. The voices forced him to commit suicide by jumping off a balcony*
- *More investigations were done due to his neck injury but fortunately he was fine*
- *He was diagnosed with somatoform disorder (conversion disorder), dissociative disorder (dissociative amnesia) and he was also thought as a possible early psychosis*

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Third vignette

- *Tom's case highlighted the importance of not harming ethical conduct in these patients after medical causes and substance abuse were excluded*
- *He required numerous physical investigations which were all normal*
- *However, family 's distress asked for second and third opinions to be sure about whether he had schizophrenia/bipolar disorder or not*
- *Poor response with medications (Fluoxetine 60 mg and Olanzapine 20 mg for six months)*
- *Risk of suicide was crucial and unpredictable*
- *Superficial rapport and blunted affect throughout the whole treatment*
- *He required long admission in order to clarify his diagnosis*
- *He was thought as a dissociative disorder and his medication was changed to Venlafaxine 275 mg mane*



BEYOND THE FRONTIERS OF THE DISSOCIATION

CONCLUSIONS



1. WORKING WITH DIFFICULT PATIENTS REQUIRES PATIENCE, HONESTY AND SAFETY
2. NOT HARMING CRITERIA
3. THERE IS ALWAYS AN IMMINENT FEAR OF BEING BETRAYED
4. ATTACHMENT COULD BE COMPROMISED SINCE EARLY CHILDHOOD
5. THE CAPACITY TO TRUST NEEDS TO BE RESTORED BEFORE STARTING ANY PSYCHOTHERAPY
6. WE NEED TO EXPLORE SLOWLY DIVERSE “SELVES” AND UNDERSTAND MORE THAN ONE REALITIES IN ONE HUMAN BEING
7. PSYCHOEDUCATION OF THE FAMILY AND TREATING TEAM
8. ADDRESS THE STIGMA OF THESE DISORDERS “ PLAYING POSSUM”
9. OUR INTEGRATION WITH GENERAL PRACTITIONERS, COLLEAGUES, NGO, AND PATIENTS’ SIGNIFICANT OTHERS, HELP US TO MAINTAIN THOSE CASES SAFE IN OUR COMMUNITY WHILE THEIR TRAUMA AND TREATMENT UNFOLD

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THANK YOU

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