Dissociation and trauma

[Psychotherapy]

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Abstract

The syndrome of dissociation has been a focus of intense study in the USA over recent years, particularly in relation to trauma. Significant advances have been made in the definition and measurement of dissociative states and its association with stressful experiences. The link between dissociation and sexual abuse in childhood has received considerable attention. There have been numerous publications on therapeutic approaches to individuals with a history of trauma. Although studies of the efficacy of these approaches have been undertaken, to date, disagreement on the psychotherapeutic treatments of choice for these individuals continues.

Abbreviation

DES-Dissociative Experiences Scale.
Introduction

There has been a tremendous growth over recent years in literature describing childhood traumatization and the development of dissociative disorders. The books by van der Kolk in 1987 [1] and Putnam in 1989 [2] reviewed much of this work and since 1988, the journal Dissociation has been entirely devoted to the burgeoning literature, which has rather loosely come to be known as 'the trauma literature'.

In this review, we briefly consider the definition of the disorder and review progress in the field of measurement of dissociative states. Trauma and dissociation have been the focus of much recent work. Less work has been performed on the theoretical understanding of dissociative states, particularly from a psychoanalytic standpoint. New or modified therapeutic approaches have been developed for these patients from a variety of theoretical perspectives; outcome studies using these approaches are considered. We have not reviewed the growing literature on dissociation as a personality trait and studies applying hypnosis and the construct of hypnotizability to the problem of dissociation. We omitted full coverage of the complex literatures on the viability of the concept of dissociative identity disorder and the heated debate concerning false memory syndrome. We also restricted the review to studies of adults because few investigations of dissociation in children exist.

The nature of dissociative disorders

Dissociative disorders generally involve an alteration of consciousness, affecting memory and identity [3]. Spiegel and Cardena [4] defined dissociation as 'structured separation of mental processes (e.g. thoughts, emotions, connotation, memory and identity) that are ordinarily integrated' (p 367). This definition implies a broader set of phenomena than are covered by the DSM-IV section on dissociative disorders [5]. DSM-IV includes dissociative amnesia, in which the individual is unable to recall a limited segment of traumatic or stressful personal information; dissociative fugue, characterized by a sudden departure from home or place of work, accompanied by a confusion of personal identity; dissociative identity disorder, in which the individual shows more than one identity or personality state, which control experience, thought and action and preclude integrated recall of personal information; depersonalization disorder, characterized by a sense of detachment from one's mental processes or bodily experience but retaining reality testing and causing distress; and dissociative disorder not otherwise specified, which includes derealization, dissociative trance disorder, unexplained loss of consciousness and Ganser syndrome.

Whereas all the above categories are examples of dissociation, from a psychotherapeutic point of view, DSM-IV does not address the complexity and heterogeneity of psychological states associated with the separation of mutually exclusive psychic experience. Other disorders that seem to be linked to DSM-IV dissociative disorders, by virtue of aetiology and underlying dysfunction, may be conversion disorders [6], somatization disorders [7] and
post-traumatic stress disorder [8,9]. Spiegel and Cardena [10] took a clinically more helpful stance in identifying dissociation as a form of defence, which involves a particular structuring of incompatible mental contents, in which one type of content is able to exclude another from consciousness.

An individual with dissociative symptoms separates him or herself radically from an aspect of experience, causing a major disruption in the continuity of autobiographical narrative [11]. It is the motivation for the defensive exclusion of experience from the autobiographical narrative that links dissociation to the experience of trauma. It is probably empirically incorrect to assert that all instances of dissociation are linked to trauma [4]; furthermore, only a minority of individuals manifest dissociative states following traumatic experiences [9]. Janet [12,13] proposed a two-component theory of dissociation. The author suggested that dissociation occurred in response to stress but he also suggested that certain people were constitutionally predisposed to this disorder by virtue of their 'degenerescence', their lack of capacity to unify content-specific elementary structures into a singular consciousness. Both these lines of explanation can be traced in current accounts of dissociative states (see Kihlstrom et al. [14] for a current account of Janet's corpus).

The measurement of dissociative experience

Putnam [15] was one of the first authors to show empirically that a personality dimension represents a continuum between minor dissociations in everyday experience and major pathology, such as dissociative identity disorder. Using a 28-item questionnaire, the Dissociative Experiences Scale (DES), Bernstein and Putnam [16] asked patients to indicate the percentage of time that they experienced disturbances of awareness, memory, identity and so on. The validity of the DES in identifying individuals with dissociative disorders has been shown in a number of studies [17] and Carlson et al. [18] demonstrated its usefulness as a screening measure for dissociative disorders.

In a population survey, Ross et al. [19,20] showed that the majority of people report dissociative experiences 10% of the time or less. DES scores are, however, continuous, with no suggestions of bimodality. Steinberg et al. [21,22] designed the Structured Clinical Interview for Dissociative Disorders, which is commonly used in epidemiological studies. Against the structured interview, a DES cut score of 30 was found by Carlson et al. [18] to have the highest levels of sensitivity and specificity. This cut score is exceeded by 5-6% of normal samples [23]+.++.

Other available instruments that are useful in screening for dissociative disorders include the Perceptual Alteration Scale [24], the Questionnaire on Experiences and Dissociation [25] and the Dissociation Questionnaire [26]. These questionnaires are all highly correlated and appear to have overlapping factor structures [23]+.++.

The prevalence of dissociative disorders


The prevalence of dissociative disorders is controversial and clearly affected by cultural factors. Few studies have used rigorous epidemiological criteria to estimate prevalence. Chu and Dill [27], using the DES, found 23% of 90 consecutively admitted patients to have scores above the cut-point of 30. Quimby and Putnam [28] found 30% in a similar study. Using the Structured Clinical interview for Dissociative Disorders, Ross et al. [29] reported a prevalence rate of 5.4% for dissociative identity disorder among psychiatric inpatients. Saxe et al. [30] found that all consecutive admissions who scored above 25 on the DES had some form of dissociative disorder; the chart review of these patients, however, illustrated that dissociative disorder had only been recognized in 21% of these individuals. These disorders are therefore likely to be underreported in clinical prevalence studies.

**Stress and dissociation**

Individuals with dissociative disorders frequently recall experiences of trauma, abuse and neglect [4]. More than 90% of patients who meet the criteria for DSM-IV dissociative identity disorder report histories of severe physical and sexual abuse [31-33]. It is notable that in the Coons and Milstein study [31], the reports of 17 out of the 20 patients were independently corroborated. It should also be noted that specifically stress-related disorders, such as acute stress disorder and post-traumatic stress disorder, are known to be associated with pervasive dissociative symptomatology [5], such as reduction of awareness of one's surroundings, selective amnesia, derealization and a subjective sense of numbing and detachment. Furthermore, patients who show acute stress disorder, in which the dissociative symptoms (particularly numbing and detachment) are especially marked, are more likely to develop post-traumatic stress disorder [34,35].

Anderson et al. [36], in a study of 51 women who had sought abuse counselling, found 88% to have a diagnosable dissociative disorder and 55% with dissociative identity disorder. In a smaller sample, Rowan et al. [37] found that 70% of adult help-seeking survivors of childhood sexual abuse met criteria for post-traumatic stress disorder. DiTomasso and Routh [38] reported highly significant correlations in 312 undergraduates between the DES and childhood experiences of physical punishment and sexual abuse. In a clinical sample of 56 patients, Kirby et al. [39] reported that patients with more frequent and earlier experiences of abuse had significantly higher scores on the DES. However, Nash et al. [40], in a study of 105 abused and nonabused women, found that although abuse was associated with the greater use of dissociation, this difference disappeared when the degree of family pathology was controlled for.

Dissociative amnesia, in which memory loss occurs after a traumatic event, is a highly controversial aspect of this condition. In a questionnaire study, Cardena and Spiegel [9] found no evidence for partial or full amnesia among dissociative reactions to the San Francisco Bay area earthquake, although the authors reported anecdotal accounts of severely affected individuals, suggesting that partial forms of amnesia may have occurred. Similarly, North
et al. [41], in their study of post-traumatic stress disorder in 136 survivors of the mass murder spree in a Texas cafeteria, found symptoms of amnesia in only 10% of the survivors, whereas intrusive recall, dreams and nightmares and avoidance of thinking about the events and reminders were present in 60-80%. The British Psychological Society working party's report on the false memory controversy [42++] also reported an absence of amnesia in survivors of the Marchioness disaster.

A full discussion of the controversy concerning therapists' suggestions and other biases affecting the recall of childhood sexual abuse is beyond the scope of this review (see Lindsay and Read [43++]). In a survey of 330 psychologists [44], 24% reported physical or sexual abuse, 40% of these had forgotten the abuse for some period and about one-half had begun to retrieve the memories in therapy. In one-half of the group in which abuse was forgotten, the trauma was externally corroborated. The likelihood of forgetting was not related to the nature of abuse (sexual or nonsexual, within or outside the family) or to the age or sex of the individual. It was, however, related to severity of abuse: individuals who had experienced multiple forms of abuse were far more likely to report forgetting that the experiences had happened. Similarly, Williams [45]+ noted that 38% of women did not report the severe sexual abuse that they were known to have experienced in childhood. Loftus et al. [46]+ cautioned against interpreting these findings as evidence for the 'repression' of these experiences: many of these women were so young at the time that they could not be expected to remember, whereas some may have chosen not to confide in the interviewer and others may have been manifesting 'normal forgetting'. Williams [47] addressed these objections and suggested that simple forgetting does not describe adequately the complex processes that influence memories of child sexual abuse. The immense subjective significance of the event would counsel against equating laboratory studies of forgetting with what must lie behind a woman failing to report that she was (for example) raped at the age of 12 by her father.

The issue of the relationship between trauma and dissociative states is clearly a complex one. Terr [48] distinguished Type I and Type II traumatic events. Type I involves single, unexpected, devastating events, such as natural disasters or rape; these result in hyperarousal and elaborate processing of the experience, which if coupled with inadequate processing capacities may lead to a distorted internal representation. Dissociation then lies in the poor integration of these events into consciousness. Type II traumas are seen as the consequences of longstanding threats (combat, ongoing physical and sexual abuse), in which, fear of recurrence and the sense of helplessness result in profound and lasting changes in the sense of self. Adaptation, the wish to make sense of the experience, may involve a modification of the self-structure (low self-esteem, guilt, shame and so on), the fantasy of omnipotent powers and control over the trauma, massive denial and strategies to remove the experience from conscious awareness.

Limited evidence for Terr's [48] model exists. Using a similar schema, it was suggested in one paper [49] that a lack of the capacity to reflect on mental states in self and other (including the abuser) may be critical in determining
the long-term consequences of abuse. The inhibition of this capacity could be a consequence of and an adaptation to abuse: the abused child may find it too painful to contemplate the mental state of the abuser, which clearly contains profound malevolence towards the child. This strategy, however, undermines the child's capacity to reflect on and adequately process the experience; serious psychiatric sequelae, including dissociation, may ensue.

**Psychoanalytic views of dissociative states and dissociative identity disorder**

The psychoanalytic approach to trauma is riddled with paradox. The psychoanalytic theory of neurosis is originally and fundamentally a trauma theory, whether traumatic experiences are conceived of as external or intrapsychic. Simon [50] acknowledged the problem psychoanalytic theory has had; taken from the index of Fenichel's [51] 1945 textbook The psychoanalytic theory of neurosis, the title of Simon's paper is "Incest—See under Oedipus complex": the history of an error in psychoanalysis [50]. Notwithstanding the limitations of classical theory, many concepts in object-relations theories are helpful in understanding the impact of trauma. Winnicott's [52] concept of potential space as an intermediate area between reality and fantasy has been adapted by many authors to explore this impact. Ogden [53] suggested that meaning is created through the possibility of negation (i.e. this is not real, it is only play) in the dialectic interplay between reality and fantasy in potential space. Disruption of this interplay may result in dissociation. Reality and fantasy are experienced as parallel but disconnected realities. A number of authors, including Stolorow et al. [54], Bollas [55, 56] and Usuelli [57], have linked disruption in the potential space to trauma on the one hand and, on the other, to individual failure to make sense of personal experience and so feel that it is real. Reality is preserved by concretization, impairment in symbolic thinking, play and the loss of the 'as if' quality of the transference. The individual with dissociative identity disorder is able to take on many personalities because the notion of selfhood and personality is without meaning to them. This condition, like all dissociative disorders, is seen as indicating an incapacity to hold in mind the totality of experience, which one then attempts to recreate in therapy.

**Psychoanalytic psychotherapy**

The aim of psychodynamic psychotherapy with these patients involves trying to establish an experience of feeling cared for and understood by another person, reducing the intense annihilatory anxieties that have been evoked by contact in the traumatic past. The therapeutic process is seen in terms of the containment and holding function of the interpersonal relationship, in which projected affects are processed and reintrojected as tolerable affective experience [58, 59]. Bromberg [60] evocatively described how the therapist must resist his inclination to correct the patients faulty perception of reality and instead create a relationship in which previously unsymbolized experiences can
find expression. A similar model of therapeutic change was put forward by Fonagy and Moran [61].

Unfortunately, evidence for the efficacy of psychodynamic techniques with dissociative disorders is sparse. Perl et al. [62] found positive benefit in 17 sexual assault victims treated in an open trial using a group approach, although no quantitative measures were used. Brom et al. [63] contrasted psychodynamic therapy, hypnotherapy and systematic desensitization with a large sample of patients with trauma, a small proportion of whom met the criteria for post-traumatic stress disorder. Patients receiving dynamic therapy showed the greatest reduction in avoidant symptoms, whereas hypnotherapy and systematic desensitization led to more reduction in intrusive thoughts.

**Interpersonal group therapy**

Group and family based treatments for trauma-related disorders are summarized by Allen and Bloom [64]. The majority of treatments offered for victims of sexual abuse are broadly based on interpersonal principles, use relatively short-term transactional groups and aim to decrease the survivor's sense of isolation, stigmatization, secrecy and shame [65,66].

Alexander et al. [67] found that 10-week interpersonal group therapy was more effective than a waiting list condition. Hazzard et al. [68] reported on a study with 148 adult female sexual abuse survivors who volunteered to participate in year-long therapy groups; 102 completed the treatment. Comparison of before and after therapy suggested improvements in locus of control, sexual symptoms and distress but only a marginally significant reduction in dissociation. Counselling after crises may have a primary preventive function in helping survivors stabilize their lives and regain a sense of safety [69]. Terr [70] recommended mini-marathon groups, in which survivors are able to tell their stories a number of times to help them integrate the reality of the events and to reduce defensive dissociative strategies. Such groups may also facilitate the construction of social support networks.

**Family therapy**

Evidence is accumulating that psychological trauma spreads up and down generations. For example, Famularo et al. [71] found that children were more likely to develop post-traumatic stress disorder after maltreatment if their mothers had histories of post-traumatic stress disorder. Traumatized and traumatizing families are described as constricted in intimacy and expressiveness with unpredictable episodes of verbal and physical aggression, weak bonds and a lack of empathy between family members. Bentovim [72] has termed these highly dysfunctional family systems 'trauma-organized family systems'. Deceit, isolation, confusion, boundary diffusion, triangulation and abusive power arise in a system focused on acting as opposed to talking or thinking. The denial of violence is seen as the major barrier: intrafamilial trauma is dissociated by the family system, just as it comes to be dissociated in the mind of the individual [73]. When the barrier of denial is overcome,
family therapy aims to help recapitulate the traumatic event, allowing for the expression of dissociated affect and the integration of the traumatic experience into a whole family story. Unfortunately, although family therapy is widely used to address trauma within the family, the outcome of these approaches has not been evaluated systematically [64].

**Cognitive and behavioural psychotherapy**

Classen et al. [74] distinguished two components in the treatment of trauma: the intellectual and the relational. Whereas the former emphasizes the meaning of the trauma and its implications, the latter may focus on developing relationships that help the survivor to feel supported, valued and connected to others. Dissociative reactions to trauma usually involve unintegrated intense affect connected to guilt about the trauma. Therapists therefore tend to use cognitive restructuring techniques (and sometimes hypnosis) to help the survivors reduce this sense of responsibility [75]. Strengthening the social network of such individuals may reduce the sense of vulnerability and rebuild trust.

Some evidence exists that cognitive-behavioural therapy is effective in the intermediate and long term. The effects are small and the results mixed. Richards et al. [76] administered imaginal and in-vivo exposure to 14 patients with chronic post-traumatic stress disorder. A combination of imaginal and in-vivo techniques in either order resulted in clinically significant gains. Anxiety management techniques, using relaxation, biofeedback and cognitive restructuring in combination with prolonged exposure and stress-inoculation training (role-playing, modelling, thought-stopping, guided self-dialogue) have been shown to be effective in combination and separately [77]. Stress-inoculation training may have been the most effective component; one-half of the patients no longer met the diagnostic criteria for post-traumatic stress disorder. Foa et al. [78] suggested that long-term effectiveness is greatest if a combination of treatments is used, in particular, stress-inoculation training, perhaps with cognitive restructuring and exposure together.

**Conclusion**

Dissociative states are measurable, occur in 5-10% of the normal population and appear to be related to personality structure. Predisposed individuals may respond to psychosocial stress with dissociative disorders or other disorders closely associated with them, such as post-traumatic stress disorder. Treatment programmes for stress-related dissociative reactions are offered by all major therapeutic approaches with different but plausible rationales. Evidence on treatment outcome is limited and so far favours the adoption of structured and systematic approaches. All approaches, in different ways, tend to include increasing psychological exposure to the trauma, which may serve to confront the discontinuities of experience so fundamental to these disorders. In this way, the different therapies may help the individual to think about and integrate previously unacceptable experience.
References and recommended reading

Papers of particular interest, published within the annual period of review, have been highlighted as:

+ of special interest
++ of outstanding interest

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