DISSOCIATION AS A TRANSDIAGNOSTIC CONSTRUCT. A COMMENTARY ON ELLERT R. S. NIJENHUIS’ PAPER “TEN REASONS FOR CONCEIVING AND CLASSIFYING POSTTRAUMATIC STRESS DISORDER AS A DISSOCIATIVE DISORDER”

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A major problem with psychiatric diagnoses concerns their specificity. Clinicians should apply consistent labels that identify, describe, and confine the patients’ condition of being peculiar to a particular group of symptoms and behaviors. Specificity is a crucial aspect of validity, and it is of course necessary for advances in treatment and scientific progress more generally. However, sometimes we should also remember that psychiatric disorders are not entities per se. As clinicians, we can observe patterns of symptoms and problem behaviors, we can even look at physiological, psychosocial, and genetic factors that are related (possibly on both an empirical and theoretical level) to these symptoms and behaviors, but in the end we can only infer biopsychosocially consistent prototypes that adhere to our current understanding of psychological health and disease. Therefore, any classification of psychiatric disorders is an attempt to operationalize multifaceted and multidimensional constructs, as human experiences are. Classifications are important, especially when they assume shared meanings within a scientific community and extend to culture and society, but they cannot describe the idiographic factors that make an individual who he or she actually is. Furthermore, when human experiences are complex and multifaceted—as those related to the concept of dissociation are—an excessive search for specificity in the definition and circumscription of a given disorder may result in a reduced sensitivity, in other terms in the risk of a parcelization of the psychic and behavioral mechanisms involved in the disorder, which may results in missing important links and common features shared by different disorders. As a matter of fact, it is not so common in clinical practice that a patient can be categorized into a single diagnostic class: for example, many substance abusers and many bulimic patients show comorbid personality disorders and/or depression, many obsessive-compulsive patients and many people suffering from somatic symptom disorder also show anxiety disorders, many people with anxiety disorders also suffer from depressive disorders, and so on. How these considerations relate with dissociative symptoms and dissociative disorders?

In the words of Cardeña and Carlson (2011, pp. 251-252), dissociative symptoms are “characterized by (a) a loss of continuity in subjective experience with accompanying involuntary and unwanted intrusions into awareness and behavior (so-called positive dissociation); and/or (b) an inability to access information or control mental functions, manifested as symptoms such as gaps in awareness, memory, or self identification, that are normally amenable to such access/
control (so called negative dissociation); and/or (c) a sense of experiential disconnectedness that may include perceptual distortions about the self or the environment.” Therefore, dissociative symptoms concern distinct yet interrelated phenomena, that can be observed at different degrees in different disorders. Moreover, according to DSM-5 (APA 2013, p. 291) dissociative disorders “are characterized by a disruption of and/or a discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior. Dissociative symptoms can potentially disrupt every area of psychological functioning” (italics added). It is rather clear that a psychological process called dissociation is necessarily implied in these symptoms and disorders, because they unequivocally take its name. Mostly important, what is not (and cannot be) expressed in the DSM-5—but is implicit in this definition—is that the process of dissociation is potentially ubiquitary. Again, disruptions and discontinuities in psychological functioning can be observed in almost every disorder, which means that dissociation could relate with almost every disorder. This suggests that dissociation may result in a key variable for a comprehensive understanding of psychopathology, regardless of the specific disorder observed (Schimmenti and Caretti 2014).

Nijenhuis' theory of structural dissociation, as presented in his article published in Psichiatria e Psicoterapia (2014) and in a number of other papers, indirectly addresses the problem of validity of the diagnosis, and its specificity in particular. Nijenhuis stated this explicitly in another paper concerning the definition of dissociation and its relation to post-traumatic stress disorder (Nijenhuis and Van der Hart 2011): “the definition of dissociation needs more specificity” (p. 469), “we are particularly concerned about the discriminant validity of liberal definitions of dissociation” (p.470), “we have tried to define a particular domain of phenomena and distinguish them from other phenomena so that the convergent and discriminative validity of the demarcated domain and its mediating actions (processes) can be studied” (p. 471). On one side, we believe that Nijenhuis’ theory has impressively improved our understanding of dissociative disorders, particularly dissociative identity disorder: the distinction between apparently normal parts (ANPs) and emotional parts of personality (EPs), which can be traced back in the works of Janet (1907) and Myers (1940), is consistent with a wealth of empirical and theoretical research showing the dramatic impact of traumatic experiences on the individuals’ integrative processes. Moreover, Nijenhuis’ theory may be useful applied in the assessment and treatment of dissociative and post-traumatic stress disorders (Van der Hart, Nijenhuis and Steele 2006). On the other side, both empirical research and clinical wisdom suggest that some of the assumptions implied in Nijenhuis’ theory of structural dissociation, as expressed in “The haunted self” (ibidem) and in other works, are too restrictive. In fact, several studies showed that there are subgroups of patients who did not receive a dissociative disorder diagnosis but were suffering from other psychiatric disorders, who scored high on dissociative symptomatology.

In our view, the constraints imposed by structural dissociation theory are not able to catch some critical features of dissociation as a psychological mechanism. In fact, Nijenhuis (2014, p. 80) stated that “the formal cause of trauma is the existence of two or more conscious subsystems of the personality as a whole biopsychosocial system” (italics added). While we agree with Nijenhuis that trauma responses may be dissociative in nature, strongly supported by empirical research (Dalenberg et al. 2012, 2014), we would argue that there is neither theoretical nor
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Clinical necessity to consider the subsystems involved in traumatic states as conscious. In fact, several patients suffering from different disorders may be qualified as structurally dissociated, because they show unintegrated mental and bodily states related to past trauma, as parts of their psychic and behavioral functioning that seem to operate independently from the other parts (Schimmenti and Caretti 2014). These parts appear at specific moments, in relation with internal or external triggers, and likely involve a system of traumatic memories with their associated emotional, behavioral and physiological states (van der Kolk and Fisler 1995, Meares 2000). Indeed, studies on memory have observed that strong aversive stimuli, as those that can be involved in severely stressful events, can even lead to strong association between these stimuli and the selected response, thus enhancing the memory of the response (e.g. Vriends et al. 2011), but research has also suggested that the reconsolidation of memory, i.e. the ability to recall specific information about an event, can be impaired in many cases (e.g. Schore 2001)—most likely due to the negative effects of glucocorticoids on the hippocampus and to other neurobiological pathways involved in stress responses. These properties of memory under the condition of trauma can prevent the episodic memory (the memory that “I was there; this happened to me”) from being retained in the first place, whereas the procedural memory and emotional learning may remain operative (Solms and Turnbull 2002).

How could we call this process, if not dissociation? This is not a matter of repression. Repression involves the individual’s unconscious attempt to repel one’s own desires, impulses, and memories not allowing them to be expressed, which implies (at least at the beginning of the process) a proactive attitude toward the distressful and/or conflictual stimuli that are pushed into the unconscious system. In many clinical conditions, and not only in dissociative or post-traumatic stress disorders, we often observe disturbing and/or fluctuating ego-states, and there is no theoretical reason to rebut the idea that these states represent the consequences rather than the causes of a disruption in mental and behavioral functioning, generated by one or more unprocessed traumata and subsequent dissociation. This may happen because traumatic states and related feelings are organized procedurally rather than symbolically, and they may involve both conscious and subconscious subsystems that can operate at different levels of complexity, awareness, and pervasiveness. These levels of functioning of the subsystems can be related to a number of variable (e.g. age, frequency, and intensity of traumata, social support or betrayal, developmental experiences, and so on, and the interactions between these factors and genetic factors as well), but they all respond to the logic of dissociation, which allows a psychic survival to the individual when stressful experiences are perceived as overwhelming (Schimmenti and Caretti, 2014).

We believe that every attempt to increase the validity of the “Dissociative Disorders” diagnostic class might be very important for a better understanding of these disorders. However, we also think that dissociation, as a psychic process, might be involved in many other disorders, and that its potential role should be considered for both assessment and treatment purposes. In our view, the construct of dissociation cannot and should not be confined to evident post-traumatic and dissociative disorders. This because theories and taxonomies are relevant cultural artifacts about a given knowledge, but clinical practice is something more: it might also be a transformative action for individuals who suffer from mental disorders.
LA DISSOCIAZIONE COME COSTRUTTO TRANSDIAGNOSTICO: COMMENTO ALL’ARTICOLO “TEN REASONS FOR CONCEIVING AND CLASSIFYING POSTTRAUMATIC STRESS DISORDER AS A DISSOCIATIVE DISORDER” DI E.R.S. NIJENHUIS

Riassunto


Parole chiave: dissociazione, trauma, classificazioni diagnostiche, trattamento

Abstract

A recent article published in Psichiatria e Psicoterapia [Nijenhuis ERS (2014). Ten Reasons for conceiving and classifying Posttraumatic Stress Disorder as a dissociative disorder. Psychiatry and Psychotherapy 33, 74-106.] has provided strong theoretical and empirical support to the reconceptualization of posttraumatic stress disorder (PTSD) as a dissociative disorder. In fact, Nijenhuis’ theory of structural dissociation represents an important advance in the understanding of dissociative processes. However, both theoretical and empirical research suggest that dissociative processes are potentially related to many psychiatric disorders, and not only to PTSD and dissociative disorders as it is fixed by specificity constraints of Nijenhuis’ model. Therefore, in this commentary we suggest (on the basis of epistemological considerations, theory and research) that a transdiagnostic dimension of dissociation, as a mental process, should be considered within a theory of structural dissociation. Furthermore, a wider consideration for the role that dissociation might play in many psychiatric disorders can be crucial for clinical practice.

Keywords: dissociation, trauma, diagnostic classifications, treatment

References

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