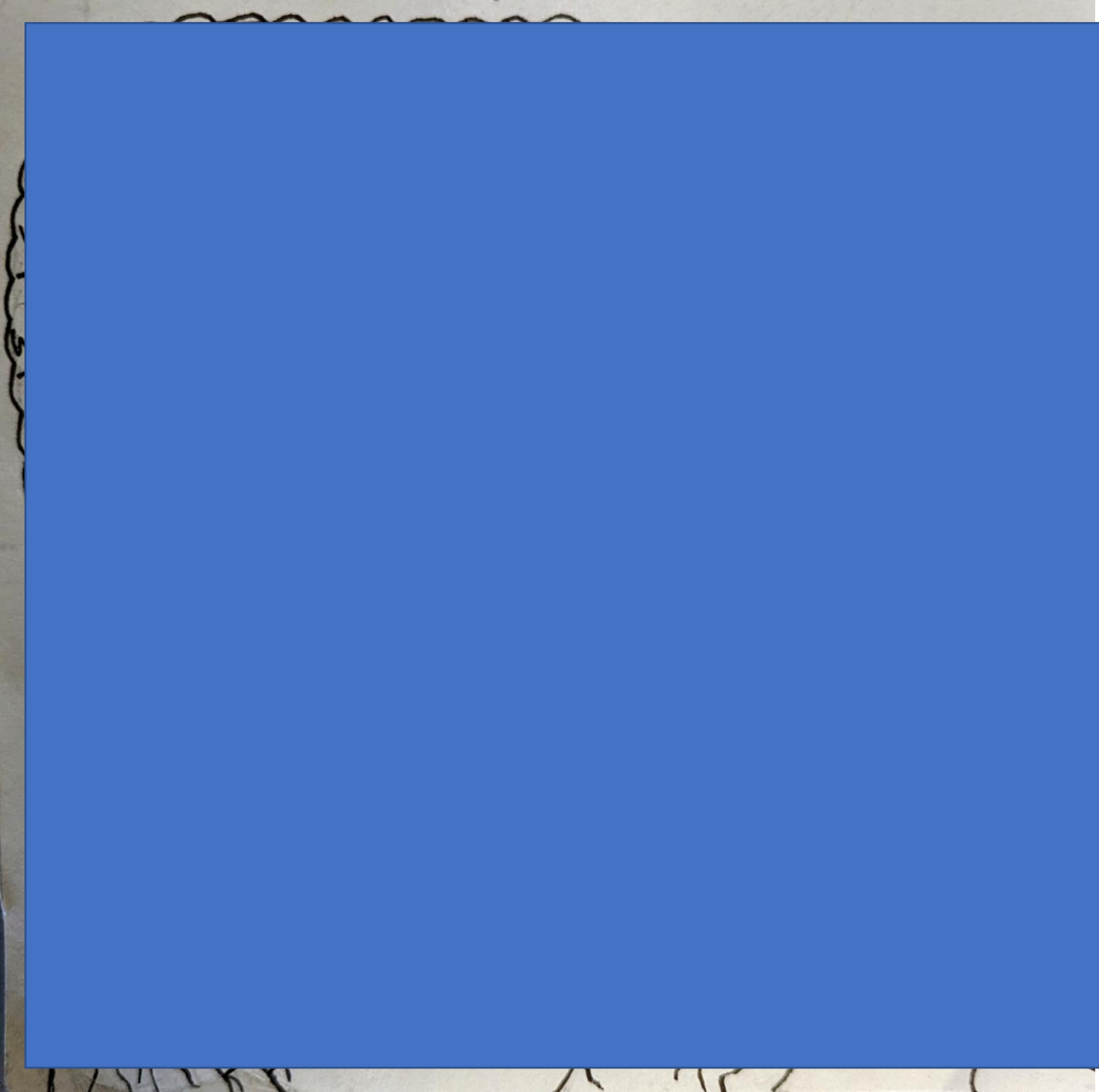
Psychotic Symptoms in Trauma-Related Disorders

Dr Leonhard Kratzer



A few (very) bold statements

- Psychotic symptoms like AVH are common in trauma-related disorders and BPD
- The ICD-11 is wrong: AVH in trauma-related disorders are neither quasi-psychotic nor pseudohallucinations, but phenomenologically similar to those in psychosis
- AVH are underlain by the same mechanisms in psychosis, trauma-related disorders, and BPD, i.e. first and foremost dissociation
- Definitions aren‘t explanations, psychiatric disorders aren‘t latent entities, symptoms aren‘t signs, and we need a phenomenological approach to dissociation
- *Psychotic PTSD* is not a thing. Yet, (Partial) Dissociative Identity Disorder is underdiagnosed and undertreated (or treated using pseudoscientific approaches)
- The treatment of severe dissociative symptoms and disorders is *a simple thing that is hard to do*

Kratzer et al. (2023)

How Important Is Reprocessing in Personalized Multicomponent Therapy? Analyzing Longitudinal Data of Inpatients With Severe PTSD

Leonhard Kratzer, PhD, Peter Heinz, MD,* Matthias Knefel, PhD,† Dina Weindl, PhD,† Stefan Tschöke, MD,‡§ Sarah V. Biedermann, MD,||§ Johanna Schröder, PhD,||¶ and Thanos Karatzias, PhD#¶,**#*

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Abstract: Treatment guidelines for complex presentations of posttraumatic stress disorder (PTSD) are often cautious about the reprocessing of traumatic memories and recommend multicomponent treatments that are widely used in clinical practice. Yet, the role of reprocessing in these multicomponent treatments remains unknown. Using naturalistic data of 97 patients treated for PTSD, we used a linear mixed model to investigate the role of reprocessing for the outcome at discharge and at 6-month follow-up. Treatment effects were significant and large ($g = 0.91–1.05$). The final model showed good fit and explained 51% of the variance. There was a significant main effect of time ($B = −8.1$ [−11.5; −4.8], $p < 0.001$), as well as a reprocessing by time interaction ($B = −17.2$ [−30.5; −3.8], $p = 0.012$), indicating better outcomes with higher levels of reprocessing. Hence, maximizing the amount of reprocessing used in multicomponent treatments for PTSD may significantly enhance outcomes.

Key Words: Posttraumatic stress disorder, eye movement desensitization and reprocessing, EMDR, exposure

(*J Nerv Ment Dis* 2023;00: 00–00)

Trauma-focused treatments for posttraumatic stress disorder (PTSD) are safe and efficacious in the long-term (Hoppen et al., 2022; Mavranezouli et al., 2020; Weber et al., 2021), irrespective of study quality (Hoppen and Morina, 2020; Morina et al., 2021) and across a wide variety of populations including survivors of childhood abuse (Ehring et al., 2014; Nosè et al., 2017; Roberts et al., 2015). Furthermore, effect sizes for trauma-focused treatments are larger compared with nontrauma-focused treatments or medication (Norman, 2022). Yet, a recent meta-analysis found an average dropout rate of 21% for guideline-recommended treatments of PTSD, despite that complex patients with comorbid substance use disorder, suicidal behavior, or psychotic symptoms are often excluded from randomized controlled trials (Varker et al., 2021). In samples with complex presentations of PTSD, dropout rates may be even higher (*e.g.*, 39% for cognitive processing therapy [Bohus et al., 2020]). Furthermore, most treatment studies have been conducted using the *DSM-IV* criteria of PTSD (Karatzias and Cloitre, 2019). This is problematic as recent evidence suggests that the structure and co-occurrence of symptoms differs for different trauma types (Karatzias et al., 2020; Stefanovic et al., 2022). Moreover, although intrusive memories are central to the understanding of PTSD (Duek et al., 2021), other aspects such as a negative self-concept are more central to complex traumatic presentations (Knefel et al., 2019), and functional impairment in such cases might be linked in particular to interpersonal difficulties and emotion regulation difficulties (Cloitre et al., 2005; Webb et al., 2022). Furthermore, a considerable proportion of efficacy and effectiveness studies of treatments of PTSD after complex trauma are problematic as they investigate PTSD symptomatology regarding a defined index trauma, that is, a single worst incident. This leads to significant underestimation of PTSD severity and overestimation of treatment effects in more complex cases (Priebe et al., 2018).

Hence, for the time being, there is insufficient evidence regarding treatment efficacy for complex PTSD as defined in *ICD-11* (Maercker et al., 2022). Whereas evidence-based trauma-focused treatments can be acceptable and effective for complex PTSD, there is evidence that childhood trauma is associated with worse treatment outcomes (Karatzias et al., 2019b; Melton et al., 2020). A recent component network meta-analysis concluded that in cases of PTSD after complex traumatic events, multicomponent interventions are most promising (Coventry et al., 2020). Multicomponent interventions are typically characterized by a combination of reprocessing of traumatic memories and skills trainings (Bohus et al., 2013; Cloitre et al., 2010; van Vliet et al., 2021). The optimal way to deliver multicomponent interventions and modular treatments remains unknown (Karatzias and Cloitre, 2019). Yet, it is widely accepted that the "one-size-fits-all" approach to the treatment of PTSD is failing patients (Cloitre, 2015) and that trauma-focused treatments need to be based upon shared decision making between patient and provider (Norman, 2022); be administered in a flexible, active, creative, and formulation-driven manner (Murray et al., 2022); and be personalized to the needs of individual patients (Cloitre et al., 2020b). For example, a dynamic and modular treatment of PTSD has been proposed for the treatment of complex PTSD (Karatzias and Cloitre, 2019), comorbid borderline personality disorder and PTSD (Bohus et al., 2013), comorbid somatic symptoms and PTSD (Kratzer et al., 2021b, 2021a), and sexual dysfunctions and PTSD (Kratzer et al., 2022a; Steil et al., 2021).

Multicomponent therapies for PTSD such as dialectical behavior therapy for PTSD (DBT-PTSD; Bohus et al., 2013), Skills Training in Affective and Interpersonal Regulation (STAIR) and Narrative Therapy (STAIR/NT; Cloitre et al., 2006), STAIR and eye movement desensitization and reprocessing (EMDR) (van Vliet et al., 2021), or dialectical behavior therapy and prolonged exposure (Harned et al., 2012, 2014) all share an exposure component. Exposure allows for fear activation and emotional engagement, as well as in-session and between-session habituation, and changes in trauma-related cognitions, all of which have been shown to be linked to better outcomes in the treatment of PTSD

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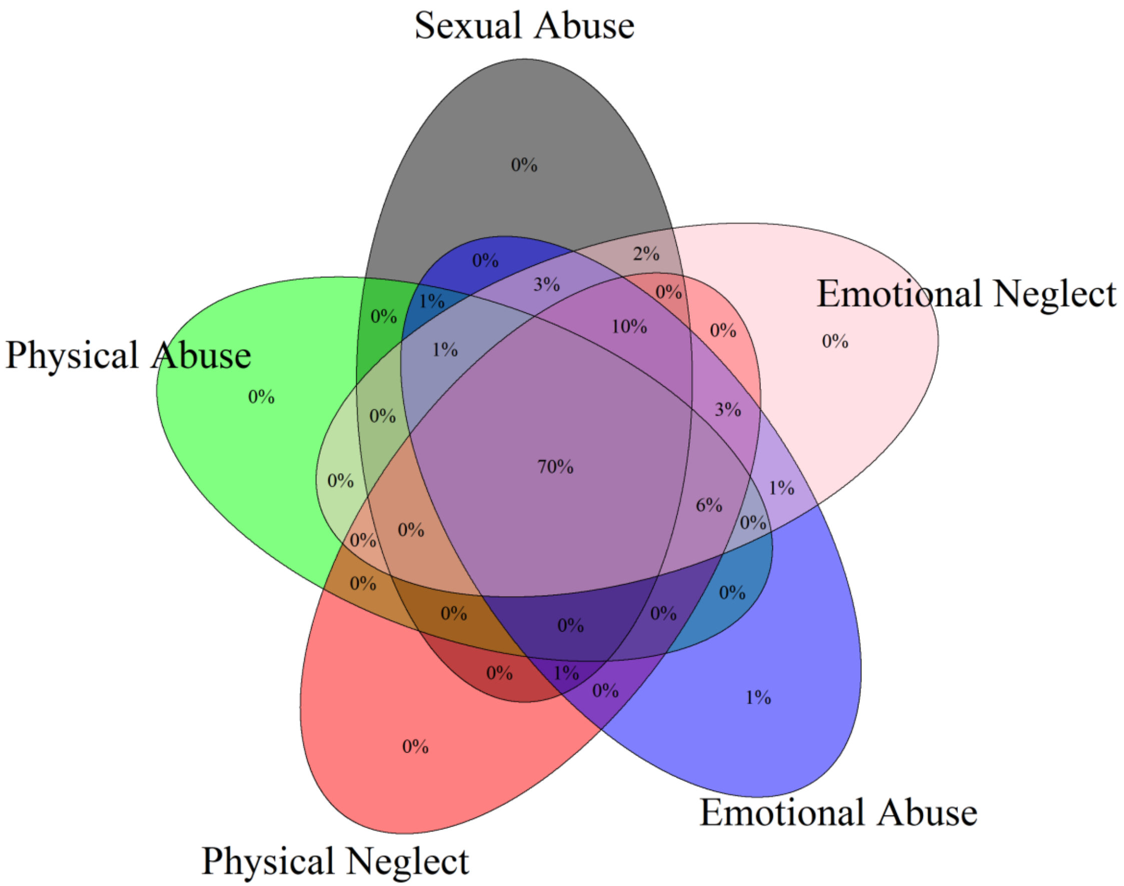

Kratzer et al. (2023)

ORIGINAL ARTICLE

How Important Is Reprocessing in Personalized Multicomponent Therapy? Analyzing Longitudinal Data of Inpatients With Severe PTSD

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*Department of Psychotraumatology, Clinic St Irmingard, Prien am Chiemsee, Germany; †Faculty of Psychology, University of Vienna, Vienna, Austria; ‡Clinic for Psychiatry and Psychotherapy I (Weissenau), Ulm University, Ulm; §Centre for Psychiatry Südwürttemberg, Ravensburg; ||Social and Emotional Neuroscience Group, Department of Psychiatry and Psychotherapy, Center of Psychosocial Medicine, University Medical Center Hamburg-Eppendorf; ¶Department of Psychology, Institute for Clinical Psychology and Psychotherapy, Medical School Hamburg, Hamburg, Germany; #School of Health and Social Care, Edinburgh Napier University; and **The Rivers Centre for Traumatic Stress, NHS Lothian, Edinburgh, Scotland, United Kingdom.

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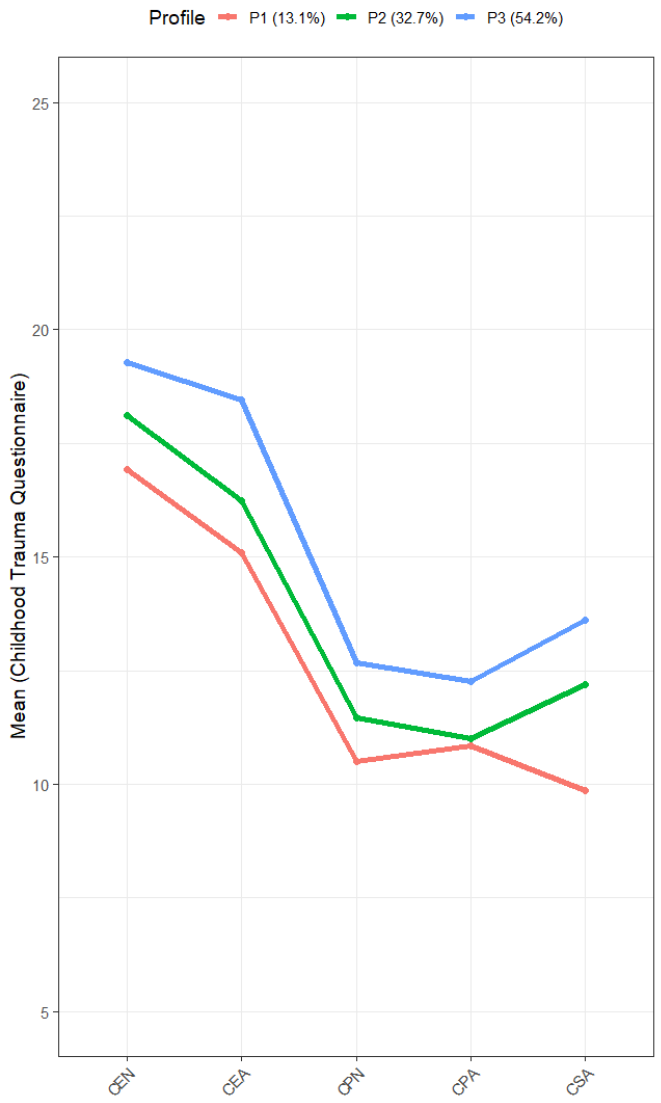
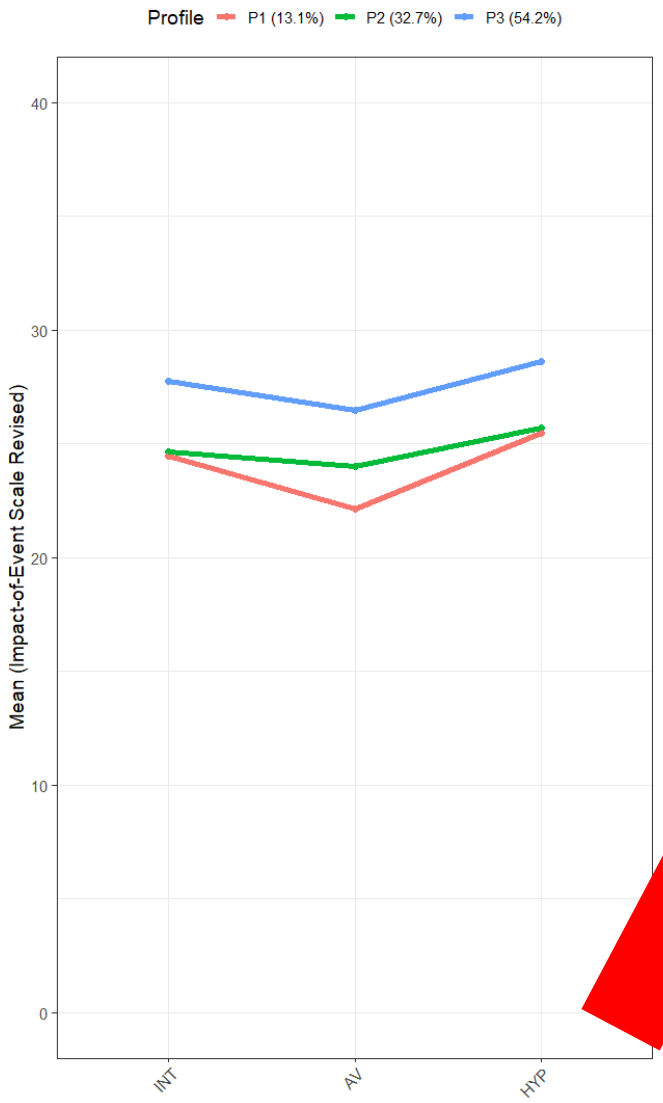
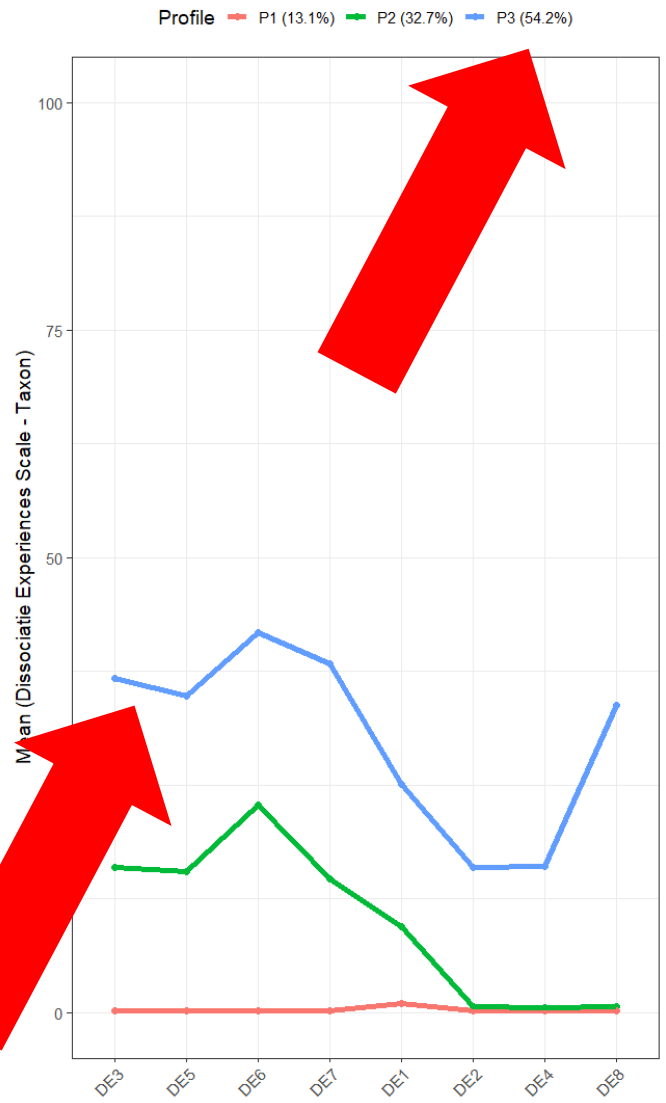
- 72.2% antidepressants, 21.7% anxiolytics, **50.5% antipsychotics**, 72.2% analgesics
- 43.3% at least one suicide attempt
- 94.9% history of multiple prior psychiatric inpatient treatments (max = 68)
- **22.7% reported to chronically suffer from auditory verbal hallucinations (AVH) most of the day (> 50%)**

LPA: Beyond the Dissociative Subtype (N = 1360)







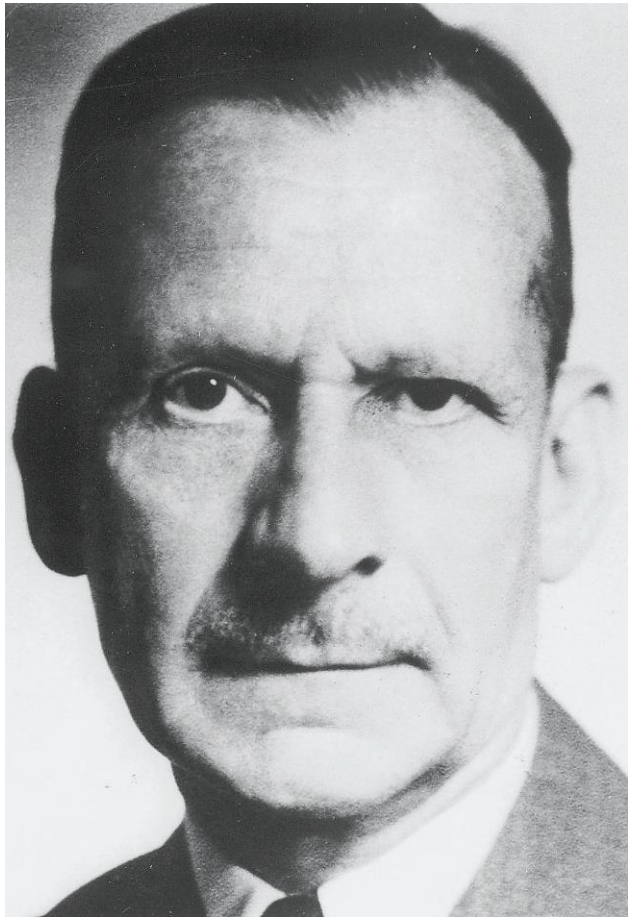
Dissociative Experiences

- DE1 = “Some people have the experience of finding themselves in a place and having no idea how they got there.”;
- DE2 = "Some people have the experience of finding new things among their belongings that they do not remember buying.";
- DE3 = “Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something, and they actually see themselves as though they were looking at another person.";
- DE4 = Some people are told that they sometimes do not recognize friends or family members.";
- DE5 = Some people sometimes have the experience of feeling that other people, objects, and the world around them are not real.";
- DE6 = "Some people sometimes have the experience of feeling that their body does not seem to belong to them.";
- DE7 = "Some people find that in one situation they may act so differently compared to another situation that they feel almost as if they were two different people.";
- DE8 = "Some people sometimes find that they hear voices inside their head which tell them to do things or comment on things that they are doing."

Schneiderian First Rank Symptoms (SFRS)

Schneider's description of **first-rank symptoms of schizophrenia** (**auditory hallucinations, thought insertion, delusion, …**) from General Psychopathology (1959):

> *'Audible thoughts; voices heard arguing; voices heard commenting on one's actions; the experience of influences playing on the body (somatic passivity experiences); thought-withdrawal and other interferences with thought; diffusion of thought; delusional perception and all feelings, impulses (drives), and volitional acts that are experienced by the patient as the work or influence of others. When any of these modes of experience is undeniably present, and no basic somatic illness can be found,* ***we may make the decisive clinical diagnosis of schizophrenia****'* (pp. 133-134)



Kluft, R. P. (1987). First-rank symptoms as a diagnostic clue to multiple personality disorder. *American Journal of Psychiatry*, *144*(3), 293–298.

Psychosis: A common comorbidity of PTSD?

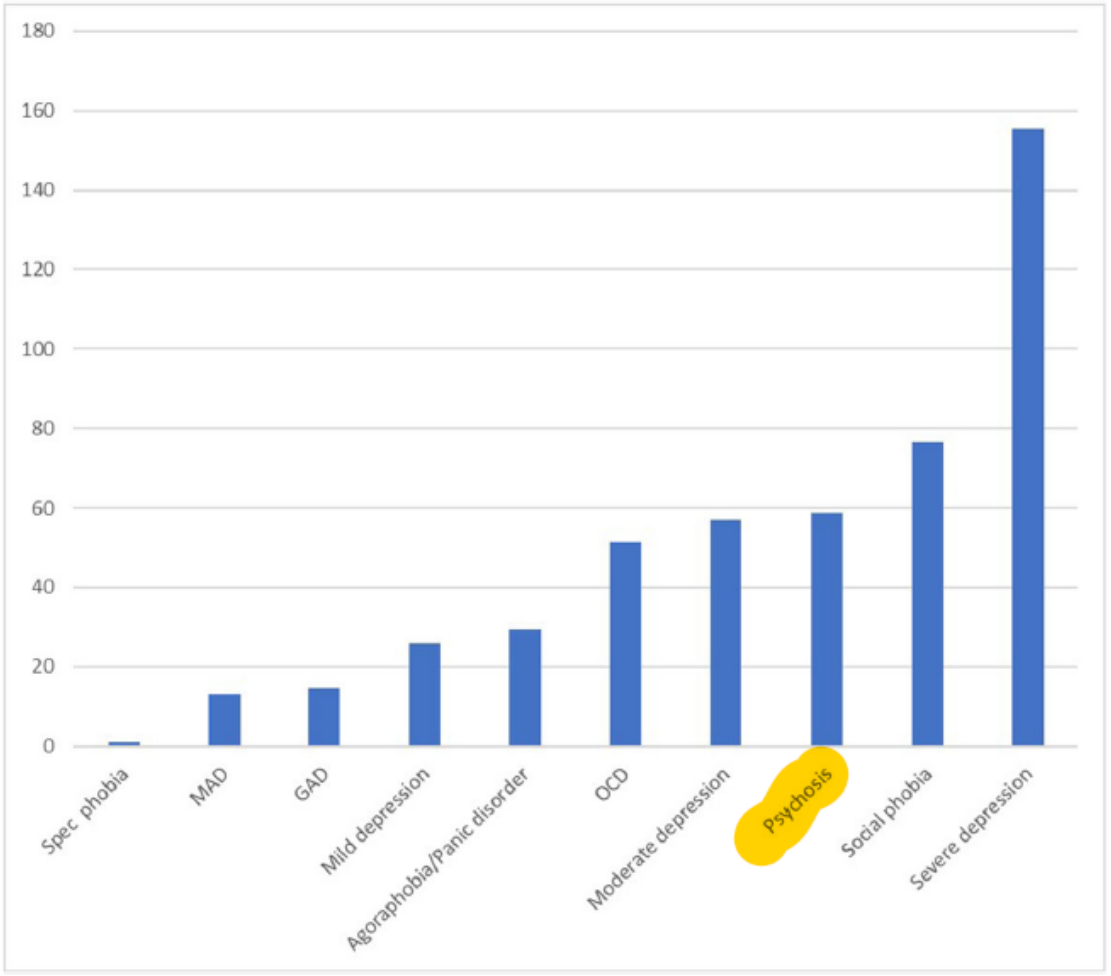


Fig. 1 Strength of association between PTSD diagnosis and other comorbidities as indicated by their odds ratio (OR)

Psychiatric Quarterly (2021) 92:321–330
https://doi.org/10.1007/s11126-020-09797-4

ORIGINAL PAPER

Check for updates

Psychiatric Co-Morbidities in Post-Traumatic Stress Disorder: Detailed Findings from the Adult Psychiatric Morbidity Survey in the English Population

T. Qassem[1,2,3,4] · D. Aly-ElGabry[3] · A. Alzarouni[5] · K. Abdel-Aziz[6] · Danilo Arnone[6,7]

Published online: 23 July 2020
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Abstract
Post Traumatic Stress Disorder (PTSD) is a condition which causes great sufferance to the individuals affected. The occurrence of comorbidities in PTSD is a frequent event with a negative impact on outcome. This study investigated the frequency of PTSD in relation to comorbidities by analyzing the results of the 2007 'Adult Psychiatric Morbidity Survey' in the English population, which included data on comorbidities. A population study conducted in the United Kingdom, this survey investigated the frequency of PTSD in the community and the relationship to comorbidities by adopting a random design to minimize selection bias, stratified by region and socioeconomic characteristics, and weighted according to design and non-response. The survey interviewed 7403 adults living in private households. Socio-demographic characteristics and psychiatric morbidity were systematically assessed. Results indicated that PTSD prevalence was 2.9%, with an excess in women (3.8%) compared to men (2.4%) as reported by the 2007 survey. Comorbidity was a very frequent occurrence in PTSD reaching 78.5% in affected cases. Major depression was the commonest condition and its frequency increased with symptoms severity up to 54%. Among anxiety disorders, social phobia was the most frequent, followed by generalized anxiety disorder, obsessive-compulsive disorder, agoraphobia and panic disorder. Substance use disorders were also common. The presence of psychotic symptoms was particularly significant with over 30% prevalence in PTSD. These results indicate that attention needs to be devoted to the presence of comorbidities. In view of the impact of comorbidities on PTSD severity, chronicity and functional impairment, early detection and treatment are likely to improve outcome.

Keywords Psychiatry · Post traumatic stress disorder · Comorbidities · Major depressive disorders · Survey

PTSD with secondary psychosis?

▸ Terrorprozess: 9/11-Angeklagter ist nicht verhandlungsfähig

Mitglied der "Hamburger Zelle"

9/11-Angeklagter ist nicht verhandlungsfähig

Stand: 22.09.2023 22:17 Uhr

Im anstehenden Terrorprozess um die Anschläge vom 11. September 2001 ist einer der fünf Angeklagten für prozessunfähig erklärt worden. Grund seien Misshandlungen in der Haft. Bei den islamistischen Attacken waren fast 3.000 Menschen getötet worden.

Ein Militärrichter auf dem US-Stützpunkt Guantanamo hat einen der Angeklagten der Terroranschläge vom 11. September 2001 für verhandlungsunfähig erklärt. Zuvor hatte ein Gremium von Militärärzten festgestellt, dass eine Jahre zurückliegende Misshandlung in Gewahrsam des Geheimdienstes CIA bei Ramzi Bin Al-Shibh eine Psychose ausgelöst habe.

„Das medizinische Gremium diagnostizierte im August bei Al-Shibh eine Posttraumatische Belastungsstörung mit sekundärer Psychose und zog eine Verbindung zu Folter und Einzelhaft während seiner vier Jahre in CIA-Gewahrsam nach seiner Festnahme 2002.“

Prog Neuropsychopharmacol Biol Psychiatry. 2019 January 10; 88: 265–275. doi:10.1016/j.pnpbp.2018.08.001.

Posttraumatic Stress Disorder with Secondary Psychotic Features (PTSD-SP): Diagnostic and Treatment Challenges

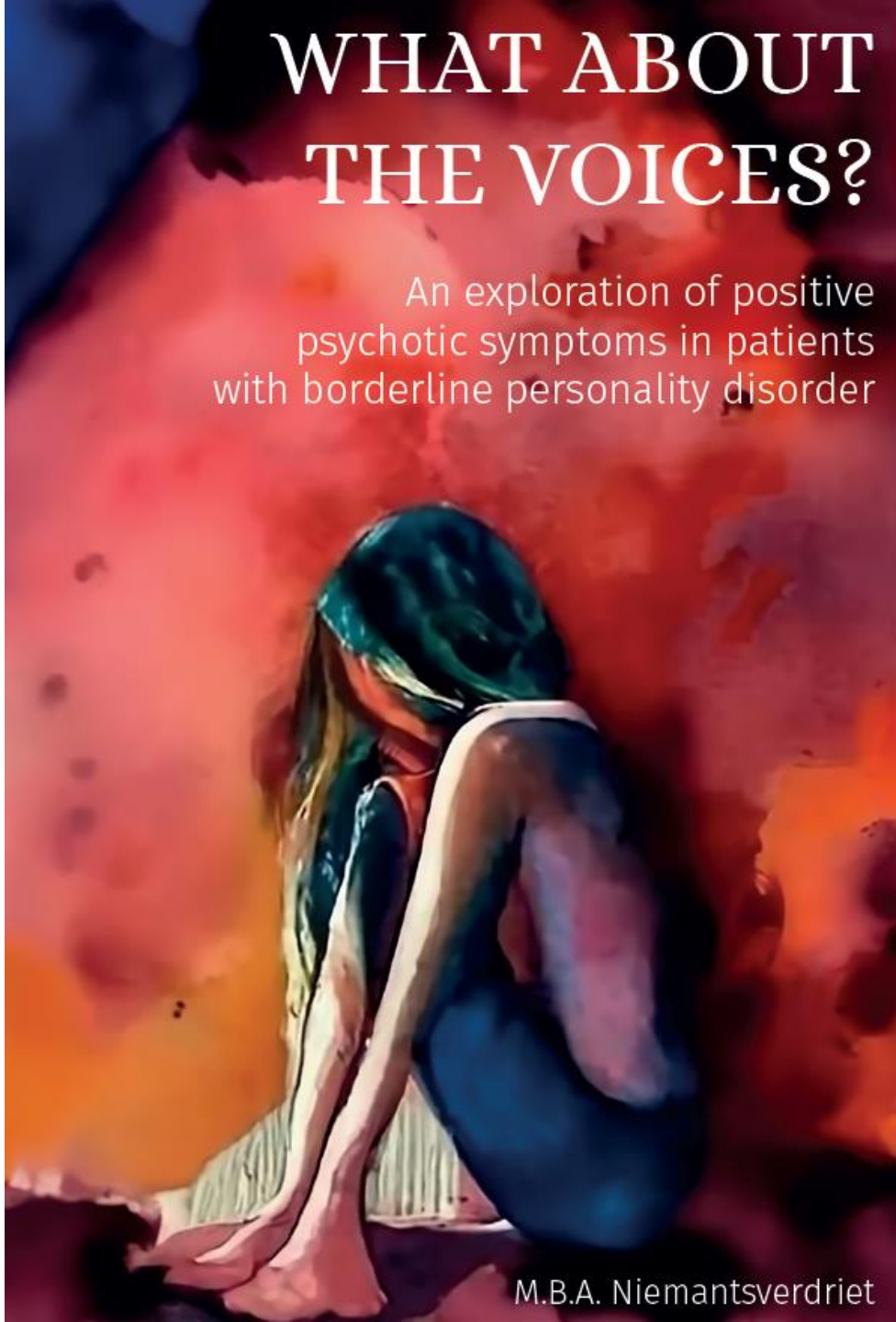
Ebele Compean, MD[a,b] and **Mark Hamner, MD**[a,b,*]

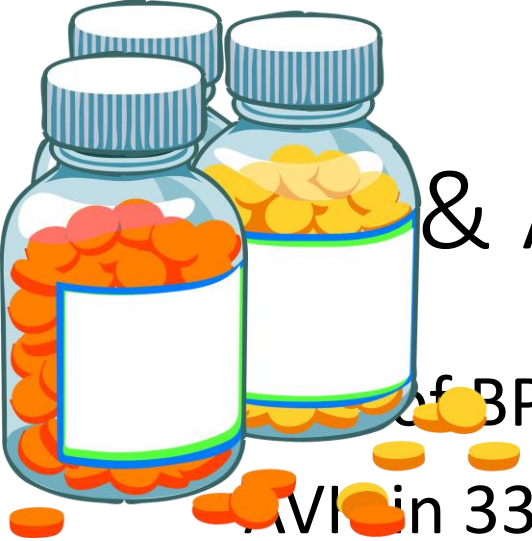
1. Meets DSM-V criteria for PTSD
2. Has positive psychotic symptoms, e.g. hallucinations and delusions
3. Cannot meet DSM-V criteria for another psychiatric disorder such as major depression with psychotic features, bipolar disorder with psychotic features, or primary psychotic disorder such as schizophrenia, brief psychotic disorder
4. PTSD symptoms precede the onset of psychotic symptoms (i.e no history of psychosis before the trauma)
5. Psychotic symptoms are not limited to flashback episodes
6. Needs preserved reality testing (i.e no formal thought dysfunction present)

Figure 1.
Proposed Diagnostic Criterion for PTSD with Secondary Psychotic Features (PTSD-SP)

BPD & AVH

- 30% of BPD patients report AVH
- AVH in 33% no further consideration, in 59% no treatment
- 10% Schizophrenia Spectrum Disorder
- AVH in BPD **“underassessed, underdiagnosed, undertreated“**
- Regret regarding a lack of psychopharmacological antipsychotic treatment
- No mentions of dissociation!





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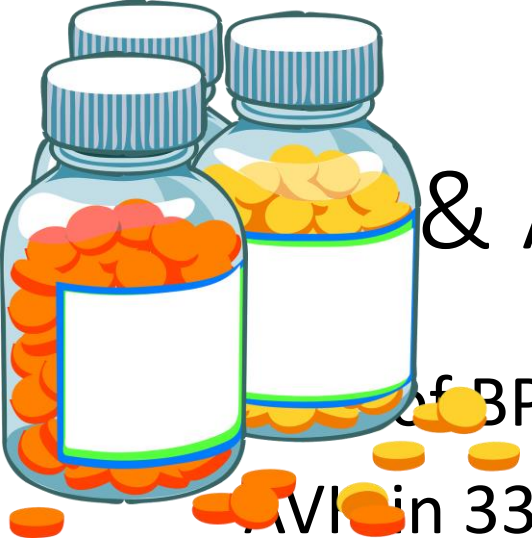
"… **all pharmacological treatments recommended today by treatment guidelines are useless or even harmful in BPD treatment**. On the other hand, our results support the usage of ADHD medications in BPD with comorbid ADHD symptoms."



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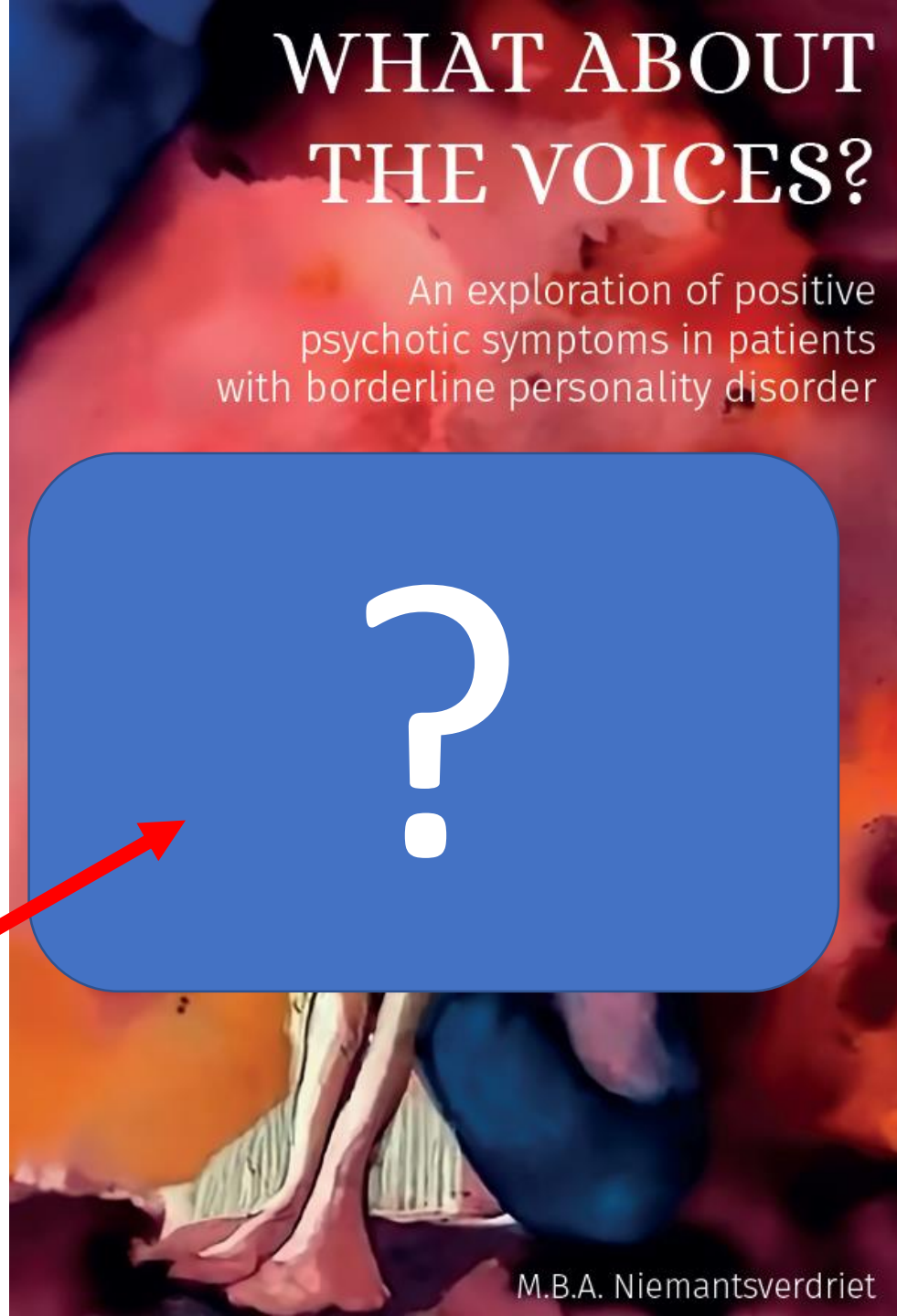
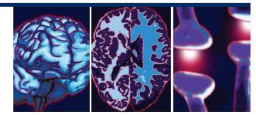


Table 1. Overview of psychopathological similarities in chronic post-traumatic stress disorder, borderline personality disorder, dissociative identity disorder and schizophrenia.

Psychopathological symptom	Chronic PTSD†	BPD‡	DID§	Schizophrenia¶
Bleuler's core symptoms				
Ambivalence	Rare	Rare	Rare	Frequent
Autism	Rare	Rare	Rare	Frequent
Distraction, incoherence	No	No	Inconsistent	Frequent
Blunted affect	No	No	Rare	Frequent
Depersonalization	Frequent	Frequent	Frequent	Sometimes
Passive/apathetic social withdrawal	Rare	No	Rare	Frequent
Emotional withdrawal	Rare	Rare	Rare	Frequent
Schneiderian first rank symptoms				
Audible thoughts	Inconsistent	Inconsistent	Inconsistent	Frequent
Arguing voices	Rare	Rare	Frequent	Frequent
Commenting voices	Frequent	Frequent	Frequent	Frequent
Influences on the body	Rare	Rare	Frequent	Frequent
Thought withdrawal	Inconsistent	Frequent	Frequent	Frequent
Thought insertion	Inconsistent	Frequent	Frequent	Frequent
Thought broadcast	Inconsistent	Rare	Inconsistent	Frequent
Feeling under external influence	Inconsistent	Frequent	Frequent	Frequent
Delusional perception	Rare	Rare	Inconsistent	Frequent
Other symptoms				
Insight into illness	Frequent	Frequent	Frequent	Rare
Bonding	Could be unstable	Stable/unstable	Sometimes stable	Autistic
Amnesia	Rare	Rare	Frequent	Sometimes
Identity alteration	Rare	Rare	Frequent	Inconsistent

†Data taken from [20,21,55,63,89,91,101].
‡Data taken from [17–19,55,81].
§Data taken from [13,15,16,62].
¶Data taken from [32,71,72,75].
BPD: Borderline personality disorder; DID: Dissociative identity disorder; PTSD: Post-traumatic stress disorder.

REVIEW



Schizophrenia or trauma-related psychosis? Schneiderian first rank symptoms as a challenge for differential diagnosis

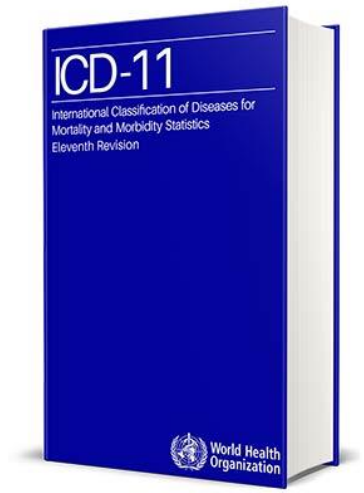
Stefan Tschöke[†], Carmen Uhlmann[†] & Tilman Steinert[†]

Practice points

- Schneiderian first rank symptoms are not specific for schizophrenic disorders, they can also be observed in severe trauma-related disorders. In these cases, according to Diagnostic and Statistical Manual of Mental Disorders-IV-text revision or International Classification of Diseases (ICD)-10, schizophrenia can be misdiagnosed.
- A trauma-related disorder should be taken into account for differential diagnosis if:
  - There is a history of childhood or adulthood traumatization
  - Amnestic episodes are obvious
  - Formal thought disorder is absent
  - Negative symptoms are absent and vivid positive symptoms are present
  - The positive symptomatology is resistant to pharmacotherapy
- The evidence for any kind of pharmacotherapy in treating trauma-related psychopathological symptoms is weak.
- In patients with concomitant symptoms of post-traumatic stress disorder, a specialized trauma therapy has the best therapeutic outcome and could open up new therapy options.

Tschöke, Stefan; Uhlmann, Carmen; Steinert, Tilman (2011): Schizophrenia or trauma-related psychosis? Schneiderian first rank symptoms as a challenge for differential diagnosis. Neuropsychiatry. In: *Neuropsychiatry* 1 (4), S. 349–360.

‘‘Quasi-psychotic pseudo-hallucinations‘‘!?



- Maercker et al. (2022) on complex PTSD:
  - “Highly relevant comorbidities exist with dissociative […] disorders, **quasi-psychotic** symptoms…“
  - “**Quasi-psychotic symptoms** […], most notably, ego-dystonic auditory or visual illusions of varying clinical severity”
- ICD-11 on PTSD: “Auditory **pseudo-hallucinations**, recognized as being the person’s own thoughts and of internal origin, can occur in Post-Traumatic Stress Disorder.”

Seminar

Complex post-traumatic stress disorder

Andreas Maercker, Marylene Cloitre, Rahel Bachem, Yolanda R. Schlumpf, Brigitte Khoury, Caitlin Hitchcock, Martin Bohus

Lancet 2022; 400: 60–72

Division of Psychopathology and Clinical Intervention (Prof A Maercker PhD, R Bachem PhD) **and Division of Neuropsychology** (Y R Schlumpf PhD), **University of Zurich, Zurich, Switzerland; National Center for PTSD Division of Dissemination and Training and Department of Psychiatry and Behavioural Sciences, Stanford University, CA, USA** (M Cloitre PhD); **American University of Beirut, Beirut, Lebanon** (Prof B Khoury PhD); **MRC Cognition and Brain Science Unit, University of Cambridge, Cambridge, UK** (C Hitchcock PhD); **Melbourne School of Psychological Sciences, University of Melbourne, Melbourne, VIC, Australia** (C Hitchcock); **Heidelberg University, Heidelberg Germany and Ruhr University, Bochum, Germany** (Prof Martin Bohus MD)

Correspondence to: Prof Andreas Maercker, Division

Complex post-traumatic stress disorder (complex PTSD) is a severe mental disorder that emerges in response to traumatic life events. Complex PTSD is characterised by three core post-traumatic symptom clusters, along with chronic and pervasive disturbances in emotion regulation, identity, and relationships. Complex PTSD has been adopted as a new diagnosis in the ICD-11. Individuals with complex PTSD typically have sustained or multiple exposures to trauma, such as childhood abuse and domestic or community violence. The disorder has a 1–8% population prevalence and up to 50% prevalence in mental health facilities. Progress in diagnostics, assessment, and differentiation from post-traumatic stress disorder and borderline personality disorder is reported, along with assessment and treatment of children and adolescents. Studies recommend multicomponent therapies starting with a focus on safety, psychoeducation, and patient-provider collaboration, and treatment components that include self-regulatory strategies and trauma-focused interventions.

Introduction

The 11th version of WHO’s *International Classification of Diseases*[1] (ICD) has introduced a new disorder—complex post-traumatic stress disorder (complex PTSD)—in addition to post-traumatic stress disorder (PTSD) under the parent category of “Disorders specifically associated with stress”. Exposure to a traumatic event is a prerequisite for consideration of either disorder. The diagnostic criteria for PTSD consist of three symptom clusters that relate specifically to the traumatic event, including re-experiencing in the here and now, avoidance of traumatic reminders, and heightened sense of threat. The diagnosis of complex PTSD is comprised of six symptom clusters, the three PTSD clusters and three symptom clusters representing pervasive and chronic disturbances in self-organisation; affect dysregulation, extremely negative self-concept, and difficulties in forming and maintaining relationships.

ICD-11 introduced complex PTSD as a diagnosis distinct from PTSD to recognise the effect that chronic or repeated trauma can have on self-organisation-related mechanisms. Exposure to particular traumatic events such as repeated childhood sexual or physical abuse, domestic violence, prolonged combat exposure, torture, and genocide campaigns is associated with substantially greater risk for complex PTSD as compared with PTSD. The often unsatisfactory therapeutic and clinical management procedures used for these patients in the past have steadily improved in recent decades. This Seminar summarises

What‘s the reasoning behind it?

- „Dissociative voice hearing is **phenomenologically different** (e.g., location) from auditory verbal hallucination in psychosis.“
- “… characterized as pseudohallucinations, since they were thought to be **mild and phenomenologically different** from those in schizophrenia”
- “Auditory pseudo-hallucinations, **recognized as being the person’s own thoughts and of internal origin**, can occur in Post-Traumatic Stress Disorder.” (ICD-11)

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Comprehensive Psychiatry 46 (2005) 147–154

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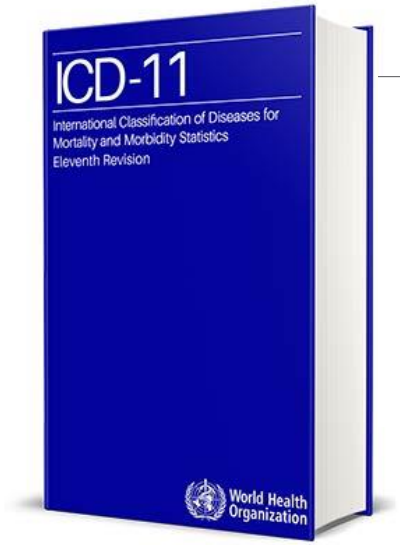
Persistent hallucinosis in borderline personality disorder

Leslie Yee, Anthony James Korner*, Sally McSwiggan, Russell Ainslie Meares, Janine Stevenson

Department of Psychological Medicine, University of Sydney at Westmead Hospital, Wentworthville, NSW 2145, Australia



Auditory Verbal Hallucinations in Borderline Personality Disorder and the Efficacy of Antipsychotics: A Systematic Review

Christina W. Slotema[1], Jan Dirk Blom[1,2,3], Marieke B. A. Niemantsverdriet[1] and Iris E. C. Sommer[4,5]*

What‘s the **data**?

- „Dissociative voice hearing is **phenomenologically different** (e.g., location) from auditory verbal hallucination in psychosis.“
- “… characterized as pseudohallucinations, since they were thought to be **mild and phenomenologically different** from those in schizophrenia”
- “Auditory pseudo-hallucinations, **recognized as being the person’s own thoughts and of internal origin**, can occur in Post-Traumatic Stress Disorder.” (ICD-11)

Psychiatry Research 292 (2020) 113314

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Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Hallucinations and other psychotic experiences across diagnoses: A comparison of phenomenological features

Maya J.L. Schutte[a,#], Mascha M.J. Linszen[a,#], Theresa M. Marschall[a,*], Dominic H. ffytche[b], Sanne Koops[c], Edwin van Dellen[d], Sophie M. Heringa[d], Arjen J.C. Slooter[e], Rob Teunisse[f], Odile A van den Heuvel[g], Afina W. Lemstra[h], Elisabeth M.J. Foncke[h], Christina W. Slotema[i], Joop de Jong[i], Susan L. Rossell[j], Iris E.C. Sommer[a]

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The phenomenology of AVH in PTSD, BPD, & SSD

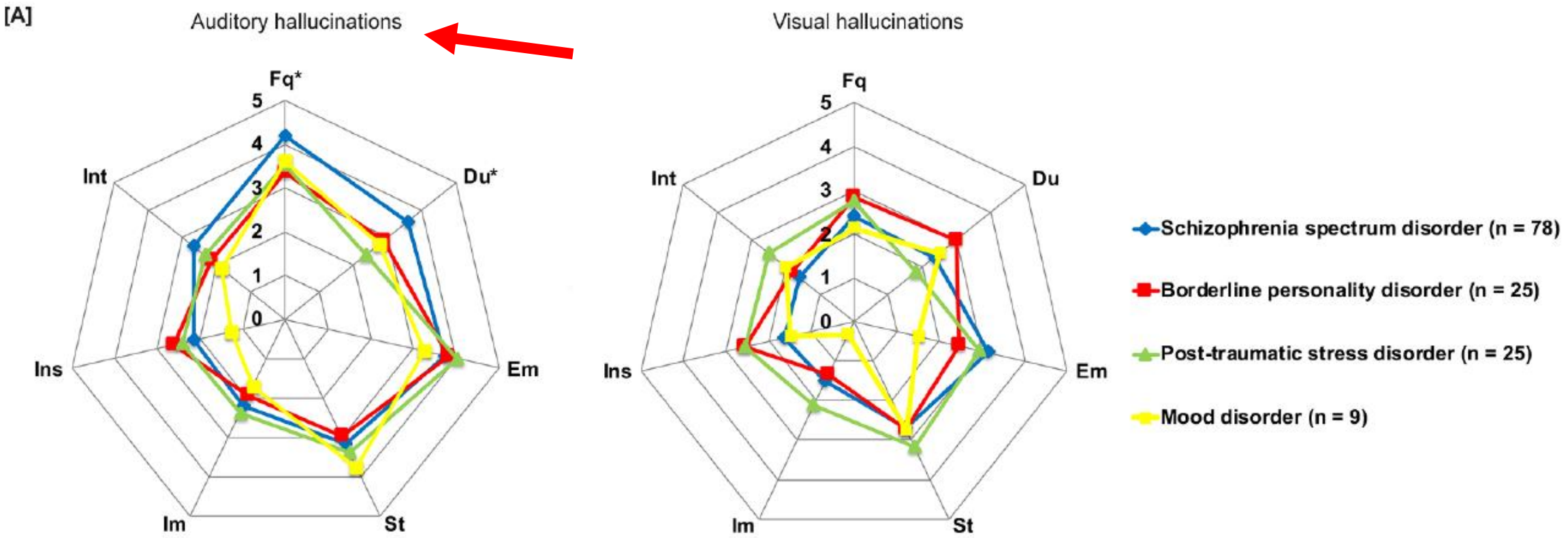


Fig. 1. Phenomenology of auditory and visual hallucinations in the major psychiatric and neurodegenerative disorders. The upper row compares the four psychiatric disorders on frequency (Fq), duration (Du), emotional valence (Em), distress (St), impact on functioning (Im), interaction (Int) and insight (Ins). The mean of the presented QPE items was calculated for each group and presented in the spider webs, with 0–5 the range of possible scores. A higher score on insight (Ins) indicates less preserved insight. The four groups showed significant differences for auditory hallucinations on frequency and duration (* Bonferroni corrected for 7 tests at $p < .05/7$).

The phenomenology of AVH in PTSD, BPD, & SSD

COMPARISON OF THE PHENOMENOLOGY OF HALLUCINATION AND DELUSION CHARACTERISTICS IN PEOPLE DIAGNOSED WITH BORDERLINE PERSONALITY DISORDER AND SCHIZOPHRENIA

Zalie Merrett, David J. Castle, MD, Neil Thomas, DPsyc, Wei Lin Toh, PhD, Josephine Beatson, MB, Jillian Broadbear, PhD, Sathya Rao, MD, DPM, and Susan L. Rossell, PhD

TABLE 4. Descriptive Statistics, One-Way ANOVA, and Paired Comparisons for AVH by Group

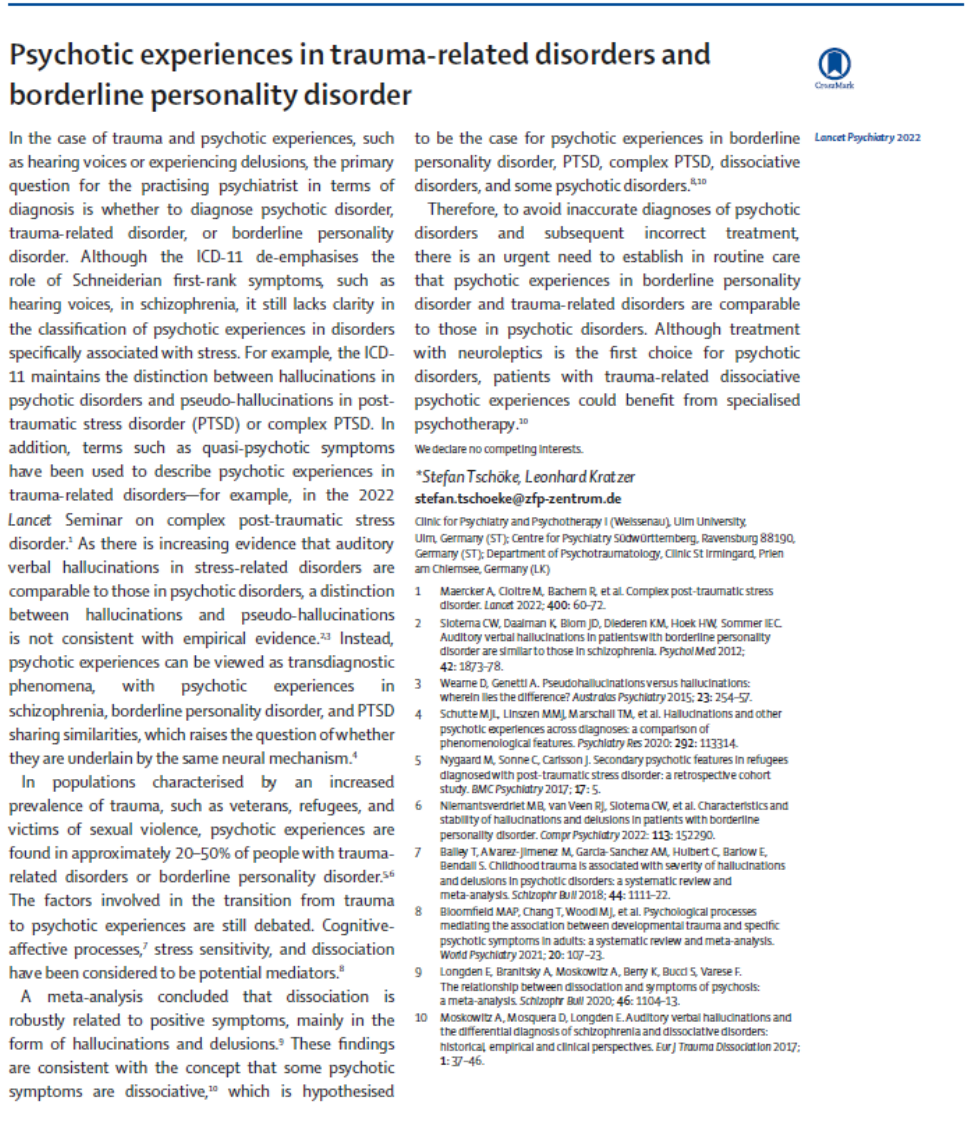
	BPD-AVH (n = 16)	SSD-L (n = 35)	SSD-H (n = 24)	p Value and Effect Size
Frequency	3.13 (1.784)	2.37 (1.848)	2.21 (1.744)	.27, 0.19
Duration	3.00 (1.713)	2.03 (1.807)	2.09 (1.849)	.17, 0.22
Emotional Valence	3.00 (1.852)	2.12 (2.100)	2.32 (2.147)	.35, 0.17
Experienced Distress	2.13 (1.893)	2.15 (1.726)	2.30 (1.845)	.94, 0.04
Impact on Functioning	2.00 (1.789)	1.44 (1.618)	1.59 (1.593)	.58, 0.13
Repetition	2.44 (1.031)	1.72 (1.173)	1.50 (.966)	***.03, 0.35***
Complexity	3.75 (1.483)	2.71 (2.023)	2.59 (2.085)	.08, 0.24
Location	2.44 (1.504)	3.08 (1.913)	2.22 (1.896)	.31, 0.22
Time of Occurrence	4.25 (1.238)	3.04 (2.150)	2.67 (2.000)	***.01, 0.34***
Insight	1.56 (1.672)	2.00 (1.799)	2.54 (1.668)	.20, 0.21
Interaction	3.38 (1.204)	1.88 (1.935)	1.52 (1.702)	***< .001, 0.41***
Complying with Commands	2.00 (1.414)	1.18 (1.466)	1.43 (1.532)	.18, 0.22

Note. Descriptive statistics are means and standard deviations; the latter shown in parentheses. Effect sizes were measured using Cohen's *f*: 0.2 = a small effect size, 0.5 = a medium effect size, 0.8 = a large effect size. Significant outcomes are shown in bold italics.

- No differences in frequency, duration, emotional valence, distress, complexity, location, insight, …
- More, not less interaction with voices in BPD than in SSD
- AVH more repetitive in BPD

Psychotic vs quasi-psychotic symptoms?

- **"… a distinction between hallucinations and pseudo-hallucinations is not consistent with empirical evidence."**
- This does not mean psychosis cannot be differentiated from trauma-related disorders



THE LANCET

Psychotic experiences in trauma-related disorders and borderline personality disorder

Lancet Psychiatry 2022

In the case of trauma and psychotic experiences, such as hearing voices or experiencing delusions, the primary question for the practising psychiatrist in terms of diagnosis is whether to diagnose psychotic disorder, trauma-related disorder, or borderline personality disorder. Although the ICD-11 de-emphasises the role of Schneiderian first-rank symptoms, such as hearing voices, in schizophrenia, it still lacks clarity in the classification of psychotic experiences in disorders specifically associated with stress. For example, the ICD-11 maintains the distinction between hallucinations in psychotic disorders and pseudo-hallucinations in post-traumatic stress disorder (PTSD) or complex PTSD. In addition, terms such as quasi-psychotic symptoms have been used to describe psychotic experiences in trauma-related disorders—for example, in the 2022 *Lancet* Seminar on complex post-traumatic stress disorder.[1] As there is increasing evidence that auditory verbal hallucinations in stress-related disorders are comparable to those in psychotic disorders, a distinction between hallucinations and pseudo-hallucinations is not consistent with empirical evidence.[2,3] Instead, psychotic experiences can be viewed as transdiagnostic phenomena, with psychotic experiences in schizophrenia, borderline personality disorder, and PTSD sharing similarities, which raises the question of whether they are underlain by the same neural mechanism.[4]

In populations characterised by an increased prevalence of trauma, such as veterans, refugees, and victims of sexual violence, psychotic experiences are found in approximately 20–50% of people with trauma-related disorders or borderline personality disorder.[5,6] The factors involved in the transition from trauma to psychotic experiences are still debated. Cognitive-affective processes,[7] stress sensitivity, and dissociation have been considered to be potential mediators.[8]

A meta-analysis concluded that dissociation is robustly related to positive symptoms, mainly in the form of hallucinations and delusions.[9] These findings are consistent with the concept that some psychotic symptoms are dissociative,[10] which is hypothesised to be the case for psychotic experiences in borderline personality disorder, PTSD, complex PTSD, dissociative disorders, and some psychotic disorders.[8,10]

Therefore, to avoid inaccurate diagnoses of psychotic disorders and subsequent incorrect treatment, there is an urgent need to establish in routine care that psychotic experiences in borderline personality disorder and trauma-related disorders are comparable to those in psychotic disorders. Although treatment with neuroleptics is the first choice for psychotic disorders, patients with trauma-related dissociative psychotic experiences could benefit from specialised psychotherapy.[10]

We declare no competing interests.

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Borderline personality disorder and auditory verbal hallucinations

Australasian Psychiatry
1–4
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Josephine Beatson Spectrum, Statewide Service for Personality Disorder, Eastern Health, Richmond, VIC, Australia

Also: typical onset at age 18-25, episodes and residuals

RESEARCH ARTICLE

WILEY

A comparison between auditory hallucinations, interpretation of voices, and formal thought disorder in dissociative identity disorder and schizophrenia spectrum disorders

Martin J. Dorahy[1,2] | Amy Nesbit[3] | Rachael Palmer[3] | Bailey Wiltshire[1] | Jacinta R. Cording[1] | Donncha Hanna[4] | Lenaire Seager[2] | Warwick Middleton[1,2]

quently co-occur with borderline personality disorder (BPD) Z) or other primary psychotic disorders. Misdiagnosis is more rst rank symptoms (FRS). This paper's objective is to improve

Conclusion: While tentative, metaphysical interpretations of voices, incoherent thoughts and word substitution may reflect more psychotic processes.

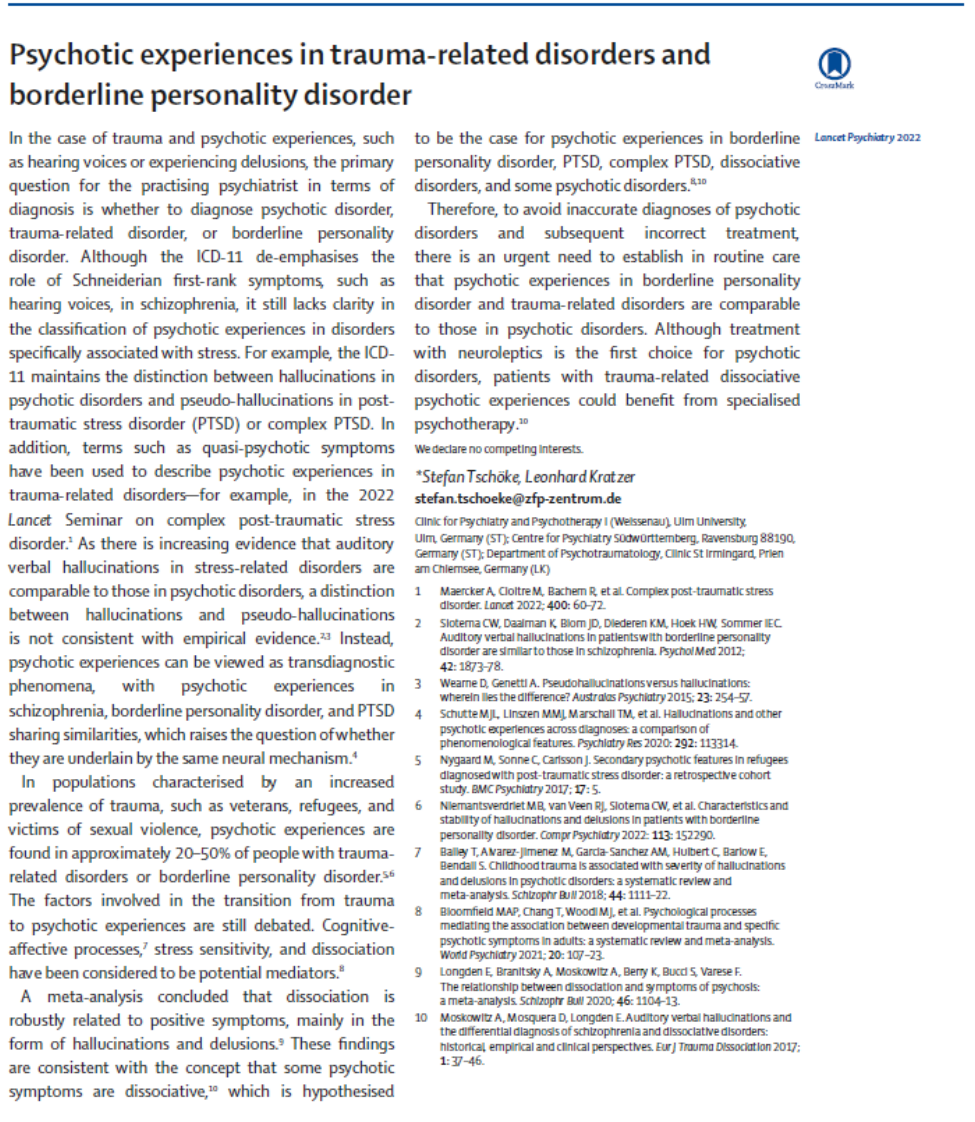
psy-

nosis from

urch suggest that AVH in BPD are often dissociative in origin ted levels of dissociation and a history of childhood trauma. urring psychotic disorder, formal thought disorder is usually absent, negative symptoms minimal or absent, bizarre symptoms absent, affect reactive and the patient retains sociability. Psychotropic medication may be less effective for the AVH in these cases, while they may improve or remit during psychotherapy for BPD.

Psychotic vs quasi-psychotic symptoms?

Yet, "… **psychotic experiences** […] **transdiagnostic phenomena**, [sharing similarities] in schizophrenia, borderline personality disorder, and PTSD […] which raises the **question of whether they are underlain by the same […] mechanism**."



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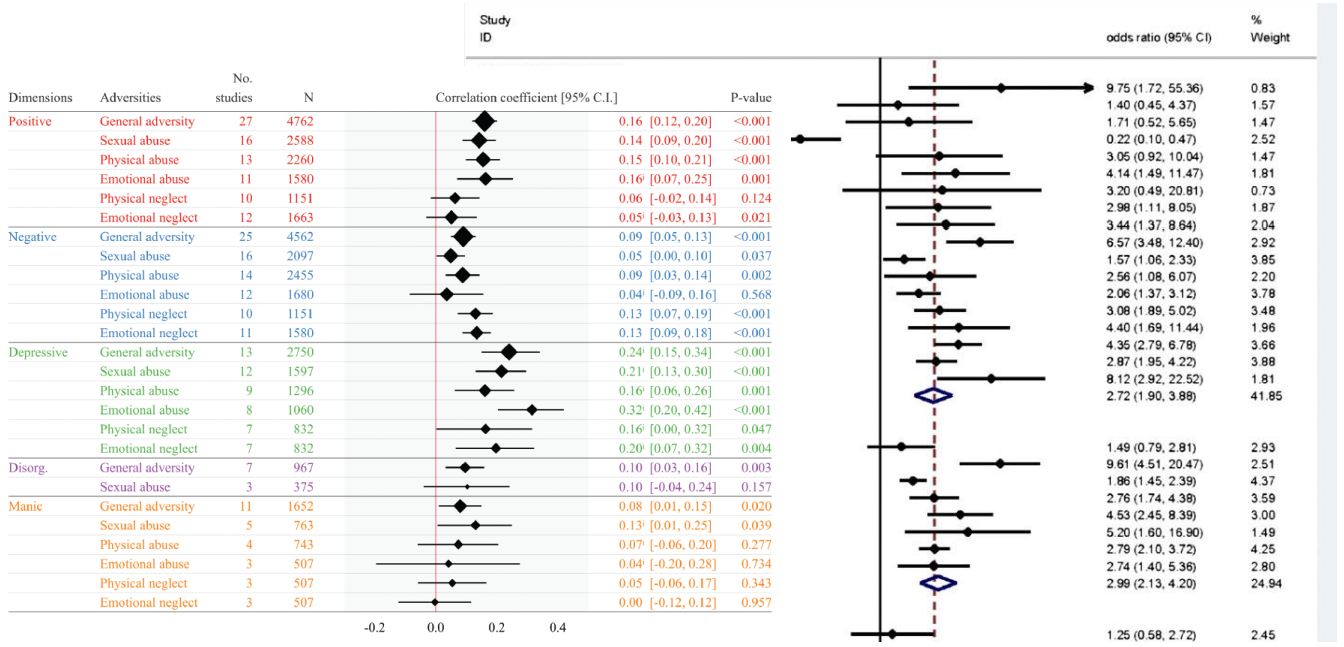
A transdiagnostic mechanism of AVH?

Schizophrenia Bulletin vol. 47 no. 4 pp. 975–985, 2021
doi:10.1093/schbul/sbaa199
Advance Access publication 9 April 2021

Association Between Specific Childhood Adversities and Symptom Dimensions in People With Psychosis: Systematic Review and Meta-Analysis

Luis Alameda[*,1,2,3], Angeline Christy[1,13], Victoria Rodriguez[1,13], Gonzalo Salazar de Pablo[4,5], Madeleine Thrush[1], Yi Shen[1], Beatriz Alameda[6], Edoardo Spinazzola[1], Eduardo Iacoponi[1,7], Giulia Trotta[8], Ewan Carr[9], Miguel Ruiz Veguilla[3], Monica Aas[1,10,11], Craig Morgan[12], and Robin M Murray[1]



Psychological Medicine, Page 1 of 14. © Cambridge University Press 2012
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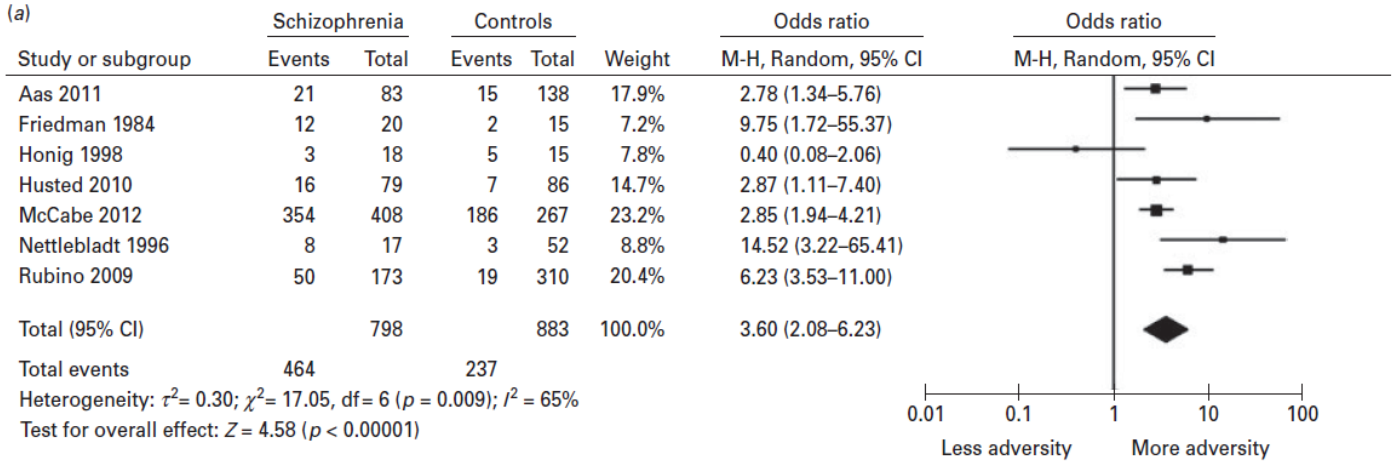
REVIEW ARTICLE

Childhood adversity in schizophrenia: a systematic meta-analysis

S. L. Matheson[1,2*], A. M. Shepherd[1,2], R. M. Pinchbeck[1], K. R. Laurens[1,2,3] and V. J. Carr[1,2]



A transdiagnostic mechanism of AVH?

Three adverse events during childhood increase the Odds Ratio of

- AVH 27-fold
- Paranoia 10-fold

Schizophrenia Bulletin vol. 38 no. 4 pp. 734–740, 2012
doi:10.1093/schbul/sbs049
Advance Access publication on April 10, 2012

Do Specific Early-Life Adversities Lead to Specific Symptoms of Psychosis? A Study from the 2007 The Adult Psychiatric Morbidity Survey

Richard P. Bentall[1,*], Sophie Wickham[1], Mark Shevlin[2], and Filippo Varese[1]

Table 2. Odds Ratios and Their Associated 95% CI for the Effects of Childhood Sexual Abuse, Victimization, Separation Variables and Total Adversity on AVHs and Paranoid Ideation

			Demographics adjusted	
	Paranoia	AVHs	Paranoia	AVHs
Gender			0.54* (0.30–0.98)	1.07 (0.58–1.97)
Age			0.96* (0.94–0.98)	0.99 (0.97–1.01)
Ethnicity			0.36* (0.17–0.75)	1.05 (0.31–3.54)
Education			1.05 (0.84–1.32)	0.98 (0.78–1.23)
Socioeconomic status			1.06 (0.87–1.31)	1.17 (0.91–1.53)
IQ			0.96* (0.94–0.99)	0.95* (0.92–0.98)
Rape	2.78 (0.93–8.28)	8.90* (1.86–42.44)	1.29 (0.38–4.41)	6.09* (1.38–26.89)
Sexual touch	1.30 (0.45–3.71)	1.22 (0.34–4.37)	1.31 (0.43–4.01)	1.68 (0.47–6.06)
Sexual talk	1.40 (0.54–3.61)	1.52 (0.58–4.01)	2.04 (0.72–5.80)	1.57 (0.50–4.95)
Physical abuse	8.52* (3.55–20.43)	4.79* (1.49–15.34)	5.99* (2.39–15.07)	3.82* (1.01–14.41)
Bullying	1.46 (0.81–2.63)	2.08 (0.99–4.37)	1.32 (0.71–2.46)	1.56 (0.71–3.43)
Institutional care	11.08* (3.26–37.62)	3.45 (0.50–23.72)	12.68* (3.56–45.11)	4.04 (0.74–21.92)
Local authority care	0.17* (0.03–0.80)	0.35* (0.04–3.45)	0.19 (0.04–1.00)	0.31 (0.03–3.02)
Number of adverse events				
1	3.33* (1.80–6.16)	2.32* (1.05–5.09)	3.70* (1.89–7.27)	2.43* (1.05–5.59)
2	7.49* (3.47–16.17)	10.80* (4.17–27.99)	7.33* (3.23–16.62)	9.14* (3.68–22.71)
3	9.92* (3.14–31.33)	27.42* (6.26–119.97)	5.65* (1.48–21.61)	17.64* (4.30–72.23)
4 or more	17.54* (2.93–104.89)	14.83* (2.80–78.55)	16.46* (2.71–99.77)	13.68* (2.33–80.27)

Note: AVH, auditory-verbal hallucinations. Adjusted demographic variables include sex, age, ethnicity, education, social class, and IQ.
*$p < .05$.

A transdiagnostic mechanism of AVH?

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doi:10.1093/schbul/sbs049
Advance Access publication on April 10, 2012

Do Specific Early-Life Adversities Lead to Specific Symptoms of Psychosis? A Study from the 2007 The Adult Psychiatric Morbidity Survey

Richard P. Bentall[1,*], Sophie Wickham[1], Mark Shevlin[2], and Filippo Varese[1]

Table 2. Odds Ratios and Their Associated 95% CI for the Effects of Childhood Sexual Abuse, Victimization, Separation Variables and Total Adversity on AVHs and Paranoid Ideation

			Demographics adjusted	
	Paranoia	AVHs	Paranoia	AVHs
Gender			0.54* (0.30–0.98)	1.07 (0.58–1.97)
Age			0.96* (0.94–0.98)	0.99 (0.97–1.01)

Psychopathology

Review Article

Psychopathology
DOI: 10.1159/000500162

Psychosis Is Not Illness but a Survival Strategy in Severe Stress: A Proposal for an Addition to a Phenomenological Point of View

Jaakko Seikkula

University of Jyväskylä, Jyväskylä, Finland

Traumatisierungen bei Psychosepatienten: Weitere Argumente gegen das „bio-bio-bio Modell“?

Traumatic Experiences in Patients with Psychosis: More Arguments Against the „bio-bio-bio Model“?

Autor Ingo Schäfer

A systematic review on mediators between adversity and psychosis: potential targets for treatment

Luis Alameda[1,2,3,4], Victoria Rodriguez[1], Ewan Carr[5], Monica Aas[1,6],

Presented by disorder group, mediator, and outcome.

Psychotic symptoms: Traumatic in origin, dissociative in nature?

RESEARCH REPORT

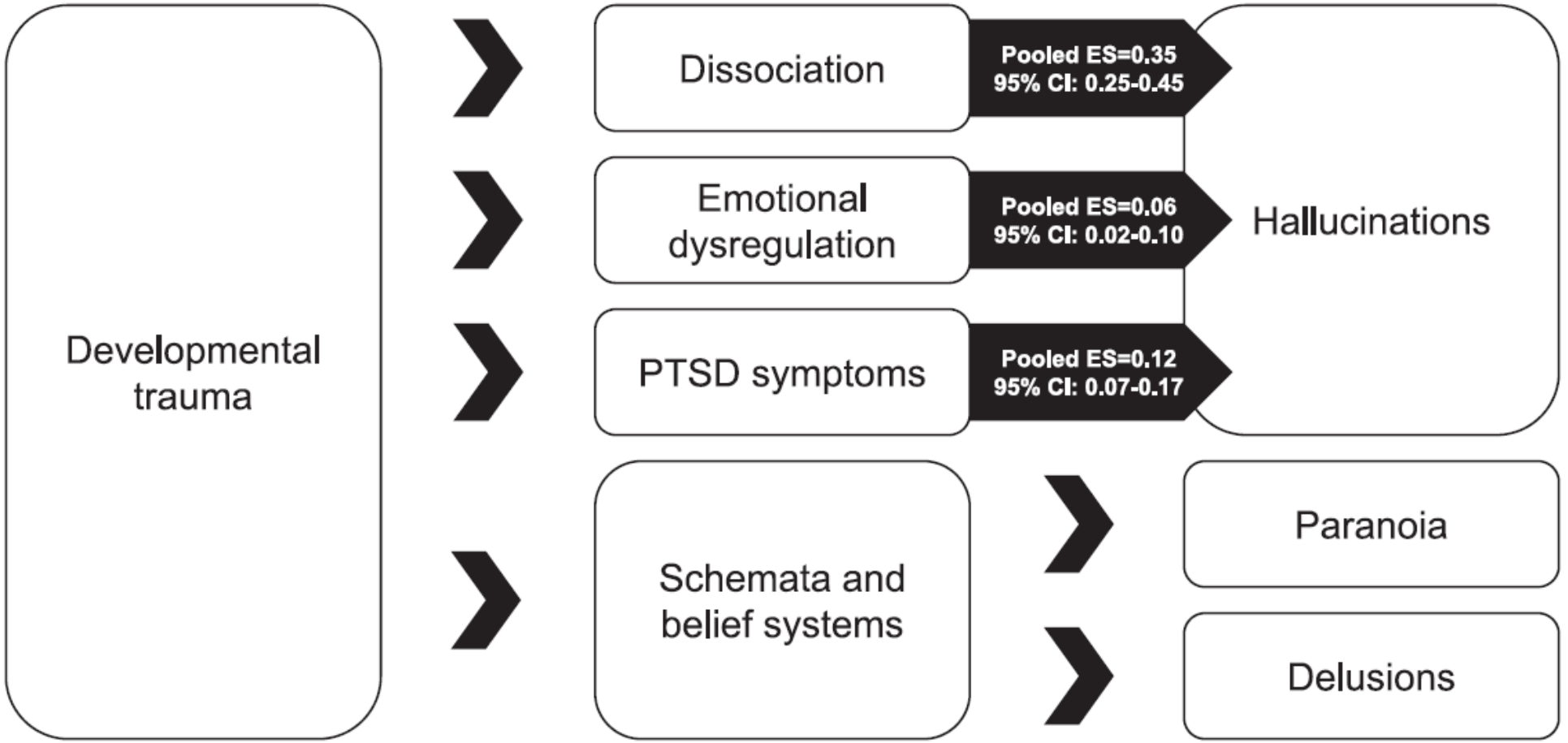
Psychological processes mediating the association between developmental trauma and specific psychotic symptoms in adults: a systematic review and meta-analysis

Michael A.P. Bloomfield[1-4], Tinya Chang[1], Maximillian J. Woodl[2], Laura M. Lyons[2], Zhen Ch
Sophie Bracke[1], Helen Kennerley[6,7], Louise Isham[7,8], Chris Brewin[9], Jo Billings[10], Talya Gree
[1]Translational Psychiatry Research Group, Research Department of Mental Health Neuroscience, Division of
Stress Clinic, St. Pancras Hospital, Camden and Islington NHS Foundation Trust, London, UK; [3]NIHR University C
College Hospital, London, UK; [4]National Hospital for Neurology and Neurosurgery, University College London
Psychology, University of Bath, Bath, UK; [6]University of Oxford, Oxford, UK; [7]Oxford Centre for Cognitive Ther
Oxford, UK; [8]Department of Psychiatry, University of Oxford, Oxford, UK; [9]Research Department of Clinical,
London, UK; [10]Division of Psychiatry, University College London, London, UK; [11]Community Mental Health Dep

*Experiencing psychological trauma during childhood and/or adolescence is associated wit
ever, we lack a clear knowledge of how developmental trauma induces vulnerability to ps
processes involved in this association is crucial to the development of preventive interventi
atically review the literature and combine findings using meta-analytic techniques to estab
the associations between developmental trauma and specific psychotic experiences (i.e., ha
studies met our inclusion criteria. We found mediating roles of dissociation, emotional dysr
symptoms (avoidance, numbing and hyperarousal) between developmental trauma and ha
role of negative schemata, i.e. mental constructs of meanings, between developmental trau
to date have been of poor quality, and the field is limited by mostly cross-sectional research.
chological pathways from developmental trauma to psychotic phenomena in adulthood. C
about their history of developmental trauma, and screen patients with such a history fo
symptoms. Well conducted research with prospective designs, including neurocognitive ass
biopsychosocial mechanisms underlying the association between developmental trauma a

Key words: Developmental trauma, psychotic symptoms, childhood, adolescence, delusi
disorder, dissociation, psychological processes

(World Psychiatry 2021;20:107–123)



Mechanisms underlying psychotic experiences?

MAJOR REVIEW

The Relationship Between Dissociation and Symptoms of Psychosis: A Meta-analysis

Eleanor Longden[*,1–3], Alison Branitsky[1], Andrew Moskowitz[4], Katherine Berry[2,3], Sandra Bucci[2,3], and Filippo Varese[2,3]

[1]Psychosis Research Unit, Greater Manchester Mental Health NHS Foundation Trust, Manchester, UK; [2]Division of Psychology and Mental Health, School of Health Sciences, Faculty of Biology, Medicine and Health, Manchester Academic Health Science Centre, The University of Manchester, Manchester, UK; [3]Complex Trauma and Resilience Research Unit, Greater Manchester Mental Health NHS Foundation Trust, Manchester, UK; [4]Department of Psychology, Touro College Berlin, Berlin, Germany

*To whom correspondence should be addressed; Psychosis Research Unit, Greater Manchester Mental Health NHS Foundation Trust, Harrop House, Bury New Road, Prestwich, M25 3BL, UK; tel: +44 161 358 1395, e-mail: Eleanor.Longden@gmmh.nhs.uk

and evaluated study quality. Ninety-three eligible articles considering 20 436 participants were retained for analysis. There was a robust association between dissociation and clinical and nonclinical positive psychotic symptoms (r = .437; 95%CI: .386 −.486), with the observed effect larger in nonclinical studies. Symptom-specific associations were also evident across clinical and nonclinical studies, and included significant summary effects for hallucinations (r = .461; 95%CI: .386 −.531), delusions (r = .418; 95%CI: .370 −.464), paranoia (r = .447; 95%CI: .393 −.499), and disorganization (r = .346; 95%CI: .249 −.436). Associations with negative symptoms were small and, in some cases, not significant. Overall, these findings confirm that dissociative phenomena are not only robustly related to hallucinations but also to multiple positive symptoms, and less robustly related to negative symptoms. Our findings are consistent with proposals that suggest certain psychotic symptoms might be better conceptualized as dissociative in nature and support the development of interventions targeting dissociation in formulating and treating psychotic experiences.

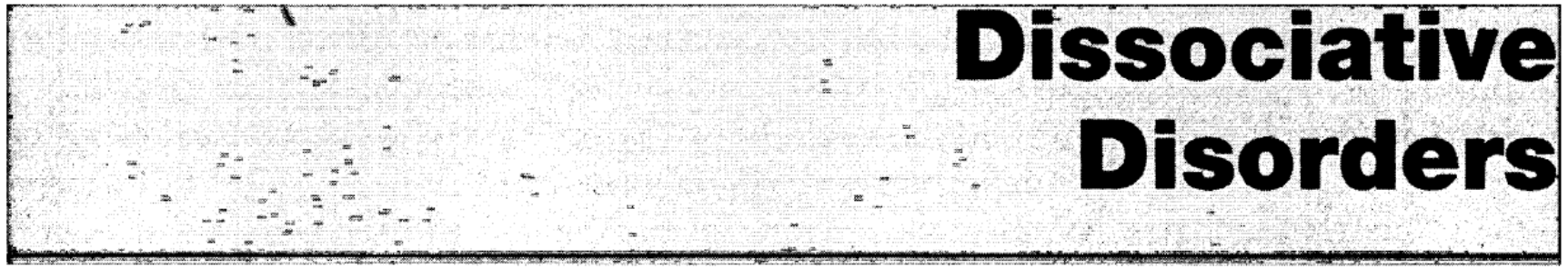
Dissociation, Trauma, and the Role of Lived Experience: Toward a New Conceptualization of Voice Hearing

Eleanor Longden
Bradford and Airedale Early Intervention in Psychosis Service, Bradford, England

Anna Madill and Mitch G. Waterman
University of Leeds

Voice hearing (VH) is often regarded as pathognomic for schizophrenia. The purpose of this article is to review and integrate historical, clinical, epidemiological, and phenomenological evidence in order to suggest that VH may be more appropriately understood as a dissociative rather than a psychotic phenomenon. First, we discuss the lifetime prevalence of VH in the general population, which is estimated to range between 1% and 16% for adult nonclinical populations and 2% and 41% in healthy adolescent samples. Second, we demonstrate how the ubiquity of VH phenomenology, including variables like voice location, content, and frequency, limits its diagnostic and prognostic utility for differentiating psychotic from trauma-spectrum and nonclinical populations. Finally, we report on the empirical associations between VH, measures of dissociation, and trauma particularly (though not exclusively) childhood sexual abuse. There are 2 main conclusions from this review. First, we argue that available evidence suggests that VH experiences, including those in the context of psychotic disorders, can be most appropriately understood as dissociated or disowned components of the self (or self–other relationships) that result from trauma, loss, or other interpersonal stressors. Second, we provide a rationale for clinicians to use psychotherapeutic methods for integrating life events as precipitating and/or maintaining factors for distressing voices. Potential mechanisms for the relationship between trauma, dissociation, VH, and clinical diagnosis are described, including the relevance of literature from the field of attachment in providing a diathesis for dissociation. Suggestions for future research are also discussed.

What is dissociation?



Dissociative disorders are characterized by a disruption of and/or 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. This chapter includes dissociative identity disorder, dissociative amnesia, depersonalization/derealization disorder, other specified dissociative disorder, and unspecified dissociative disorder.

Dissociative symptoms are experienced as a) unbidden intrusions into awareness and behavior, with accompanying losses of continuity in subjective experience (i.e., "positive" dissociative symptoms such as fragmentation of identity, depersonalization, and derealization) and/or b) inability to access information or to control mental functions that normally are readily amenable to access or control (i.e., "negative" dissociative symptoms such as amnesia).

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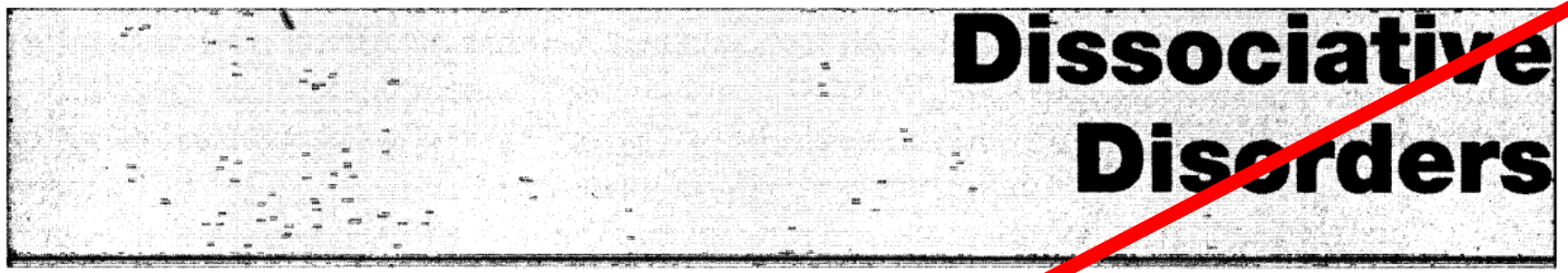

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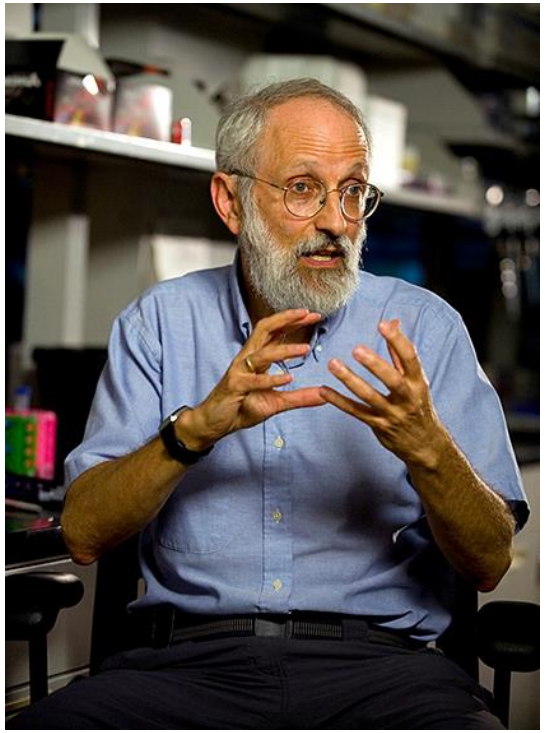
Toward a Philosophical Structure for Psychiatry

Kenneth S. Kendler, M.D.



This article, which seeks to sketch a coherent conceptual and philosophical framework for psychiatry, confronts two major questions: how do mind and brain interrelate, and how can we integrate the multiple explanatory perspectives of psychiatric illness? Eight propositions are proposed and defended: 1) psychiatry is irrevocably grounded in mental, first-person experiences; 2) Cartesian substance dualism is false; 3) epiphenomenalism is false; 4) both brain→mind and mind→brain causality are real; 5) psychiatric disorders are etiologically complex, and no more "spirochete-like" discoveries will be made that explain their origins in simple terms; 6) explanatory pluralism is preferable to monistic explanatory approaches, especially biological reductionism; 7) psychiatry must move beyond a prescientific "battle of paradigms" to embrace complexity and support empirically rigorous and pluralistic explanatory models; 8) psychiatry should strive for "patchy reductionism" with the goal of "piecemeal integration" in trying to explain complex etiological pathways to illness bit by bit.

(Am J Psychiatry 2005; 162:433–440)

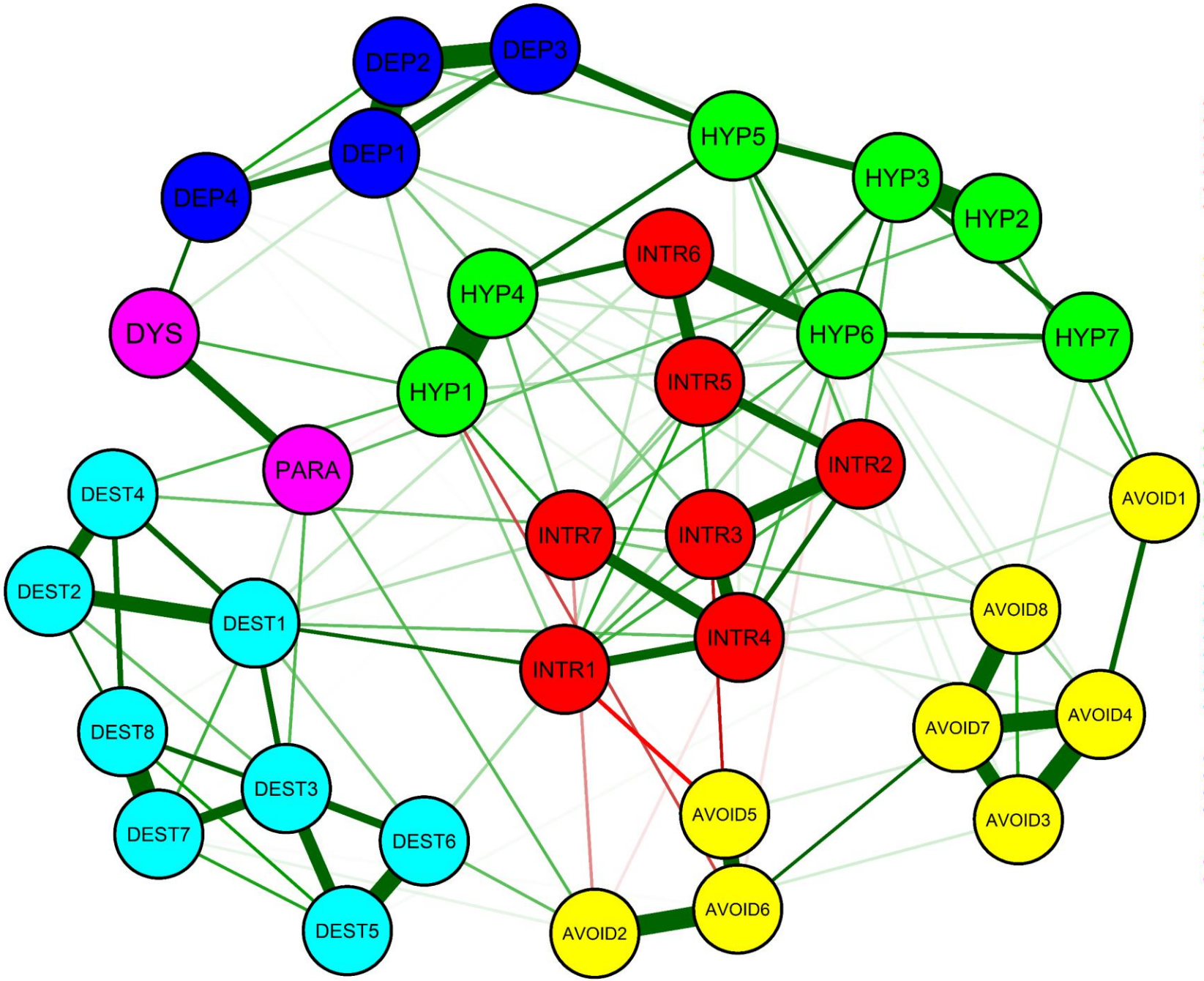
Psychological Medicine

cambridge.org/psm

Original Article

Sexual symptoms in post-traumatic stress disorder following childhood sexual abuse: a network analysis

Leonhard Kratzer[1], Peter Heinz[1], Rebecca Schennach[2,3], Matthias Knefel[4], Günter Schiepek[5,6,7], Sarah V. Biedermann[8] and Melanie Büttner[9]



Intrusions
- INTR1: Any reminder brought back feelings about it
- INTR2: Other things kept making me think about it.
- INTR3: I thought about it when I didn't mean to
- INTR4: Pictures about it popped into my mind.
- INTR5: I found myself acting or feeling like I was back at that time.
- INTR6: I had waves of strong feelings about it.
- INTR7: I had dreams about it.

Avoidance
- AVOID1: I avoided letting myself get upset when I thought about it or was reminded of it
- AVOID2: I felt as if it hadn't happened or wasn't real.
- AVOID3: I stayed away from reminders of it.
- AVOID4: I tried not to think about it.
- AVOID5: I was aware that I still had a lot of feelings about it, but I didn't deal with them.
- AVOID6: My feelings about it were kind of numb.
- AVOID7: I tried to remove it from my memory.
- AVOID8: I tried not to talk about it.

Hyperarousal
- HYP1: I had trouble staying asleep
- HYP2: I felt irritable and angry
- HYP3: I was jumpy and easily startled
- HYP4: I had trouble falling asleep.
- HYP5: I had trouble concentrating.
- HYP6: Reminders of it caused me to have physical reactions, such as [...]
- HYP7: I felt watchful and on-guard.

Dissociation
- DEST1: ... finding themselves in a place and have no idea how they got there.
- DEST2: ... finding new things among their belongings that they do not remember buying.
- DEST3: ... feeling as though they are standing next to themselves or watching themselves [...]
- DEST4: ... sometimes do not recognize friends of family members
- DEST5: ... feeling that other people, objects, and the world around them are not real.
- DEST6: ... feeling that their body does not seem to belong to them.
- DEST7: ... feel almost as if they were two different people
- DEST8: ... hear voices inside their head that tell them to do things or [...]

Depression
- DEP1: I feel down and depressed.
- DEP2: I no longer enjoy doing things I used to enjoy.
- DEP3: When I want to do something I lack energy and get tired quickly.
- DEP4: I lack self-esteem and have no self-confidence.

Sexuality
- DYS: I have difficulties engaging in sexual activities.
- PARA: I have a problem with my sexual preferences.

Stop looking for signs of illness, start looking for the meaning of subjective alterations of experience (i.e. symptoms)

The phenomena of dissociation

„The phenomena of pathological dissociation are recurrent, jarring, involuntary intrusions into executive functioning and sense of self. Thus, dissociative symptoms are startling, alien invasions of one's mind and one's experience. ***The essential experience of pathological dissociation is one of unanticipated, involuntary, and inexplicable intrusion or disruption.***"

Paul Dell

Box 1. The subjective/phenomenological model of dissociative identity disorder

General dissociative symptoms (4 of 6 required)

- Memory problems
- Depersonalization
- Derealization
- Posttraumatic flashbacks
- Somatoform symptoms
- Trance

Evidence of the partially dissociated intrusions of another self-state, as indicated by either 1 or 2:

1. Clinician observation of a self-state that claims (or appears) to be someone other than the person being interviewed, as indicated by the person's
   - Co-conscious awareness of the activities of the self-state; and
   - Remembering what the self-state said and did
   - Experiencing the self-state as ''other.''
2. At least 6 of the following 11 symptoms of intrusion by a partially dissociated self-state:
   - Child voices
   - Internal struggle, conversation, or argument
   - Persecutory voices that comment harshly, make threats, or command self-destructive acts
   - Speech insertion (unintentional or disowned utterances)
   - Thought insertion or withdrawal
   - ''Made'' or intrusive feelings and emotions
   - ''Made'' or intrusive impulses
   - ''Made'' or intrusive actions
   - Temporary loss of well-rehearsed knowledge or skills
   - Disconcerting experiences of self-alteration
   - Self-puzzlement

Evidence of the fully dissociated intrusions of another self-state (ie, amnesia), as indicated by either 1 or 2:

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2. Recurrent amnesia, as indicated by the person's report of multiple incidents of at least two of the following:
   - Time loss
   - ''Coming to''
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   - Being told of disremembered actions
   - Finding objects among one's possessions
   - Finding evidence of one's recent actions

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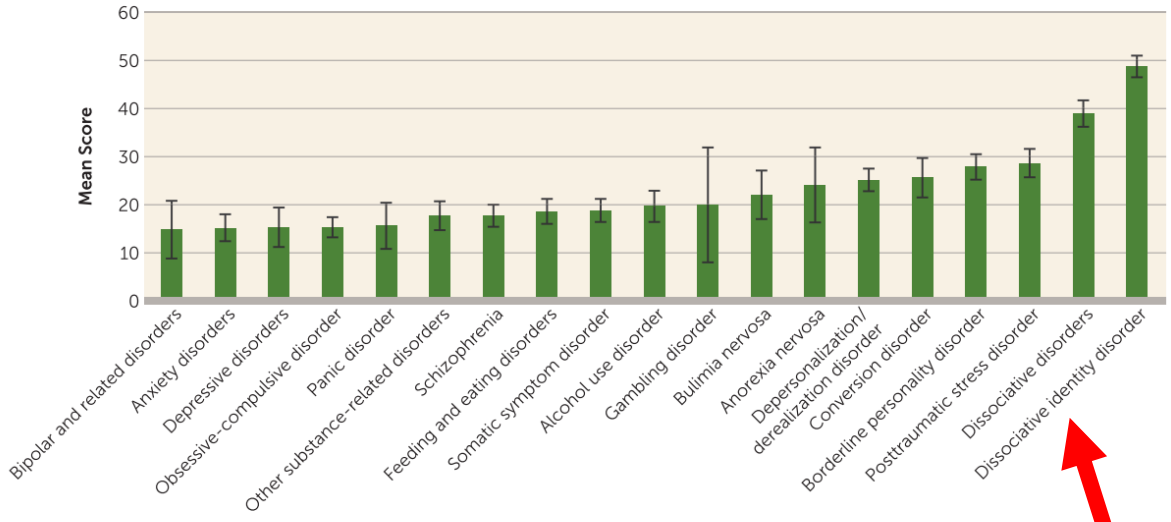
How to diagnose severe dissociation?

FIGURE 2. Mean Dissociative Experiences Scale Score for Each Diagnostic Group in a Meta-Analysis of Dissociation in Psychiatric Disorders[a]



Lyssenko et al., 2018

COMMENTARY

Dissociative identity disorder needs re-examination

Peter Tyrer

COMMENTARY ON… DISSOCIATIVE IDENTITY DISORDER[†]

Peter Tyrer is Emeritus Professor of Community Psychiatry in the Centre for Psychiatry at Imperial College, London, and Honorary Professor in Psychiatry at the University of Nottingham, UK.
Correspondence Professor Peter Tyrer, Imperial College, 7th Floor, Commonwealth Building, Hammersmith Hospital, London W12 0NN, UK. Email: p.tyrer@imperial.ac.uk

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[†]See this issue.

SUMMARY

Dissociative identity disorder (DID) is as real as any other psychiatric disorder but has been over-diagnosed by gullible clinicians, especially in forensic settings. Its classification has been poor, but the new ICD-11 classification, especially of partial DID, should help research and practice.

DECLARATION OF INTEREST

None.

KEYWORDS

Dissociative disorders; forensic mental health services; personality disorders.

Dorahy *et al* (2014) describing it as 'a complex, valid and not uncommon disorder, associated with developmental and cultural variables, that is amenable to psychotherapeutic intervention' goes beyond the available data. But some facts are incontrovertible. DID is found not only in 'patients who have been coached' (Paris 2019), is often associated with early trauma and may last for many years in the absence of any obvious motivation explaining persistence.

Trauma-dissociation is over-stated

Where the research data have been overblown is in adopting the trauma-dissociation model as the only cause. Such cause has not been demonstrated; in my view, it could only be properly evaluated by a large cohort study starting in infancy and some are now planned (Huntjens 2019). Lynn *et al* (2014), after reviewing the current evidence, conclude that 'the field should now abandon the simple trauma-dissociation model and embrace multifactorial models that accommodate the diversity of causes'. Trauma alone will not do, and even though it dominates the literature on the subject it is freely acknowledged that this cannot be the only precipitant, as trauma lies behind a panoply of mental disorders (Temple 2019).

DID: Shadow Costs & Economic Burden

JOURNAL OF INSURANCE MEDICINE
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J Insur Med 2000;32:71–78

Underwriting Considerations for Dissociative Disorders

Polly M. Galbraith, MD; Patricia J. Neubauer, PhD

Objective.—Dissociative identity disorder (DID) has been diagnosed more frequently and is under greater scrutiny. Because of the number of comorbid conditions, the underwriting risks must be evaluated to determine morbidity and mortality implications.

Background.—The number of diagnosed cases of DID has increased in recent years. The diagnosis often coexists with other diagnoses such as bipolar disorder, major depression, post-traumatic stress disorder, anxiety disorder, somatization, personality disorders, and psychotic disorder. A high incidence of substance abuse and eating disorders is found in the population diagnosed with DID.

The shadow costs of dissociative identity disorder

The editorial entitled 'Dissociative identity disorder: out of the shadows at last?'[1] considers that the diagnosis has often been rejected through misleading information, and the prejudices derived therefrom, and through self-protection, a cultural dissociation from the reality of the impact of severe trauma on later clinical presentations. Psychiatrists can then choose to 'dislike' the diagnosis and refuse to use it in a way that would never happen, without severe medico-legal consequences, for schizophrenia or bipolar affective disorder. This occurs despite evidence t
sociative identity disorder (DID) are s
impaired, have high rates of severe con
risk for non-suicidal self-injury and s
another reason for mental health servic
sive perspectives, and stigmatising/scap
diagnosis, while denying those in need o
ment is considered prohibitively expens
value[3] and specialist psychotherapy for
but recovery with therapy often has a nc

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Psychological Trauma:
Theory, Research, Practice, and Policy

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The Economic Burden of Dissociative Disorders: A Qualitative Systematic Review of Empirical Studies

Original Articles

Revisiting the concept of severe mental illness: severity indicators and healthcare spending in psychotic, depressive and dissociative disorders

Ana Isabel Gonzalez Vazquez, Natalia Seijo Ameneiros, Juan Carlos Díaz del Valle, Ester Lopez Fernandez & Miguel Angel Santed Germán

Pages 670-676 | Received 25 Sep 2016, Accepted 11 Apr 2017, Published online: 10 Aug 2017

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K. K. Jepsen
, Vikersund, Norway

ın Kleven
Hospital, Oslo, Norway

)oi: 10.32481/djph.2022.05.010

Understanding, identifying and
e dissociative
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ngs

	Depressive	Psychotic/ bipolar	Dissociative
Hospitalisations (number)	0.9	1.16	0.91
Average stay by diagnosis (days)	10.1	21.4	14.6
Length of stay (days)	9.09	24.82	13.28
Hospitalization healthcare spending (€)	2131.88	5821.97	3115.96
Emergencies (number)	0.87	2.03	10.28
Emergencies healthcare spending (€)	314.58	734.03	3717.14
Total spending (€)	2446.46	6555.70	6833.11

Dissociation, described simply, is the la
tion between things that are normally c
associated (International Society for t
Trauma and Dissociation 2011). T
description of the concept is credite
Janet (1859–1947) in his medical t
mental des hystériques in 1892. Janet
the first to propose a connection betwe
the individual's past and their present
ties and that dissociation was the
psychological defence against overwhel
ence. He identified dissociation as the
underlying hysteria, which at the time i

Trauma-Related Dissociation and the Dissociative Disorders:

Neglected Symptoms with Severe Public Health Consequences

Stacey M. Boyer, PsyD;[1] Jennifer E. Caplan, MA;[2] Lisa K. Edwards, MA[2]

1. Director, Psychology Services, Outpatient and Embedded Behavioral Health, ChristianaCare
2. Widener University Institute for Graduate Clinical Psychology
3. Widener University Institute for Graduate Clinical Psychology

Frank Corrigan, Trauma Psychotherapy Scotland, UK; **Alastair Hull**, NHS Tayside, UK.
Email: fmcorrigan@aol.com

MID Report

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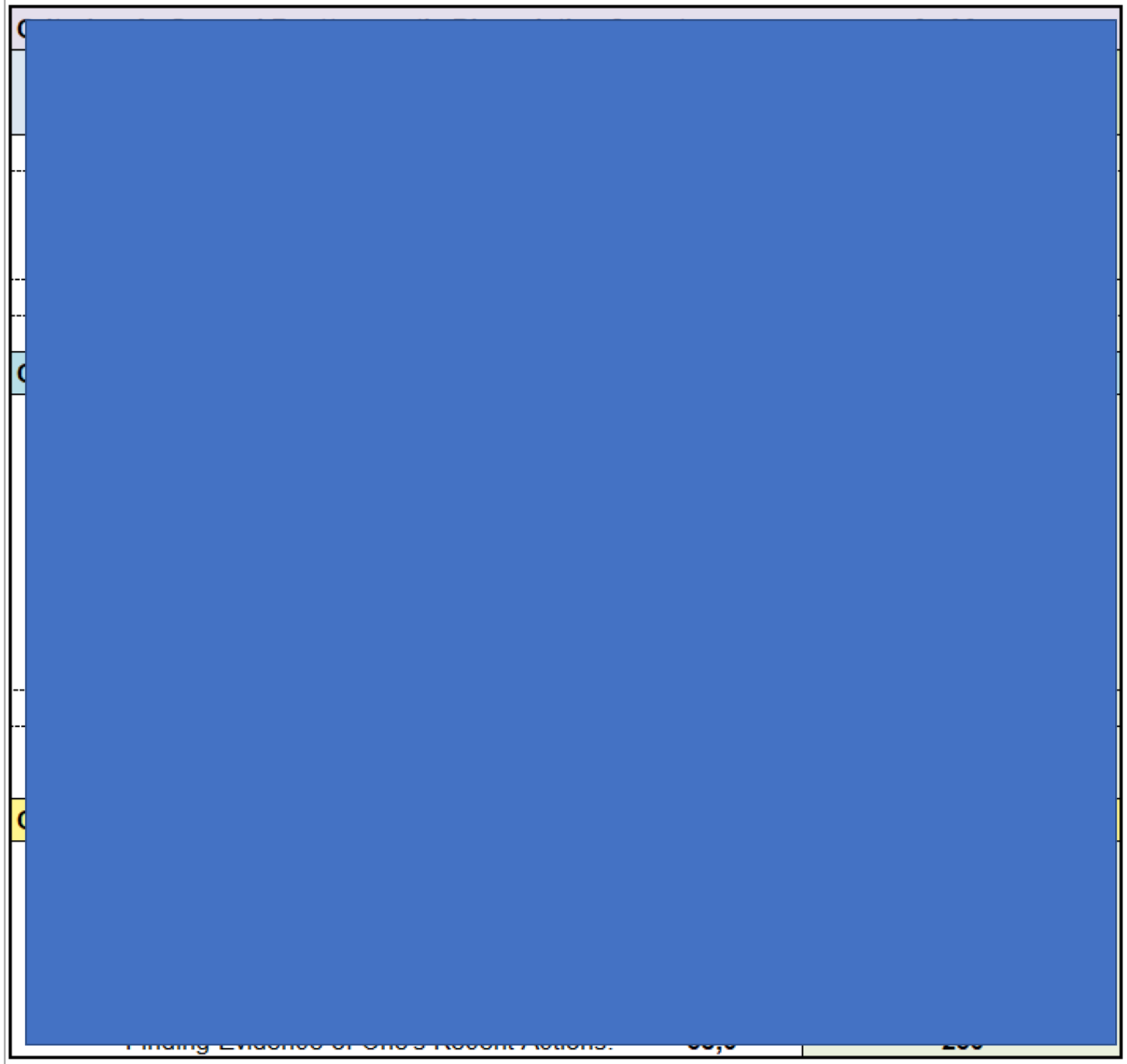

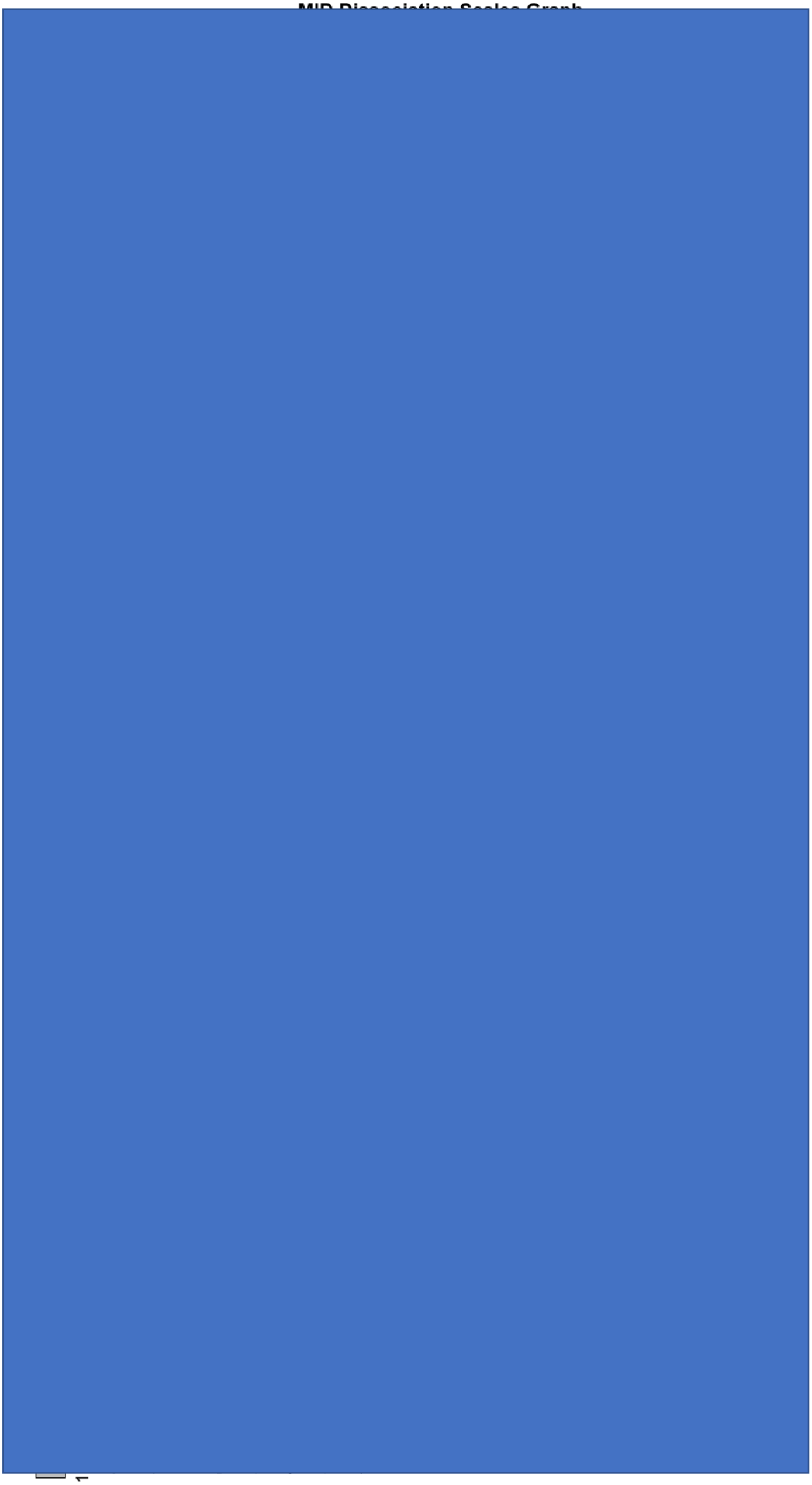

Treatment: A simple thing that is hard to do?

BRIEF REPORT

Treating Adults With Complex Posttraumatic Stress Disorder Using a Modular Approach to Treatment: Rationale, Evidence, and Directions for Future Research

Thanos Karatzias[1,2] and Marylene Cloitre[3]
[1]Edinburgh Napier University, School of Health & Social Care, Edinburgh, United Kingdom
[2]NHS Lothian, Rivers Centre for Traumatic Stress, Edinburgh, United Kingdom
[3]National Center for PTSD Dissemination and Training Division, VA Palo Alto Health Care System & Stanford University, Palo Alto, California, USA

Psychotherapy and Psychosomatics

Innovations

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Accepted after revision: January 11, 2013
Published online: May 22, 2013

Dialectical Behaviour Therapy for Post-traumatic Stress Disorder after Childhood Sexual Abuse in Patients with and without Borderline Personality Disorder: A Randomised Controlled Trial

Martin Bohus[a] Anne S. Dyer[a] Kathlen Priebe[a] Antje Krüger[a]
Nikolaus Kleindienst[a] Christian Schmahl[a] Inga Niedtfeld[a] Regina Steil[b]

[a]Department of Psychosomatic Medicine and Psychotherapy, Central Institute of Mental Health, Medical Faculty Mannheim/Heidelberg University, Mannheim, and [b]Department of Psychology and Sports Sciences, Institute of Psychology, Johann Wolfgang Goethe University, Frankfurt am Main, Germany

- Ultra-complex patients don‘t need ultra-complex treatments, but modular treatments
- Strategies to work with
  - emotional dysregulation and dissociation
  - alters?
  - voices?
  - dissociative amnesia?
  - traumatic memories?

Treatment: A simple thing that is hard to do?

BRIEF REPORT

Treating Adults With Complex Posttraumatic Stress Disorder Using a Modular Approach to Treatment: Rationale, Evidence, and Directions for Future Research

Thanos Karatzias[1,2] and Marylene Cloitre[3]
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Psychotherapy and Psychosomatics

Innovations

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Dialectical Behaviour Therapy for Post-traumatic Stress Disorder after Childhood Sexual Abuse in Patients with and without Borderline Personality Disorder: A Randomised Controlled Trial

Martin Bohus[a] Anne S. Dyer[a] Kathlen Priebe[a] Antje Krüger[a]
Nikolaus Kleindienst[a] Christian Schmahl[a] Inga Niedtfeld[a] Regina Steil[b]

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- Ultra-complex patients don‘t need ultra-complex treatments, but modular treatments
- Strategies to work with
  - **emotional dysregulation and dissociation**
  - alters?
  - voices?
  - dissociative amnesia?
  - traumatic memories?

Is DID a severe form of BPD?

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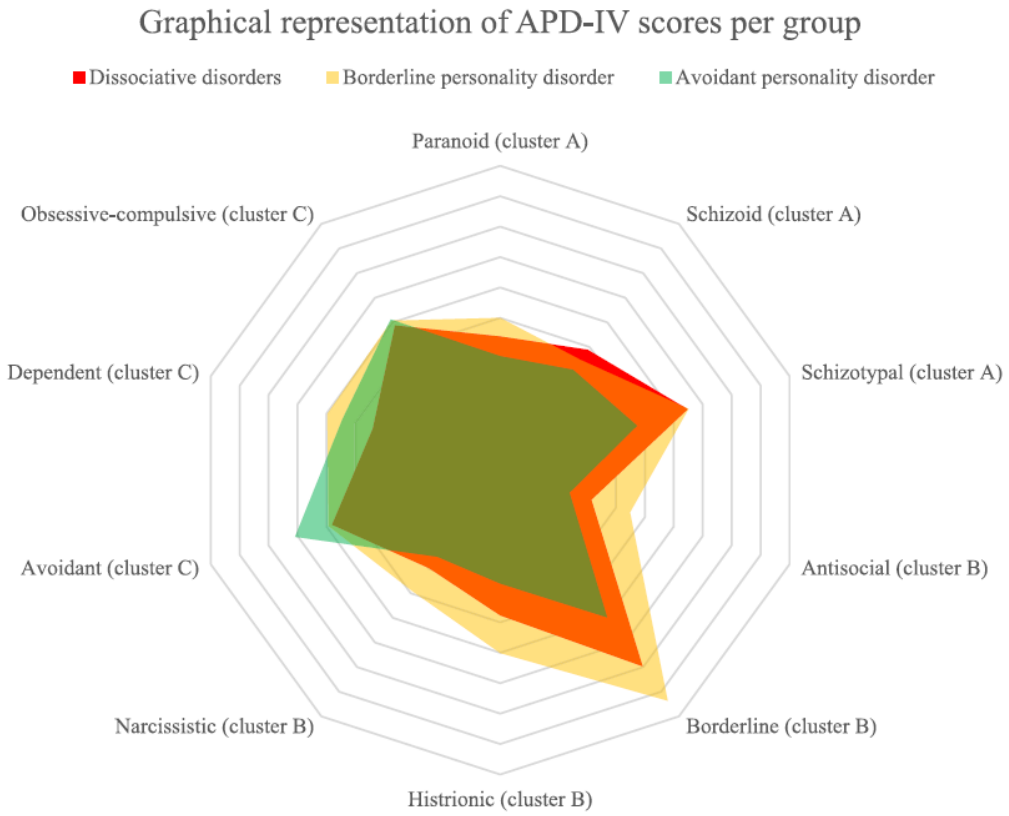
RESEARCH ARTICLE

WILEY

Personality disorder traits, maladaptive schemas, modes and coping styles in participants with complex dissociative disorders, borderline personality disorder and avoidant personality disorder



Key Practitioner Message

- This study suggests that complex dissociative disorders may be considered personality-related disorders.
- Participants with complex dissociative disorders scored on the various personality constructs at the level of participants with personality disorders and they showed a unique pattern of personality disorder traits, schemas and modes in comparison to participants with a personality disorder.
- Following these results, an adapted form of schema therapy using the presented mode model could be a viable option for the treatment of complex dissociative disorders.

‘‘Stabilizing treatment‘‘

A Survey of Practices and Recommended Treatment Interventions Among Expert Therapists Treating Patients With Dissociative Identity Disorder and Dissociative Disorder Not Otherwise Specified

Bethany L. Brand
Towson University

Amie C. Myrick
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Richard J. Loewenstein
Sheppard Pratt Health System, Baltimore, MD

Catherine C. Classen
University of Toronto

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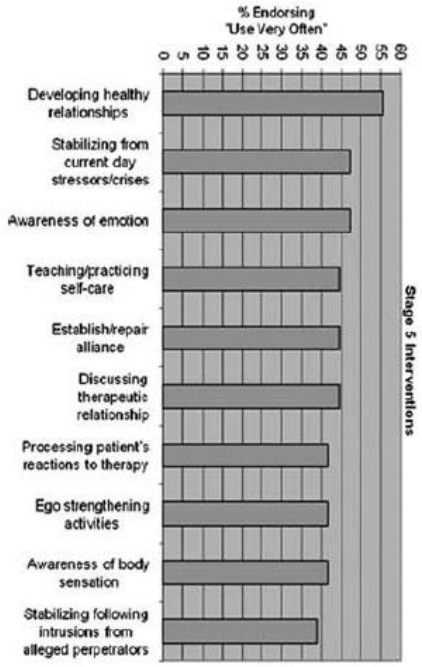
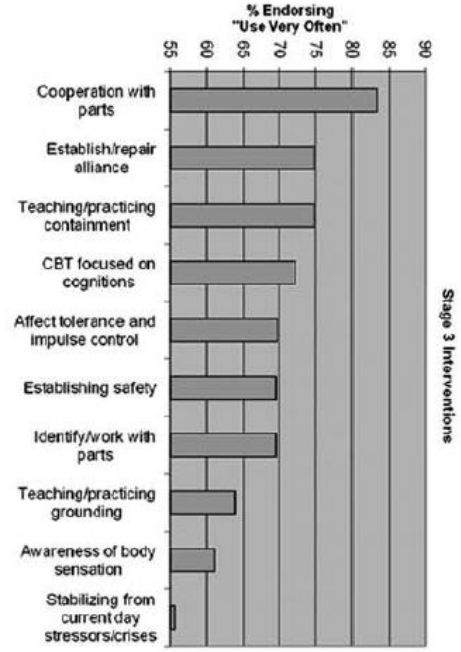
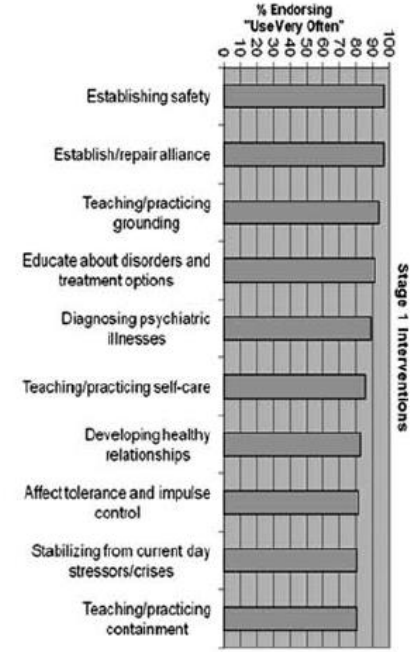
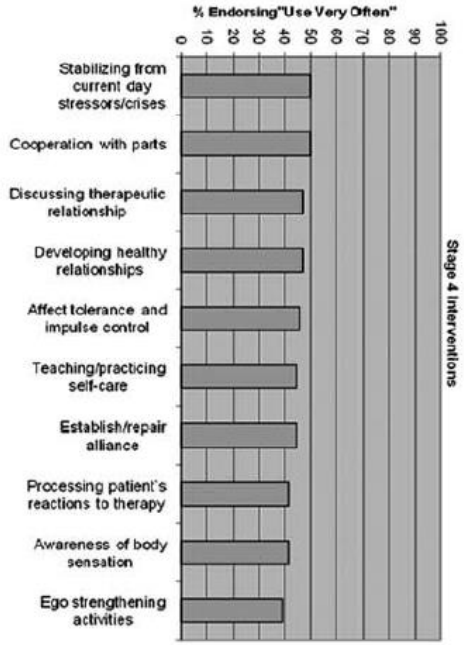
Cincinnati Children’s Hospital Medical Center and University of North Carolina School of Medicine

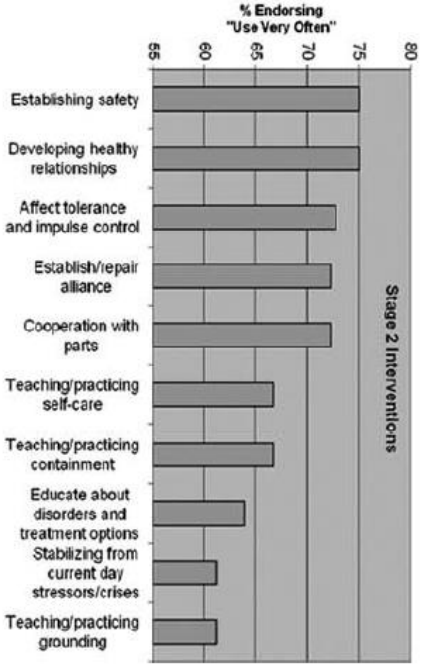
Little empirical evidence exists about the treatment of dissociative identity disorder and dissociative disorder not otherwise specified. Thus, we must rely on the clinical literature, which advocates a staged course of treatment. A survey of 36 international experts in the treatment of dissociative disorder (DD) was conducted to learn what treatment interventions they recommended at each stage of treatment. These highly experienced therapists recommended a carefully staged treatment consisting of three phases. In the initial phase, they advocated emphasizing skill building in development and maintenance of safety from dangerousness to self or others and other high-risk behaviors, as well as emotion regulation, impulse control, interpersonal effectiveness, grounding, and containment of intrusive material. In addition, they recommended specific trauma-focused cognitive therapy to address trauma-based cognitive distortions. They uniformly recommended identifying and working with dissociated self states beginning early in treatment. They advised the use of exposure or abreaction techniques—albeit modified to not overwhelm these complex dissociative patients—balanced with core, foundational interventions for the middle stage. The last stage of treatment is less clearly delineated and more individualized. Unification of self states appears to occur in only a minority of patients with DD. This study provides directions to pursue for future training and research on DD.











Is skills training useful? Yes!

Bækkelund et al. BMC Psychiatry (2022) 22:338
https://doi.org/10.1186/s12888-022-03970-8

BMC Psychiatry

RESEARCH Open Access

Group treatment for complex dissociative disorders: a randomized clinical trial

Harald Bækkelund[1,2,3*], Pål Ulvenes[1,3], Suzette Boon-Langelaan[4] and Espen Ajo Arnevik[5]

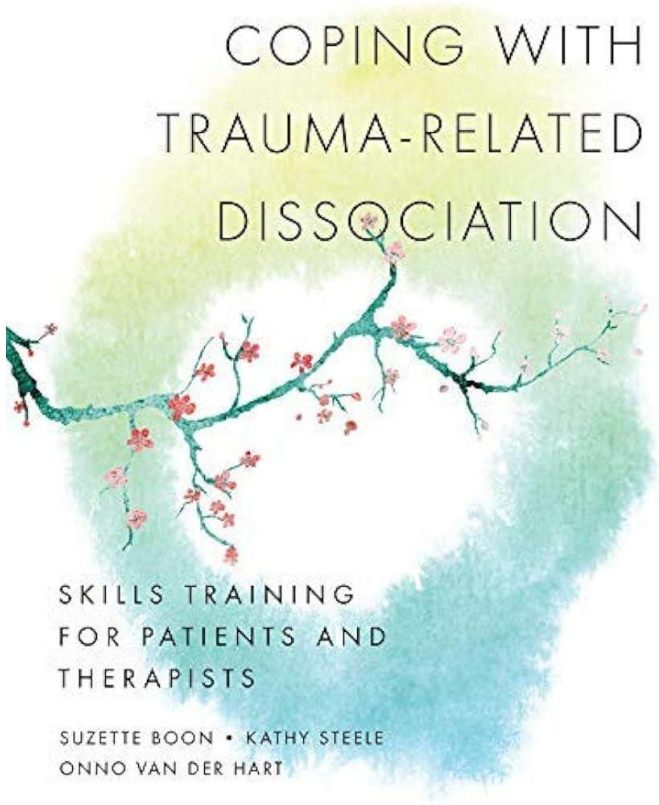


Table 5 Mean, Standard deviation, and effect sizes from assessment to follow-up

Measure and allocation	Assessment	T1 Pre treatment	T2 Switching - point	T3 Switching replication	T4 Follow up CTR	Effect size (*d*) Pre – switching point	Effect size (*d*) pre – follow up
GAF							
EXP		41.7 (5.7)	43.9 (6.3)	48.4 (6.3)		0.4 (−0.1 – 0.9)	1.1 (0.6 – 1.7)**
CTR		40.9 (8.2)	44.2 (8.7)	45.7 (4.2)	46.6 (6.7)	0.4 (−0.1- 0.8)	0.7 (0.3-1.2)*
PSS-SR							
EXP	32.9 (6.3)	33.3 (5.5)	33.2(6.5)	33.3 (6.9)		0.0 (−0.5 – 0.4)	−0.1 (−0.6 – 0.4)
CTR	34.6 (8.3)	34.6 (7.3)	36.5 (6.4)	34.5 (5.9)	29.5 (7.9)	−0.2 (−.0.6 – 0.1)	0.6 (0.1 – 1.1)**
DES							
EXP	34.6 (29.8)	36.5 (15.9)	38.2 (16.1)	36.0 (16.6)		−0.1 (−0.5 – 0.2)	−0.1 (−0.4 – 0.3)
CTR	41.9 (21.2)	47.8 (18.6)	45.4 (13.6)	40.8 (13.6)	37.9 (11.5)	−0.1 (−0.6 – 0.3)	0.2 (−0.3 – 0.7)
SCL90							
EXP	1.8 (0.9)	1.8 (0.7)	1.7 (0.8)	1.7 (0.9)		0.1 (−0.4 – 0.6)	0.1 (−0.4-0.6)
CTR	1.9 (0.7)	1.9 (0.9)	1.9 (0.9)	1.9 (1.0)	1.6 (0.8)	0.0 (−0.4 – 0.4)	0.4 (−0.1 – 0.9)*
IIP							
EXP	1.7 (0.6)	1.8 (0.1)	1.7 (0.6)	1.7 (0.6)		0.0 (−0.6 – 0.5)	0.0 (−0.4 – 0.4)
CTR	1.7 (0.5)	1.7 (0.7)	1.7 (0.5)	1.6 (0.8)	1.4 (0.7)	0.0 (−0.3 - 0.3)	0.4 (0.0 – 0.9)

Note: Data displayed as mean (std. deviation) or effect size (95% confidence interval). *$p < 0.05$, **$p < 0.01$, based on paired-samples tests; *GAF* Global Assessment of Functioning, *PSS-SR* PTSD Symptom Scale Self Report, *DES* Dissociative Experiences Scale, *IIP 64* Inventory of Interpersonal Problems 64, *SCL* 90 = Symptom Checklist 90

Is skills training sufficient? No!

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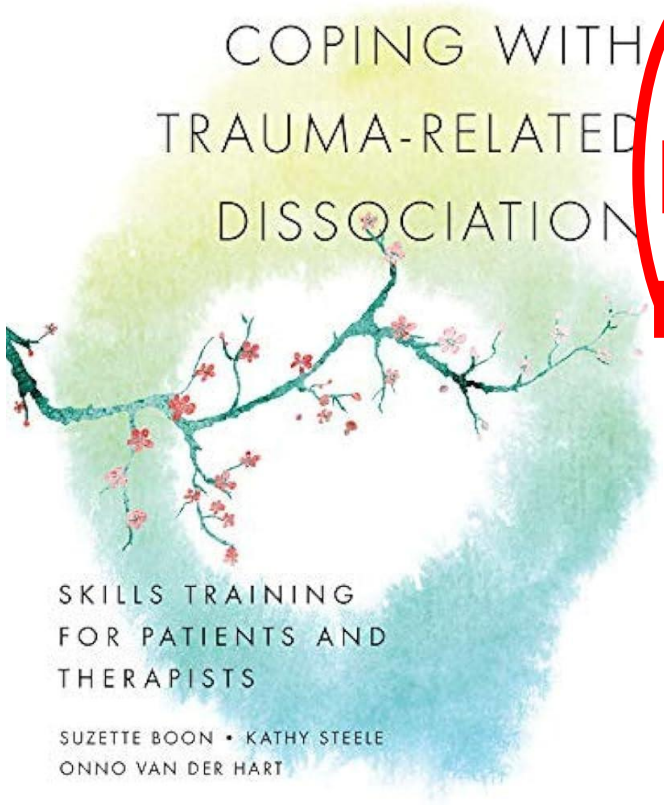

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- Ultra-complex patients don‘t need ultra-complex treatments, but modular treatments
- Strategies to work with
  - emotional dysregulation and dissociation
  - **alters?**
  - voices?
  - dissociative amnesia?
  - traumatic memories?

No reification of dissociative states

It is clinically disastrous to not hold the DID patient responsible for behavior, even if experienced by some self-states with amnesia or lack of subjective agency

Richard Loewenstein (2022)

Self-states as modes

Detached protector

Detached self-soother

Compliant surrender

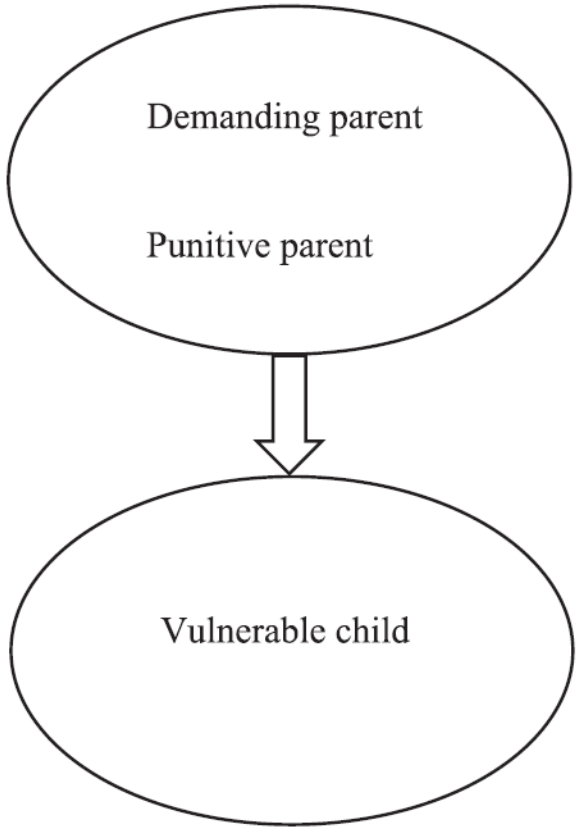

FIGURE 2 Schema mode model of CDD.

Name identity	Age	Behavior	Function of the behavior	Emotion	Need	Mode

A simple thing that is hard to do?

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Targeting dissociation using cognitive behavioural therapy in voice hearers with psychosis and a history of interpersonal trauma: A case series

Filippo Varese*[1,2], Maggie Douglas[3], Robert Dudley[3,4], Samantha Bowe[5], Thomas Christodoulides[3], Stephanie Common[6], Tim Grace[6], Victoria Lumley[6], Laura McCartney[3], Sonia Pace[3], Thomas Reeves[3], Anthony P. Morrison[1,5] and Douglas Turkington[7]

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A treatment protocol to guide the delivery of dialogical engagement with auditory hallucinations: Experience from the Talking With Voices pilot trial

Eleanor Longden*[1,2,3], Dirk Corstens[4], Anthony P. Morrison[1,2], Amanda Larkin[1], Elizabeth Murphy[1], Natasha Holden[1], Ann Steele[1], Alison Branitsky[1,2,3] and Samantha Bowe[1]

Voice hearers' experiences of the Making Sense of Voices approach in an NHS setting

Craig Steel[a], Joachim Schnackenberg[b,c], Zoe Travers[d], Eleanor Longden[e], Emily Greenfield[d], Lynette Meredith[a], Hayley Perry[f] and Dirk Corstens[g]

Making Sense of Voices: a case series

Craig Steel[a], Joachim Schnackenberg[b,c], Hayley Perry[d], Eleanor Longden[e], Emily Greenfield[f] and Dirk Corstens[g]

[a]School of Psychology and Clinical Language Sciences, University of Reading, Reading, UK; [b]Stiftung Diakoniewerk Kropp & St Ansgar gGmbH Kropp, Kropp, Germany; [c]EFC Institut, Hohn, Germany; [d]Thames Valley Clinical Trial Unit, University of Reading, Reading, UK; [e]Greater Manchester Mental Health NHS Foundation Trust, Manchester, UK; [f]Berkshire Healthcare Foundation Trust, Bracknell, UK; [g]MET ggz Roermond and Maastricht University, Netherlands

Compassion Focused Approaches to Working With Distressing Voices

Charles Heriot-Maitland[1,2], Simon McCarthy-Jones[3], Eleanor Longden[4] and Paul Gilbert[5]**

Engaging dialogically with auditory hallucinations: design, rationale and baseline sample characteristics of the Talking With Voices pilot trial

Eleanor Longden[a,b,c], Dirk Corstens[d], Melissa Pyle[a], Richard Emsley[e], Sarah Peters[b], Nisha Chauhan[a], Nikki Dehmahdi[a] and Anthony P. Morrison[a,b]

Psychosis
2011, 1–10, iFirst Article

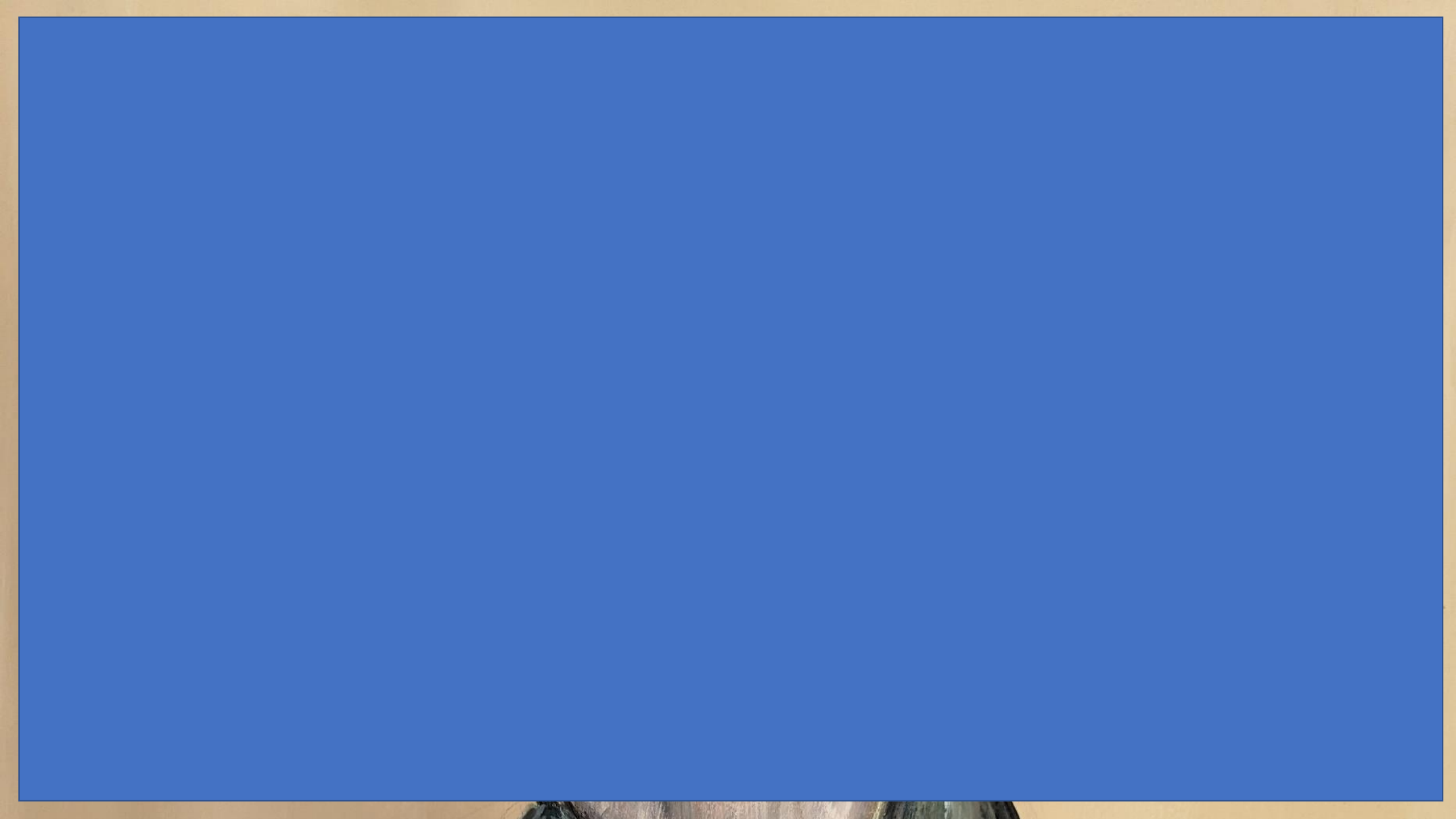
Routledge
Taylor & Francis Group

BRIEF REPORT

Talking with voices: Exploring what is expressed by the voices people hear

Dirk Corstens*[a], Eleanor Longden[b] and Rufus May[c]

[a]*RIAGG Maastricht, Maastricht, The Netherlands;* [b]*School of Psychological Sciences, University of Leeds, Leeds, UK;* [c]*Bradford District Care Trust, Bradford, UK*



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There is no objective amnesia

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Behaviour Research and Therapy 45 (2007) 775–789
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Memory transfer for emotionally valenced words between identities in dissociative identity disorder

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[b]Maastricht University, Department of Clinical, Medical, and Experimental Psychology, Maastricht, The Netherlands
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Abstract

The present study aimed to determine interidentity retrieval of emotionally valenced words in dissociative identity disorder (DID). Twenty-two DID patients participated together with 25 normal controls and 25 controls instructed to simulate DID. Two wordlists A and B were constructed including neutral, positive and negative material. List A was shown to one identity, while list B was shown to another identity claiming total amnesia for the words learned by the first identity. The identity claiming amnesia was tested for intrusions from list A words into the recall of words from list B and recognition of the words learned by both identities. Test results indicated no evidence of total interidentity amnesia for emotionally valenced material in DID. It is argued that dissociative amnesia in DID may more adequately be described as a disturbance in meta-memory functioning instead of an actual retrieval inability.
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PLoS one

Inter-Identity Autobiographical Amnesia in Patients with Dissociative Identity Disorder

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Abstract

Background: A major symptom of Dissociative Identity Disorder (DID; formerly Multiple Personality Disorder) is dissociative amnesia, the inability to recall important personal information. Only two case studies have directly addressed autobiographical memory in DID. Both provided evidence suggestive of dissociative amnesia. The aim of the current study was to objectively assess transfer of autobiographical information between identities in a larger sample of DID patients.

Methods: Using a concealed information task, we assessed recognition of autobiographical details in an amnesic identity. Eleven DID patients, 27 normal controls, and 23 controls simulating DID participated. Controls and simulators were matched to patients on age, education level, and type of autobiographical memory tested.

Findings: Although patients subjectively reported amnesia for the autobiographical details included in the task, the results indicated transfer of information between identities.

Conclusion: The results call for a revision of the DID definition. The amnesia criterion should be modified to emphasize its subjective nature.

Citation: Huntjens RJC, Verschuere B, McNally RJ (2012) Inter-Identity Autobiographical Amnesia in Patients with Dissociative Identity Disorder. PLoS ONE 7(7): e40580. doi:10.1371/journal.pone.0040580

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Competing Interests: The authors have declared that no competing interests exist.

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OPEN ACCESS PEER-REVIEWED
RESEARCH ARTICLE

Inter-identity amnesia for neutral episodic self-referential and autobiographical memory in Dissociative Identity Disorder: An assessment of recall and recognition

Rosemary J. Marsh, Martin J. Dorahy, Chandele Butler, Warwick Middleton, Peter J. de Jong, Simon Kemp, Rafaele Huntjens

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Abstract

Amnesia is a core diagnostic criterion for Dissociative Identity Disorder (DID), however previous research has indicated memory transfer. As DID has been conceptualised as being a disorder of distinct identities, in this experiment, behavioral tasks were used to assess the nature of amnesia for episodic 1) self-referential and 2) autobiographical memories across identities. Nineteen DID participants, 16 DID simulators, 21 partial information, and 20 full information comparison participants from the general population were recruited. In the first study, participants were presented with two vignettes (DID and simulator participants received one in each of two identities) and asked to imagine themselves in the situations outlined. The second study used a similar methodology but with tasks assessing autobiographical experience. Subjectively, all DID participants reported amnesia for events that occurred in the other identity. On free recall and recognition tasks they presented a memory profile of amnesia similar to simulators instructed to feign amnesia and partial information comparisons. Yet, on tests of recognition, DID participants recognized significantly more of the event that occurred in another identity than simulator and partial information comparisons. As such, results indicate that the DID performance profile was not accounted for by true or feigned amnesia, lending support to the idea that reported amnesia may be more of a perceived than actual memory impairment.

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Subjective amnesia – a metacognitive problem

Autobiographical Memory Specificity in Dissociative Identity Disorder

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Repeated Retrieval of Generalized Memories can Impair Specific Autobiographical Recall: A Retrieval Induced Forgetting Account

Noboru Matsumoto[1], Satoshi Mochizuki[2], Laura Marsh[3], and Jun Kawaguchi[4, 5]
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[3] MRC Cognition and Brain Sciences Unit, University of Cambridge
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Keywords: retrieval-induced forgetting, overgeneral memory, autobiographical memory specificity, depression, rumination

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The Dissociation-Related Beliefs About Memory Questionnaire (DBMQ): Development and Psychometric Properties

Rafaële J. C. Huntjens[1], Martin M. J. Dorahy[2, 3], Danielle Read[2], Warwick Middleton[2, 3], and Agnes van Minnen[4]
[1] Department of Experimental Psychotherapy and Psychopathology, University of Groningen
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Clinical Impact Statement
Dissociative symptoms are common in people reporting exposure to traumatic stress. For instance, people report amnesia for (parts of) their trauma history. Beliefs about the way memory works and beliefs related to fears of overwhelming emotion related to past memories may be an important factor explaining the occurrence and/or maintenance of reported memory problems. This paper reports the development of a questionnaire designed to assess beliefs about memory functioning with regard to dissociation. We found that a short questionnaire (16 items) could reliably measure these beliefs. These beliefs were associated with trait dissociation and posttraumatic avoidance symptoms.

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Evidence of a Continuum of Trait Mindfulness Deficits in Psychiatric Disorders

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Dear Editor,

Trait mindfulness has been linked to behavioral regulation, reduced psychopathology, and subjective well-being [1]. Yet, trait mindfulness deficits are a poorly understood concept in psycho-

to the retrospective nature of our investigation, formal consent of the local ethics committee was not required. All procedures were in accordance with the Helsinki Declaration as revised in 2013.

To compare FMI scores between diagnostic groups, a 1-way ANOVA with Welch's correction and Games-Howell post hoc test at 5% significance level were performed using R version 3.5.0 [6]. 95% confidence intervals for Cohen's d were calculated based on noncentral t-distributions.

The 1,823 inpatients (female = 1,372; male = 451) had a mean age of 51.7 years (SD = 11.5). Please see the online supplementary material for details on the sample and a table of the mean CTQ scores and standard deviations across diagnostic groups (see www.karger.com/doi/10.1159/000493365 for all online suppl. material). The ANOVA yielded significant variation of FMI scores among the diagnostic groups ($F(6, 1{,}816) = 25.6$, $p < 0.001$, $\eta^2 = 0.08$ [0.06–0.10]). Means and standard deviations of the FMI scores of the different diagnostic groups can be obtained from Table 1.

Post hoc analyses showed that trait mindfulness levels in dissociative identity disorder were significantly lower than in BPD (d = 0.63 [0.25, 1.01]), PTSD (d = 0.84 [0.53, 1.15]), MDD-ct (d = 1.17 [0.87, 1.47]), AD (d = 1.14 [0.69, 1.58]), and MDD-noct (d = 1.48 [1.16, 1.79]). The trait mindfulness scores for dissociative disorder not otherwise specified were significantly lower than for MDD-ct (d = 0.61 [0.35, 0.87]), AD (d = 0.61 [0.22, 1.01]), and MDD-noct (d = 0.92 [0.65, 1.19]). BPD was found to differ significantly regarding trait mindfulness from MDD-ct (d = 0.43

N = 1823; Freiburg Mindfulness Inventory
DID: less trait mindfulness that both BPD (d=.63) and PTSD (d=.84)

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- Overgeneral autobiographical memory
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  - Lack of self-reference
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  - Fear of losing control
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  - Positive beliefs about amnesia*
  - Lack of self-reference
  - Fragmentation
  - Fear of losing control
- Mentalizing / mindfulness deficits

**** "Dissociative amnesia protects me, otherwise I'd go crazy." – Cognitive Therapy!***

Treatment: A simple thing that is hard to do?

BRIEF REPORT

Treating Adults With Complex Posttraumatic Stress Disorder Using a Modular Approach to Treatment: Rationale, Evidence, and Directions for Future Research

Thanos Karatzias[1,2] and Marylene Cloitre[3]
[1]Edinburgh Napier University, School of Health & Social Care, Edinburgh, United Kingdom
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Dialectical Behaviour Therapy for Post-traumatic Stress Disorder after Childhood Sexual Abuse in Patients with and without Borderline Personality Disorder: A Randomised Controlled Trial

Martin Bohus[a] Anne S. Dyer[a] Kathlen Priebe[a] Antje Krüger[a]
Nikolaus Kleindienst[a] Christian Schmahl[a] Inga Niedtfeld[a] Regina Steil[b]

[a]Department of Psychosomatic Medicine and Psychotherapy, Central Institute of Mental Health, Medical Faculty Mannheim/Heidelberg University, Mannheim, and [b]Department of Psychology and Sports Sciences, Institute of Psychology, Johann Wolfgang Goethe University, Frankfurt am Main, Germany

- Ultra-complex patients don‘t need ultra-complex treatments, but modular treatments
- Strategies to work with
  - emotional dysregulation and dissociation
  - alters?
  - voices?
  - dissociative amnesia?
  - **traumatic memories?**

frontiers | Frontiers in Psychiatry

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A Transtheoretical Model and Treatment of Dissociative Identity Disorder: A Case Report

Autorinnen/Autoren
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ZUSAMMENFASSUNG

Die dissoziative Identitätsstörung ist die schwerste dissoziative Störung und kann in ihrer Komplexität weder durch das Trauma-Modell noch durch das soziokognitive Modell hinreichend erklärt werden. Transtheoretische Modelle legen eine Interaktion von traumatischen Erfahrungen mit kulturellen, kognitiven und sozialen Einflüssen für die Ätiopathogenese des Störungsbildes nahe. Daraus ergeben sich bedeutende Impulse für die Behandlung, in der neben einer Verarbeitung traumatischer Erinnerungen auch eine Verbesserung der Emotionsregulation sowie eine Modifikation dysfunktionaler Annahmen über das Gedächtnis erfolgen sollte. Einer Ausgestaltung von Teilidentitäten sollte kein Vorschub geleistet werden. Ein derartiges therapeutisches Vorgehen im Rahmen stationärer Psychotherapie wird beschrieben.

ABSTRACT

Dissociative identity disorder is the most severe of the dissociative disorders and neither the trauma model nor the sociocognitive model provide a satisfactory account of its complexity. Transtheoretical models propose an interaction of traumatic experiences as well as cultural, cognitive, and social factors in the development of the disorder. This perspective has important implications for the treatment which should encompass a reprocessing of traumatic memories, emotional regulation skills, and a modification of dysfunctional beliefs about memory. An elaboration of dissociative identities should be prevented. A corresponding inpatient treatment approach is described.

Schema therapy for Dissociative Identity Disorder: a case report

Nathan Bachrach[1,2]*, Marleen M. Rijkeboer[3,4], Arnoud Arntz[4] and Rafaële J. C. Huntjens[5]

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Treatment for Dissociative Identity Disorder (DID) often follows a practice-based psychodynamic psychotherapy approach that is conducted in three phases: symptom stabilization, trauma processing, and identity integration and rehabilitation. The pe
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symptoms have been
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investigated in sever
based treatment for
adaptations for DID
female patient with D
disorder, and BPD. F
which included direc
The patient improvec
symptoms, as well as
beliefs about the self,
to stop her punitive
participate adequately
be a viable treatment
this patient group.

KEYWORDS
schema therapy, Dissoc

Check for updates

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A brief cognitive-behavioural treatment approach for PTSD and Dissociative Identity Disorder, a case report

Agnes van Minnen [a,b,*], Marleen Tibben [c]

[a] Radboud University Nijmegen, Behavioural Science Institute (BSI), the Netherlands
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ABSTRACT

Background and objectives: We described a new treatment model for Posttraumatic Stress Disorder (PTSD) and Dissociative Identity Disorder (DID), based on cognitive-behavioural principles. In this model, dissociation is seen as a maladaptive avoidant coping strategy. In addition, we stress that patients have dysfunctional beliefs about dissociation. Both elements, avoidance behaviour and dysfunctional beliefs, are challenged during the brief, intensive trauma-focused treatment. When the PTSD-symptoms decrease, the patient is offered a fare-well ritual to say goodbye to their identities in one or more additional sessions.
Methods: We illustrate this treatment approach with a case report of a woman with PTSD as a result of sexual abuse in her childhood, and DID with four identities. Treatment outcome was measured at intake, at pre-treatment, at post-treatment and at 3 and 6 months follow-up.
Results: After the short treatment of only 2 weeks, she no longer fulfilled the DSM-5 diagnostic criteria for PTSD nor DID. These results were maintained at the follow-ups.
Limitations: Although we included a baseline-controlled time phase, it was not a controlled study, and only one patient was treated.
Conclusions: This new treatment model for DID-patients is promising but results should be interpreted cautiously since we described only one patient.

„A hurtful bumpy road that helps“

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RESEARCH ARTICLE

The bumpy road of trauma-focused treatment: Posttraumatic stress disorder symptom exacerbation in people with psychosis

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Stichting tot Steun Vereniging tot Christelijke Verzorging van Geestes- en Zenuwzieken

Abstract
Concern for symptom exacerbation and treatment drop-out is an important barrier to the implementation of trauma-focused therapy (TFT), especially in people with a psychotic disorder. This study, which was part of a multicenter randomized controlled trial, investigated posttraumatic stress disorder (PTSD) symptom exacerbation during eye movement desensitization reprocessing (EMDR) therapy and prolonged exposure (PE) in a sample of 99 participants with PTSD and psychosis. Symptom exacerbations during the first four sessions (early exacerbation) and between-session exacerbations over the course of therapy were monitored using the PTSD Symptom Scale–Self Report. Analyses of covariance and chi-square tests were conducted to investigate exacerbation rates and their associations with treatment response and drop-out. Both early exacerbation

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Significant improvement of posttraumatic stress disorder and psychotic symptoms after inpatient Eye Movement Desensitization and Reprocessing treatment: A case report with 6-month follow-up

Sir,

Recent findings suggest a relationship between psychological trauma and schizophrenia spectrum disorders[1] that is partially mediated by posttraumatic stress symptoms.[2] Even though there is evidence that trauma-focused treatments are beneficial for patients with psychotic symptoms,[2] patients with psychosis are still often excluded from first-line treatments of posttraumatic stress disorder (PTSD) due to fears that psychotic symptoms might exacerbate during trauma reprocessing. We want to encourage clinicians to apply trauma-focused therapy to patients with PTSD and psychotic symptoms.

Our patient was a 53-year-old woman diagnosed with PTSD and schizotypal personality disorder according to Diagnostic and Statistical Manual of Mental Disorders, 4th Edition criteria. She reported flashbacks, insomnia, nightmares, avoidance, hyperarousal, severe derealization and depersonalization, feelings of guilt, constricted affect, obsessive ruminations with aggressive and sexual content, magical thinking, paranoid ideas, social phobia, and visual, body, and acoustic hallucinations. Her trauma history was assessed using the Childhood Trauma Questionnaire and consisted of childhood sexual abuse, emotional abuse and neglect. For more than 20 years, she had had several suicidal crises, inpatient, and outpatient treatments. At the time of admission, her stable medication consisted of 15 mg aripiprazole, 350 mg quetiapine, and 375 mg venlafaxine. She was in early pension and described to profit from outpatient cognitive behavioral therapy (CBT) and medication. Yet, so far nothing had helped to significantly reduce intrusions, nightmares, and hallucinations.

The patient received a multimodal, integrative, and disorder-specific inpatient treatment with various group therapies, for example, psychoeducation, mindfulness training, art therapy, exercise therapy, emotion regulation, and social skills trainings.[4] Case conceptualization followed the Eye Movement Desensitization and Reprocessing (EMDR) guidelines for psychosis[5] and the cognitive model of psychosis.[6] Treatment lasted 12 weeks and consisted of 16 individual 50-min treatment sessions of CBT and ten additional 100-min sessions of EMDR. Symptom levels were assessed daily using an individualized diary card. We used standard EMDR to process traumatic memories of childhood sexual abuse, whereas the goal of reducing psychotic symptoms was targeted by processing hallucinations associated to the patient's dysfunctional beliefs about the world and herself ("The world is dangerous," "I cannot protect myself"). For example, we targeted a recurring hallucination of body disintegration and penetration of body boundaries related to the cognition "I am lost," tonic immobility, disgust and panic. EMDR helped the patient to form alternative cognitions like "I can help myself" and significantly reduced aversive emotions.

Even though the patient described EMDR sessions as demanding and frightening, she considered them helpful for "finally learning to express in words what happened." After an initial increase of anxiety, hallucinations and dissociative experiences, symptoms decreased. The score for intrusions in the Impact-of-Event Scale–Revised remained stable from first assessment to dismissal (from 31/35 to 29/35) but had decreased significantly 6 months after dismissal (4/35; improvement of 2.6 standard deviation [SD]). The reduction of avoidance symptoms (22/40-15/40) was maintained at follow-up (12/40; improvement of 1.1 SD). Hyperarousal decreased significantly, too (from 26/35 to 19/35 to 5/35; improvement of 1.9 SD). These improvements reflect both reliable and clinically significant changes. In the HEALTH-49, the patient described significant reductions of depressive symptoms (from 3/4 to 0.7/4 to 0.2/4; improvement of 2.8 SD), anxious symptoms (from 3/4 to 1.8/4 to 0.2/4; improvement of 3.0 SD), and interpersonal difficulties (from 3.1/4 to 2.6/4 to 2.1/4; improvement of 0.9 SD). We also observed significant changes in self-efficacy (from 2.2/4 to 3/4 to 3.8/4; improvement of 1.7 SD) and mindfulness (from 61/120 to 83/120 to 99/120; 3.3 SD) which was assessed using the Freiburg Mindfulness Inventory. The Dissociative Experiences Scale–Taxon score decreased from 18% to 1% and remained stable at follow-up (1%). The PANSS score decreased from 64 to 46 which reflects a clinically important difference.

In sum, reprocessing of traumatic memories effectively helped the patient to remit from PTSD and positive psychotic symptoms. Symptom levels had decreased even further at 6-month follow-up. The patient reported that her disturbing "images" had vanished, that she felt well, that she could now "handle everyday life" and that she was doing voluntary work. She decided to end her outpatient CBT treatment but still consults her psychiatrist regularly. As we observed initial increases of psychotic symptoms, inpatient treatment might be a useful option in the treatment of PTSD and psychotic symptoms.

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"It hurt but it helped": A mixed methods audit of the implementation of trauma-focused cognitive-behavioral therapy for psychosis

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Background: Emerging evidence supports the safety, acceptability, and efficacy of trauma therapies for people experiencing post-traumatic stress and psychosis, despite common concerns about iatrogenic harm when processing trauma memories for this population. However, to date there have been no mixed-method studies examining whether trauma-focused therapy can be implemented in routine care. This study reports an audit of a post-traumatic stress in psychosis clinic based in an inner-city trust in the U.K. National Health Service.

Materials and methods: People under the care of psychosis community mental health teams with a significant history of past trauma were referred to the clinic by their multidisciplinary clinicians. Referral outcomes were recorded, including the proportion of people for whom trauma-focused cognitive-behavior therapy for psychosis was indicated. Post-traumatic stress symptoms were assessed pre- and post-therapy for clinically significant change on the Post-traumatic Stress Checklist (version 4) and Post-traumatic Stress Checklist (version 5). A subgroup of service users was also interviewed about their experience of therapy, with transcripts analyzed using inductive thematic analysis.

Bold statements revisited

- Psychotic symptoms like AVH are common in trauma-related disorders and BPD
- The ICD-11 is wrong: AVH in trauma-related disorders are neither quasi-psychotic nor pseudohallucinations, but phenomenologically similar to those in psychosis
- AVH are underlain by the same mechanisms in psychosis, trauma-related disorders, and BPD, i.e. first and foremost dissociation
- Definitions aren‘t explanations, psychiatric disorders aren‘t latent entities, symptoms aren‘t signs, and we need a phenomenological approach to dissociation
- *Psychotic PTSD* is not a thing. Yet, (Partial) Dissociative Identity Disorder is underdiagnosed and undertreated (or treated using pseudoscientific approaches)
- The treatment of severe dissociative symptoms and disorders is *a simple thing that is hard to do*