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PSYCHOTERAPEUTIC APPROACHES TO DISSOCIATIVE AND PERSONALITY DISORDERS

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Abstract

Dissociative and personality disorders are frequently characterized by a severe psychopathology, high rates of comorbidity and impairments. Experience with aversive events is believed to be an important etiological factor in the development of these disorders. The psychotherapeutic approaches to these disorders pay particular attention to such issues. Available treatments of dissociative disorders take into account comorbidity issues, which are very often explained by a personal history of extremely stressful situations. Therefore there are no universal intervention strategies for treating dissociative disorders. Treatment needs to address the specific problems and histories of the affected individuals. As with personality disorders, the pathological personality structure determines the development of complex interactional and emotional deficits, disturbed perception of self and others, and impulse control problems. These deficits constitute the primary focus of psychotherapy rather than the actual personality disorders. This present work reviews several effective psychotherapeutic techniques for the treatment of dissociative and personality disorders. It discusses theoretical considerations and presents practical aspects as well as empirical evidence of psychotherapeutic strategies for patients with dissociative and personality disorders.

Keywords: psychotherapy, dissociative disorders, personality disorders, trauma-related and other comorbidities

1. Dissociation and Dissociative Disorders (DDs)

Dissociation is a different state of consciousness characterized by partial or complete disturbance of the integration of a person's normal conscious or psychological functioning (cognitive, emotional and/or perceptual) [1]. Most common dissociative experiences include derealisation (altered perception of the external world so that it seems unreal or strange) and depersonalization (feelings of detachment from one's emotions, body and/or immediate surroundings, e.g. watching oneself from a point outside one's own body) [2]. Dissociation has been also described as a *compartmentalization of experience* [3]: psychological processes (i.e. memory, emotions, and perception) that are integrated under usual circumstances become separated to various degrees.

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DDs are conditions that involve *disruptions/breakdowns of fundamental psychological processes, such as memory, awareness, identity and/or perception* [2]. Patients with DDs escape from reality involuntarily, especially when they are confronted with situations subjectively perceived as stressful. Usually the development of these disorders is the *response to psychological aversive/traumatic situations* [2], used as cognitive and emotional processing mechanisms and coping strategies to deal with very stressful, negative/traumatic events and memories. There are *five types of DDs* listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), as follows:

- *Depersonalization disorder:* episodes of *detachment from self/surroundings*, which is perceived as *unreal* (lacking in control over self or being outside of self). The person is aware that this is only a feeling and does not correspond to reality.
- *Dissociative amnesia: significant inability of autobiographic recall* as a consequence of traumatic experiences.
- *Dissociative fugue: sudden, unexpected actual escape from usual surroundings* accompanied by *experience of impaired recall of the past*, possibly leading to confusion about own identity and the assumption of a new identity.
- *Dissociative identity disorder (DID):* the interchange between two or more distinct *personality states* with *impaired memory* of significant personal information among these states.
- *Dissociative disorder not otherwise specified (DDSNOS):* forms of pathological dissociation *not enclosed by any of the specific DDs*.
- *Conversion disorder:* in the ICD-10 classified as a DD while in the DSM-IV categorized as a *somatoform disorder*.

2. Personality Disorders (PDs) and their shared characteristics

PDs are psychological disorders in which a person's *long-term behaviours, emotions, and thoughts* are *extremely deviant from their cultural accepted norms*, socially *inflexible*, and *cause serious problems* in important areas of functioning [2]. *Ten types of personality disorders* have been classified in *three clusters* on the axis II of the DSM-IV:

- *Cluster A* (odd or eccentric disorders) includes: (1) *paranoid PD* (irrational suspicions and mistrust of others); (2) *schizoid PD* (lack of interest in social relationships, seeing no point in sharing time with others, anhedonia, introspection); (3) *schizotypal PD* (characterized by odd behaviour or thinking);
- *Cluster B* (dramatic, emotional or erratic disorders): (1) *antisocial PD* (a pervasive disregard for the law and the rights of others); (2) *borderline PD/BPD* (extreme 'black and white' thinking, instability in relationships, self-image, identity and behaviour often leading to self-harm and impulsivity); (3) *histrionic PD* (pervasive attention-seeking behaviour including inappropriately seductive behaviour and superficial or

exaggerated emotions); (4) *narcissistic PD* (a pervasive pattern of grandiosity, need for admiration, and a lack of empathy);

- *Cluster C* (anxious or avoidant disorders): (1) *avoidant PD* (social inhibition, feelings of inadequacy, extreme sensitivity to negative evaluation and avoidance of social interaction); (2) *dependent PS* (pervasive psychological dependence on other people); (3) *obsessive-compulsive PD* (characterized by rigid conformity to rules, moral codes and excessive organization).

Because PDs mainly affect social interactions, it has been often emphasized that they are basically *interactional disturbances* [4]. Starting from this idea, Peter Fiedler noted that by looking at the major deficits caused by PDs, one may establish a set of *characteristics shared to some degree by all PDs* [5]. According to Fiedler, the shared characteristics are as follows:

- *Disturbances in social interactions:* they significantly affect relationships in private life (family, friends) and work (execution of duties and responsibilities, handling criticism, adherence to rules);
- *Disturbances of emotional perception and experience:* dominance of negative emotions and/or inadequate emotional expression (anxiety, insecurity, sadness, emotional instability, theatrical behaviour);
- *Disturbances of reality perception:* distorted perception and misjudgement of external circumstances and relationships;
- *Disturbances of self-perception and self-presentation:* unrealistic self-assessment and evaluation of own abilities;
- *Disturbances of impulse and self-control:* e.g. tendencies of aggression, promiscuity, substance abuse, suicidal and parasuicidal behaviours, adventurous escapades, delinquency.

3. Comorbidity and Differential Diagnosis of DDs and PDs

Psychological comorbidities may be *highly complex* and necessitate special attention within the diagnostic and psychotherapeutic research and process.

Pathological dissociation occurs very rarely as a single, isolated disturbance. DDs are most commonly part of *complex psychopathological patterns* resulting from the *cognitive and emotional processing of traumatic experiences*. Additionally, DDs are being often under diagnosed in the clinical practice. Fiedler [5, p. 484] illustrates this phenomenon by exemplifying the prior diagnoses given to patients with DID: affective disorders (50-70%), anxiety disorders (29-46%), somatoform and somatisation disorders (15-19%), schizophrenia (14-40%), BPD (60-80%). While the diagnosis of schizophrenia was subsequently proved to be incorrect in most cases, the other diagnoses were most frequently secondary comorbid diagnoses.

In most people with specific mental disorders, a PD can be simultaneously diagnosed. For example, approximately 50% of the persons with anxiety and depressive disorders additionally show an avoidant PD, dependent PD,

obsessive-compulsive PD or BPD [5]. Research showed that certain PDs constitute *risk factors* for the later development of other specific disorders: e.g. BPD is a significant predictor of affective disorders [5]. Moreover, the *association between different PDs* is also very common: the diagnosis of a PD increase the probability for fulfilling the criteria of an additional PD.

4. Treatment for DDs

As already mentioned above, persons with DDs simultaneously present with other main psychological problems that need to be addressed in treatment. In most cases of DDs treatment has to particularly consider the *management of trauma-related symptoms and disorders*. *Flexibility, creativity and unconventional interventions* are the leading strategies for treating dissociation.

In the meanwhile, *integrated trauma-focused therapy approaches in cases of prevailing DDs* have been developed [6]: for example, the treatment for depersonalization disorder has been integrated in the therapeutic approaches for PTSD. Such treatments usually consist of *three phases*: (1) *crisis intervention*, (2) working at a soon *restoration of the ability to be remember* the amnesic episodes (e.g. by means of free associations, but also by using phantasies, dreams, hypnosis), and (3) developing the *awareness of the past traumatisation*, which has to be processed and reintegrated within the autobiographic memory. There are also very similar therapeutic strategies for dissociative amnesia, fugue and DESNOS.

Additionally, effective techniques of *dealing with dissociative states during therapy* have been made available. Therapists frequently do not recognize when their patients are dissociated or in a state of cognitive and emotional inaccessibility. These phenomena have been called *stuck-states* [7], i.e. dysfunctional schemes, in which patients are unable to perceive the reality and to learn new information (e.g. states of depersonalization or derealisation). According to evolutionary theories, dissociative states are hard-wired biological *defence mechanisms* developed along with the classic Freeze-Flight-Fight reactions. Although involving risks for bodily injuries, dissociation is the remaining survival strategy to reduce extreme affect and facilitate adaptive behaviour to inescapable threat by a superior aggressor [8]. Subsequently, dissociative responses to threatening situations may become *classically conditioned*, so that they reappear when the traumatic memory is reactivated, e.g. during trauma-focused therapy [9]. Furthermore, dissociation may become a *chronic, generalized pattern of reaction* elicited by various stress situations, even minor everyday stressors [10]. Various psychotherapeutic approaches have developed *helpful interventions for dissociative states* occurring during therapy. Several authors have summarized such strategies in this area, e.g. Martin Bohus [11]. Here are several examples:

- Short interruption for *stress regulation*, clear instruction to *vary the body posture*, *mindfulness exercises* or *change of the setting*(e.g. carrying out the session in standing or walking);

- Training for *self-management of dissociation* based on the concept of classical conditioned dissociative responses (*playing dead* program): teaching of *anti-dissociative skills* for efficient exposure and cognitive restructuring techniques (e.g. *self-observation* and *distress tolerance skills* according to the *dialectic behavioural therapy* by using *strong sensory stimuli*, for more details see below). These skills may be trained during the therapeutic session.

4.1. Treatment Guidelines of DID

DID is the most complex and difficult to treat DD. Onno van der Hart et al [12] developed a *trauma-related model of structural dissociation* that attempts to explain trauma-related disorders such as PTSD, BPD, and DID. This model relies on that same assumption that stress situations reactivate biologically predetermined behavioural responses. This model views dissociative responses of previously traumatized persons as *emotional parts of the personality (EPs)*, which are carrying the memories of previous traumatic experiences. When people are in their EP, they may be experiencing the emotions or cognitions that occurred during the traumatic event. The EPs are dissociated from the so-called *apparently normal part of the personality (ANP)*, which is that part of personality dealing with activities of daily living and mostly fading traumatic memories out. By this organization, reactivation of traumatic memories can be avoided during the daily activities. According to this theory, there are three *types of dissociation*: *primary*, *secondary*, and *tertiary* dissociation (see Table 1). By this view, DID patients may be understood as persons with several personality subsystems (each consisting of one ANP and several EPs), which may explain the alternating personality states that take control over the affected person and the impaired autobiographic memory among these states.

Since the *main psychotherapeutic aim* is *the integration of the dissociated personality states*, the treatment of DID is very complex and prolonged, necessitates a very *stable psychotherapist-patient relationship* [6, p. 484], and includes different techniques [International Society for the Study of Trauma and Dissociation, *Treatment Guidelines*, http://www.isst-d.org/education/treatmentguidelines-index.htm#adults, accessed 28 February 2012]. *Three main therapeutic stages* have been delimitated: (1) *building the therapeutic relationship* (empathy, safety, trust etc.); (2) *integration of different, more or less dissociated personality states*; (3) because of the very complex symptomatology (e.g. schyzotypical, borderline, histrionic personality characteristics), treatment is complex and requires a *detailed problem analysis* and therapy planning ahead. In addition to the integrating strategies of the personality states, a set of *directive and supporting techniques* are being employed [6, p. 484], such as: (a) continuous information and education of patients about their disorder, the etiologic causalities, and the therapeutic goals and procedures; (b) facilitation of trauma-related remembrance by conducting therapeutic sessions in relaxed/hypnotic states; (c) use of various techniques

such as video and tape recordings for an accurate documentation and confrontation with different aspects of personality; (d) *contract management* techniques to prove the validity of the agreements between patient and therapist; (e) strengthening of *personal resources*, e.g. positive relationships, competences, and other well-functioning areas.

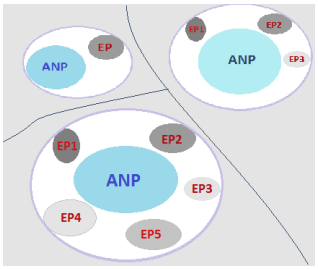
Type of dissociation	Diagnosis	Parts of the previously traumatised personality	
Primary	PTSD	One ANP and one EP experienced as "not me". In EP the trauma-related re-experiencing in form of flashbacks, emotions and cognitions takes place.	
Secondary	BPD DESNOS	One ANP and several EPs. Some EPs include active defence responses (arousal, flight, fight), whereas others exhibit dissociative responses (numbing, derealisation).	
Tertiary	DID DDNOS	Several EPs and several ANPs. More separation between parts of personality and reduced awareness from each other. The parts of personalities may be organised in substructures corresponding to particular developmental periods.	

Table 1. Schematic illustration of the *three types of structural dissociation* in the aftermath of exposure to aversive events according to the model of van der Hart. (While primary dissociation comprises persons with simple PTSD, secondary dissociation corresponds to complex PTSD and BPD, and tertiary dissociation describes persons with complex DDs, such as DID.)

5. An overview of main psychotherapeutic approaches for PDs

Personality has long been considered to be mostly formed during childhood and adolescence, after which it does not longer change significantly. Nowadays it is recognized that the development and maturation of personality are *continuous processes*, which last a lifetime [13]. This corresponds to the *salutogenesis* perspective on the development of the personality. The psychotherapy of PDs is based on this perspective, according to which personality may be positively influenced, even when dealing with severe PDs.

Psychotherapy is the *core treatment* for PDs. During psychotherapy, patients learn about their condition and their mood, feelings, thoughts and behaviour. Patients also learn appropriate ways to manage their symptoms. Several *general guidelines for the treatment of PDs* have been defined: *not the PDs themselves are being treated, but the resulting shared characteristics of PDs* described above [5] (i.e. complex interaction problems, problems in the domains of emotional experience, reality perception, the self-assessment and/or presentation, and impulse control problems). Therapy of PDs should be especially oriented to the immediate reality and to *here and now* and should focus on concrete changes in the immediate future. Because PDs produce symptoms as a result of poor or limited coping skills, psychotherapy aims at identifying perceptual distortions and their historical sources and facilitating the development of more adaptive modes of perception and responses to social and environmental stressors.

Main types of psychotherapy for PDs include: *cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT), psychodynamic psychotherapy, psychoeducation (PEd)*. Psychotherapy can take place in different settings: individual sessions, group psychotherapy or sessions that include family or friends.

CBT is based on the idea that *cognitive errors* due to long-standing beliefs influence the meaning attached to interpersonal events. It combines features of both cognitive and behaviour therapies to help patients *identify unhealthy, negative beliefs and behaviours* and *replace them* with healthy, positive ones. The *cognitive therapy* for PDs [14] deals with *prototypical cognitive schemata/dysfunctional cognitive and perceptive styles* regarding themselves, other persons, relationships, and situations. This *very active form of psychotherapy* identifies the distortions and en*gages the patient in efforts to reformulate perceptions and behaviours*. Within psychotherapy for PDs, therapeutic sequences may be repeated often over the course of years.

DBT for PDs is a type of CBT was developed by Marsha Linehan [15] that teaches *behavioural skills* to help patients tolerate stress, regulate their emotions and improve their relationships with others. Linehan elaborated a biosocial etiological model of BPD that has been further developed by other authors [11] and constitutes the basis of DBT (see Figure 1). Although it has been originally conceived for the treatment of BPD, it has been also successfully used with other *cluster B* personality disorders to ameliorate impulsivity [16].

The emphasis of this manual-based therapy is on the development of coping skills to improve affective stability and impulse control and on reducing self-harmful behaviour. DBT includes *four skill modules* (see Figure 2): *mindfulness* (skills derived from traditional Buddhist practice improving the capacity to pay attention to the current reality and thus helping individuals to non-judgmentally accept and tolerate strong emotions in new/upsetting situations); *interpersonal effectiveness* (include successful strategies for asking for what one needs, saying no, and coping with conflict situations); *emotion regulation* (training to recognize, influence and adequately express emotions); *distress tolerance* (used to improve ability to accept, in a non-evaluative way, both oneself and the current situation to allow individuals to make wise decisions). A particular category of *distress tolerance skills* are helpful emergency interventions in acute crises/dissociative states. They employ strong, non-harmful sensory stimuli, such as cold showers, strong odours, spicy flavours, etc.

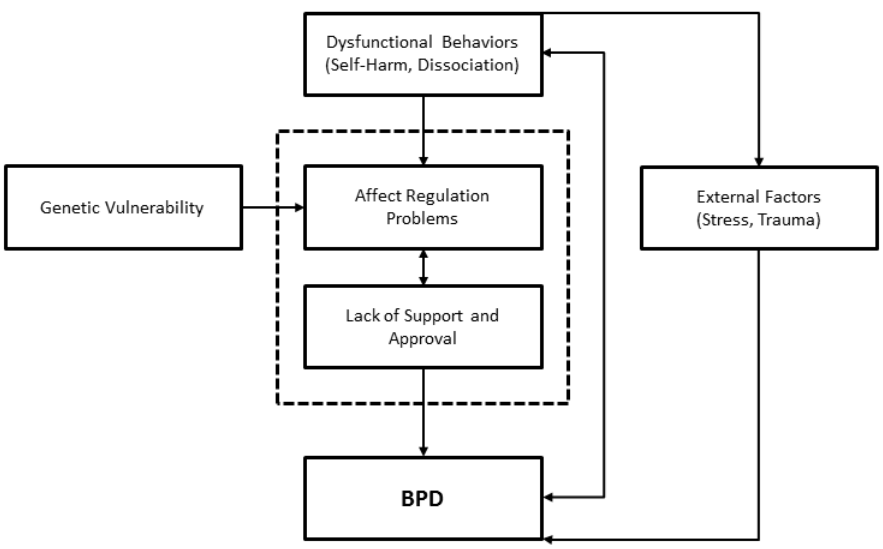


Figure 1. Synthetic presentation of the biosocial aetiological model of BPD according to Linehan [15] and Bohus [11].

Psychodynamic psychotherapy examines the ways that patients perceive events, based on the assumption that perceptions are shaped by early life experiences. Psychodynamic oriented research primarily addresses PDs from the perspective of *object relations theory*. For example, the development of BPD is viewed as a result of early interpersonal experiences dominated by neglect, abuse and invalidation through unpredictable parental behaviours, lack of empathy or affection, offensive or anxious parents. This leads to the development of serious problems of identity and self-esteem and the fear of abandonment and persecution originating in the early childhood cannot be

overcome [17]. Psychotherapy focuses on increasing patients' awareness of unconscious thoughts and behaviours, developing new insights into their motivations, and resolving conflicts to increase the level of subjective satisfaction. Treatment is usually prolonged over several years at a frequency from several times a week to once a month and makes use of techniques of transference and counter transference [18].

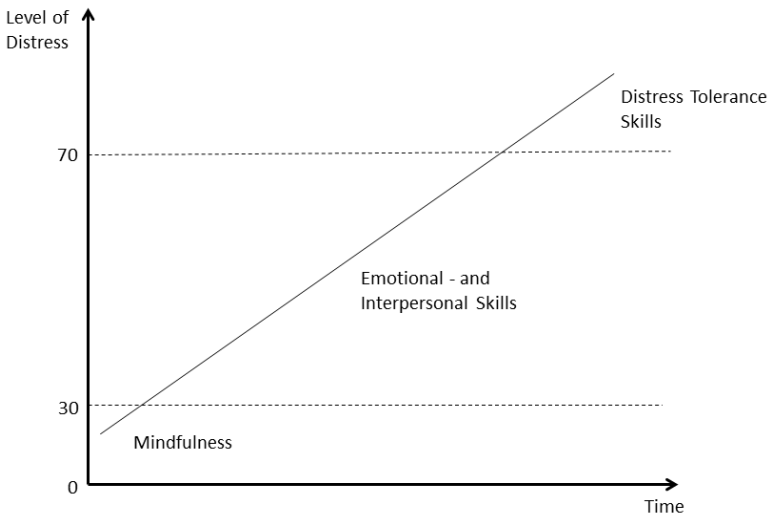


Figure 2. Helpful behavioural skills employed as a function the stress level according to the DBT-approach.

PEd for PDs teaches patients (and sometimes relatives and friends) about their disorder, including treatments, coping strategies and problem-solving skills. The patient education on the formation and maintenance of the disorder in terms of CBT is often the basis for subsequent treatment steps. Patients are also enabled to be aware of their own resources and opportunities that will help them to avoid possible relapses and to contribute themselves to their own health on the long- term. PEd for PDs specifically aims at make these patients aware of the necessity for a time-consuming and demanding confrontation with their difficulties, provide them support and hope at the same time in order to counteract the widespread tendency of a fatalistic estimation of their prognosis [19].

2. Conclusions

Treatment of DDs and PDs may be difficult and long-lasting, but most patients may learn new ways of coping and living healthy lives even in cases of complex disorders, which frequently result as a consequence of severe traumatisation. Psychological comorbidities traumatic antecedents are very

important and necessitate special attention within the diagnostic and psychotherapeutic research and process: priorities need to be set.

The leading strategies for the treatment of pathological dissociation are flexibility, creativity and unconventional interventions. In the case of PDs, the complex interaction problems, problems in the domains of emotional experience, reality perception, the self-assessment and or presentation, and impulse control constitute the focus of therapy. Therapy of PDs should be especially reality-oriented and the related to here and now and should aim at concrete changes in the immediate future.

The substantial advances in understanding the aetiology and increasing the efficiency of psychotherapeutic interventions demonstrate the importance of the evidence-based approach in Psychology.

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