Opinion Paper

The treatment of traumatic memories in patients with complex dissociative disorders

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A B S T R A C T

To overcome their traumatic memories, survivors need to integrate them into their personality. In patients with complex dissociative disorders who generally have experienced severe and chronic relational traumatization, this integration requires a paced and regulated approach within a relational context. Management and resolution of traumatic memories require, above all, an understanding and treatment of dissociation. The dissociative organization of these individuals’ personality includes at least one part of the personality primarily engaged in daily living, while trying to avoid traumatic memories, and at least one other part primarily fixated in traumatic memories, i.e., sensorimotor and in many cases highly affectively charged re-enactments of traumatic experiences, including innate defensive action tendencies in the face of perceived or actual threat. The treatment of traumatic memories should generally be embedded in a phase-oriented treatment – the current standard of care – in order to ensure that it will not exceed the patient’s capacity as a whole person to integrate these re-enactments.

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“First of all, we must not forget that the actions requisite for dispelling traumatic memories, the actions which will achieve liquidation, are often difficult and costly”. Pierre Janet (1919/25, p. 697)

According to the current standard of care, the treatment of traumatic memories of patients with complex trauma-related disorders – including dissociative identity disorder (DID) and DSM-5 other specified dissociative disorder (OSDD) (DSM-IV dissociative disorder not otherwise specified [DIDNOS]) – involves a phase-oriented treatment approach (e.g., Brown, Schefflin, & Hammond, 1998; Chu, 1998; Courtois, 1999; Gelin, 2003; Herman, 1992; Kluft, 1993; Nijenhuis, 2017; Van der Hart, Nijenhuis, & Steele, 2006; Steele, Boon, & Van der Hart, 2017). Phase-oriented treatment has its origins in the pioneering work of Pierre Janet (1898, 1919/25), who described three phases in the overall treatment:

• stabilization and symptom reduction, to which safety and skills building was subsequently added in the past few decades;
• treatment of traumatic memories;
• personality (re)integration and rehabilitation (Van der Hart, Brown, & Van der Kolk, 1989).

These treatment phases are not linear, but are often alternated or seamlessly interwoven after an initial period of stabilization, depending on the needs of the patient (Courtois, 1999). For example, a brief stabilization intervention may take place in the session, which is followed by work on a traumatic memory and then by some integrative intervention in daily life – all in one session.

This article will highlight the necessary skills for therapists and patients for phase 2, treatment of traumatic memories. We strongly recommend that therapists not engage in these interventions unless they are thoroughly familiar with phase 1 treatments, and the patient is sufficiently stable. That is, the patient must be able to engage in integrative mental actions during and following the confrontation with the traumatic memories, so that they become transformed into narrative memories. Thus, we first describe some initial stabilization approaches that are commonly necessary before the treatment of traumatic memories is considered.

1. Traumatic memory and dissociation of the personality

Traumatic memories are maintained by the dissociative organization of the patient's personality across the spectrum of complex trauma-related disorders. As we described elsewhere
The traumatized patient’s personality is unduly (but not completely) divided among two or more psychobiological subsystems. These subsystems are overly rigid in their functions and too closed to each other, resulting in ongoing integrative failures that continue to effect adaptation and creative action in the present. One prototypical personality subsystem is called the emotionally normal part of the personality (EP; Myers, 1940; Van der Hart et al., 2006). As EP, the patient is fixated in traumatic memories, that is, in sensorimotor and in many cases highly emotionally charged re-enactments, especially action tendencies of defense against perceived or actual threat. In some cases, however, as EP patients are fixed in re-enactments that involve a degree of hypoactivation; some may even lose consciousness. The other prototypical dissociative part of the personality is called the apparently normal part of the personality (ANP; Myers, 1940; Van der Hart et al., 2006), which focuses on living daily life, and is fixated in avoidance of traumatic memories, and often of emotional and bodily feelings related to these memories. As ANP, the patient may appear relatively “normal” on first observation, but has negative symptoms of detachment, numbing, and partial or complete amnesia for the traumatic experience, and experiences occasional intrusions from EP.

Dissociative parts of the personality are defined as subsystems that include their own phenomenal experience and conception of who they are, of the world, and of they are a part of this world (Nijenhuis, 2015, 2017; Nijenhuis & Van der Hart, 2011). The term ‘phenomenal’ stands for ‘consciously experienced’, and ‘known or derived through the senses’ (Nijenhuis, 2015, 2017). Like everyone’s phenomenal experience and conception of self, world, and self as a part of this world, dissociative parts’ phenomenal experience and conception of self, world, and self as a part of this world are not pre-given. These experiences and conceptions are rather enacted, that is, brought forth in ongoing mental action inasmuch as individuals or dissociative parts of an individual are not engaged in dreamless sleep or are otherwise unconscious.

This enactment gives a first-person perspective, a phenomenal experience and conception of being an ‘I’. This ‘I’ includes particular bodily feelings, emotions, perceptions, and thoughts. It constitutes the groundwork of one’s point of view regarding oneself (phenomenal ‘I-me, myself, mine’ relationships, or a quasi-second-person perspective), other people (phenomenal ‘I-You’ relationships or a second-person perspective), and objects. In the case of physical or ‘technical’ ‘I-thing’ relationship, one can speak of a third-person relationship. For example, clinicians engage in a third-person relationship regarding their patients when they assess the presence of a particular mental disorder.

Mentally healthy individuals enact one first-person perspective, one ‘I’. They may have internal conflicts, may not be fully integrated in some other regard. However, their phenomenal experience and conception of who they are remains basically stable. For example, they may say, “one the one hand I want this, and on the other hand I want that”, but this ‘I’ as such remains singular. Individuals with a dissociative disorder bring forth more than one ‘I’. This feature is actually the essence of every dissociative disorder. While every dissociative disorder thus involves a lack of integration, not every lack of integration implies the existence of a dissociative disorder (Nijenhuis, 2015). This means that, while the overall goal of therapy – not just Phase 2 – involves fostering integration. Integration remains a challenge for the person after therapy has ended, like for anybody else.

Following Janet, two basic levels of integrative actions can be distinguished: “synthesis” and “realization”. Synthesis pertains to those basic integrative mental and behavioral actions through which experiences, such as perceptions, movements, thoughts, affects, memories, and a sense of self, are bound together (linked) and differentiated (distinguished from each other). It forms the basis of the higher-order actions of realization. Realization includes the promotion of two additional mental actions, i.e., “personification” and “presentification”. Personification involves the mental actions of making one’s personal experience and actions one’s own (Janet, 1935; Van der Hart et al., 2006). Personification thus involves two mental actions:

- owning perceptions, sensations, affects, and thoughts;
- developing a sense of agency.

Presentification involves being mindfully present, while remaining aware of the context of one’s past and future, and leading to adaptive and sometimes creative actions in the present (Janet, 1928; Van der Hart et al., 2006).

Clinicians who treat individuals with dissociative disorders must realize and appreciate the existence of plural phenomenal experiences and conceptions of self, world, and self as a part of this world. If they fail in this regard, their clinical efforts will remain fruitless. The multiplicity implies that a dissociative part does not experience and conceive a different dissociative part as ‘a part of I, me, myself’ but as a ‘You’, or a ‘thing’. That is, what should be experienced and conceived in the form of a first-person perspective (‘I’) and quasi-second-person perspective (‘I-me, mine, myself’ relationship), is actually experienced and conceived in the form of a second-person perspective (‘I-You’ relationship) or third-person relationship (‘I-thing’ relationship) (Nijenhuis, 2017). For example, an ANP may experience and conceive an EP as ‘someone else’ or as a ‘voice’ or as a disturbing other ‘thing’ (e.g., a symptom). The ANP may say or believe, “this girl [an EP] does not belong to me, she should be removed”, or “the voice disturbs me, please remove it”.

When a dissociative part is amnestic of another dissociative part, the amnestic dissociative part can be said to have a zero-person perspective regarding the other part.

The treatment of dissociative disorders involves the progression from a zero-person perspective (if applicable) to a third-person perspective (if applicable) to a second-person perspective, and eventually to a quasi-second-person and first-person perspective (Nijenhuis, 2017). The final goal is in principle a (re)integration of the individual as one conscious and self-conscious system rather than as a collection of two or more conscious and self-conscious subsystems. This work includes the integration of traumatic memories that one or more dissociative parts recurrently re-enact. Whereas the involved re-enactments can occasionally intrude on one or more other dissociative parts, these intrusions do not lead to the integration and realization of the involved traumatic memories for the duration of the dissociative disorder. That is why the integration of traumatic memories is commonly a goal of treatment inasmuch as the traumatized individual can develop the required integrative capacity and motivation.

2. Levels of dissociation of the personality

The undue prototypical division of the personality into a single ANP and a single EP represents “primary dissociation of the personality”, and characterizes simple post-traumatic dissociative disorders, including PTSD. In this term, “primary” does not mean the first developmental (i.e., ontogenetic) form, but dissociation’s most simple form. It must also be noted that there are milder divisions of personality, such as “ego-states” – which are not identical with dissociative parts – and serious unresolved conflicts among two or more different interests within an individual. Neither of these forms includes the distinct first- and second-person perspectives as described above. Including these integrative difficulties in the category of dissociation would render
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