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## Opinion Paper

# Ten reasons for conceiving and classifying posttraumatic stress disorder as a dissociative disorder<sup>☆</sup>



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## ABSTRACT

DSM-5 includes a subtype of PTSD ‘with dissociative symptoms’. However, as presented and discussed in this article, there are solid conceptual, theoretical, empirical, and clinical reasons to comprehend and classify any form of PTSD as a dissociative disorder. The conceptual grounds pertain to philosophical principles seldom discussed or realized in the field of psychotraumatology. The theoretical grounds particularly involve the understanding of dissociation as a division of the personality as a whole biopsychosocial system in two or more conscious subsystems. Empirical reasons include the presence of cognitive-emotional and sensorimotor dissociative symptoms—i.e., manifestations of a dissociation of the personality—in PTSD. There are also major structural and functional neural commonalities between PTSD and complex dissociative disorders. Clinically, there is close correspondence at the level of assessment and treatment. PTSD and dissociative identity disorder can be parsimoniously conceived as minor and major forms of personality dissociation, as Pierre Janet would have avowed.

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In the DSM-5 (APA, 2013), posttraumatic stress disorder (PTSD) has become classified in the new chapter on trauma- and stressor-related disorders. The reclassification is an improvement over PTSD’s previous classification as an anxiety disorder given involvement of other intense trauma-related affects such as anger (Kardiner, 1941), disgust (Badour, Bown, Adams, Bunaciu, & Feldner, 2012), survivor guilt (Koranyi, 1969), other types of guilt, and shame (Wilson, Drozdek, & Turkovic, 2006).

The dissociative disorders that DSM-5 recognizes are placed next to, but are not a part of the trauma- and stressor-related disorders. This organization reflects “the close relationship between these diagnostic categories. Both acute stress disorder and posttraumatic stress disorder contain dissociative symptoms, such as amnesia, flashbacks, numbing, and depersonalization/derealization” (p. 291). Another link is that particularly but not exclusively patients with complex dissociative disorders have, like patients with acute stress disorder (ASD) and PTSD, lived adverse events.

From its introduction, there have been recurrent discussions if PTSD is best seen as an anxiety disorder or as a dissociative disorder (Brett, 1996; Van der Hart, Nijenhuis, & Steele, 2005, 2006). The deliberation was far from new. Charcot (1889) and Page

(1891) asserted that railway spine/traumatic neurosis and traumatic hysteria (i.e., dissociative disorders) involved the same symptoms, hence constitute one disorder. Myers (1940) described that shell shock, a forerunner of PTSD, involves a dissociation of the personality that Janet (1907) had defined as a core feature of hysteria. Myers invented the term shell shock, because he felt that brave soldiers who broke down could not have hysteria, a disorder he and many others associated with women despite recurrent documentation that both genders can develop hysteria (e.g., Sydenham [Dewhurst, 1966], Charcot, 1889; Janet, 1907). Still, Horowitz (1976) was clear that the disorder that was to be called PTSD involves a division of the personality. Studying Vietnam veterans, others agreed (Wang, Wilson, & Mason, 1996).

Are trauma- and stress-related disorders and dissociative disorders two of a kind? An inquiry into the matter requires crystal-clear (definitions of the) concepts of dissociation, dissociative symptoms, and dissociative disorders. This clarity does not exist in the DSM-5 and the field more generally. The terms ‘dissociation’, ‘dissociative symptoms’, and ‘dissociative disorders’ are defined and used in confusing and contradictory ways (Nijenhuis & Van der Hart, 2011).

For example, DSM-5 includes two subtypes of PTSD with dissociative symptoms, one for individuals older than six years, and one for younger children. Both are characterized by persistent or recurrent negative symptoms of depersonalization/derealization. However, DSM-5 also recognizes positive dissociative symptoms that occur in any form of PTSD.

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The objectives of this article are to:

- explain that ‘events’ do not exist in isolation from individuals who experience and conceive them;
- detail that ‘traumatic events’ cannot be seen as efficient causes of trauma as a biopsychosocial injury;
- emphasize that ‘trauma’ cannot be fully understood in terms of material and efficient causation, but requires an analysis of its formal and final causes;
- demonstrate that its formal cause is a dissociation of the personality as a whole biopsychosocial system, and its final cause a differentiated will;
- provide empirical evidence that PTSD and dissociative disorders involve positive and negative, and cognitive-emotional and sensorimotor dissociative symptoms;
- discuss that PTSD and complex dissociative disorders involve highly similar volumetric brain abnormalities, functional physiological abnormalities, and functional brain abnormalities
- discuss that PTSD and dissociative disorders essentially involve the same treatment aims and methods;
- conclude that the most parsimonious option is to propose and further explore a dimension of complexity of trauma-related dissociation of the personality.

## 1. Trauma

### 1.1. Trauma: ontological considerations and the problem of efficient causation

What is trauma and what causes it? The common understanding is that trauma constitutes an isolated event or constellation of events:

trauma as event(s) → causes → physical or mental disruption.

For example, the DSM-5 A criterion for PTSD (and ASD) regards and delimits the concept of trauma to actual or threatened death, serious injury, or sexual violence. The concept of trauma as an isolated event is empirically overinclusive, because a particular adverse event does not injure all who live or observe it. The concept is empirically underinclusive, because individuals can develop biopsychosocial pathology after other events such as emotional neglect and maltreatment (Draijer & Langeland, 1999; Tomoda et al., 2010). These empirical grounds preclude the definition of ‘trauma’ as an isolated event.

A conceptual problem is that the term ‘trauma’ means ‘injury’. To avoid confusion, it is better to reserve the term ‘trauma’ for a particular injury, and to exchange the term ‘trauma as an event’ for the term ‘adverse event’ or ‘potentially traumatizing event’.

While this move constitutes a conceptual and empirical improvement, it does not remedy another nasty problem that concerns the presumed causal relationship between an isolated adverse event and the injury that may follow. In a mechanistic worldview, injuries are caused by adverse events:

isolated adverse event → mechanically causes → trauma as injury.

Physically, it might be a blow to the head. Mentally, it could be a metaphorical blow to the mind such as betrayal. Philosophical realists concede that adverse isolated events might, as any event, constitute a collection of stimuli existing in the objectively existing world to which an organism reacts. They hold that “the world is objectively real, you are part of this objectivity, and scientists can study and grasp the world in an objective fashion because there is universal reason and because they have access to this universal reason”:

isolated adverse event as apart of objective reality → affects  
→ subject as apart of that reality.

With Aristotle, who distinguished between four different types of causes, one might say that particular isolated adverse events can be the efficient cause of the injury, that is, to events that bring the injury into being:

isolated adverse events as efficient cause → can linearly cause  
→ trauma as injury.

The deep problem is that an event would not be if it were isolated from an experiencing and knowing subject. Without a conscious subject, an event (an object, a constellation and dynamic of objects) would not exist the philosophical idealist explains. Schopenhauer (1818/1844/1958) agreed that the world is our idea, but he added that without matter – without an embrained body and an embodied brain – there would be no subject. Without a mind, there is no matter, and without matter, no mind could exist. Brain, body, and environment occur together, constitute each other, and are dependent on each other (Northoff, 2003; Schopenhauer, 1818/1844/1958):

subject ← co-occurrence → object

subject ← co-constitution → object

subject ← co-dependency → object.

Ontologically, there are intrinsic relationships between the brain, body, and the environment. The living brain cannot exist without a wider living body, just as this body requires a living brain. And the embodied and embrained subject necessarily exists in an environment, whereas the environment would not exist, if there were no conscious subject. There is, thus, ontological embedment of the brain, body, and environment:

brain ← intrinsically related → body

brain/body ← intrinsically related → material/social environment

The realization that brain, body, and environment exist and change in virtue of each other moves philosophy and psychology from absolutism to relativism, from thinking of subject and object as isolated entities with their own ‘absolute’ ontological properties to an understanding of subjects and objects in terms of ontological relationships. There is no environment and there are no events as changes in the environment as the respective context that exist in separation of a subject. What exist are dynamic configurations of brain, body, and environment (Northoff, 2003).

With respect to trauma, there is ontological embedment of conscious subjects (brain, body) and adverse events. These embedded adverse events involve changes in the actual and historical environment as their context that a subject can observe (i.e., sense, perceive, conceive) and effectuate (Northoff, 2003). Embedded events are adverse when these changes are adverse to the involved subject. Embedded events that may cause a biopsychosocial injury are adverse/potentially traumatizing. Those that have caused this injury have been traumatizing.

To say that an embedded event was traumatizing means that it was an important dynamic causal factor with respect to the biopsychosocial (see below) injury that ensued. The event is not the only causal factor. For example, the probability of an injury will also depend on contextual embedded events such as previous adverse embedded events, lack of social support in the aftermath of the event(s), the subject’s age and stage of brain maturation, and genetic make-up.

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