Working with complex trauma and dissociative disorders

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TRAUMA AND DISSOCIATION SERVICE

TDS is an out-patient psychotherapy national trauma unit for the treatment of adults suffering from PTSD, Complex PTSD (CPTSD) and Dissociative Disorders (DD).

We deliver NICE treatments as well as innovative attachment base treatments including Sensorimotor Psychotherapy and Lifespan Integration Psychotherapy.

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“Man is to be identified by his affirmative thought, by the singular truths of which he is capable, by the Immortal which makes of him the most resilient and paradoxical of animals.”

Alain Badiou
SUMMARY OF THE PRESENTATION

- PTSD (ICD-11)
- Neuroscience: Cortical vs subcortical processing and the autonomical arousal model
- modalities of treatment
- working with people with complex presentations or where treatment has failed
- trauma and dissociation: what works
  - Clinical case

The Earliest Acoustic Memory (Mismatch Negativity: MMN)
  - Clinical case

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• Jenny 46 y old. In and out of hospitals since age 11 after arson attack, she is in a forensic locked unit.
  
  • Diagnosis: chronic psychosis

• She has not responded to treatment and when tried to be discharged, she threatens to kill herself and severely self-harms

• She has a history of sexual abuse from age of 8 to 16 within the family context; as well as, physical and verbal abuse.

  • She has no early childhood memories prior to age 8 and of her school attendance.

• Begins to drink at 11 years of age. Never stable relationships or jobs. Her only friends are patients from the inpatient unit.

  • During the assessment, she fulfills criteria for CPTSD and DD (severe) no psychotic symptoms are present.
What predicts who will develop CPTSD/DD

• We don’t know

• NSPCC: 1 in 20 children have been sexually abused.

• Different services see the same patients in different ways.

• Multiple diagnoses, interventions and outcomes.

• Tertiary referral centre may not reflect the whole picture.

• In our services we may see a sub-selections of these individuals; not representative of the majority of the cases.
Aetiological factors and clinical presentations

Genetic factors
- Epigenetics
- Transgenerational traumas
- Other

Environmental factors
- Psychosis
- EUPD
- CPTSD
- Dissociative disorders
- Anxiety
- Depression
- Substance misuse
- Panic Disorder...

• Neglect
• Abuse
• CSA
• other
A NOISY BRAIN

• Response to trauma is complex.

• Chronic physiological arousal and the failure to regulate autonomic reactions to internal or external stimuli affects people’s capacity to utilise emotions as signals.

• They tend to *react* to things rather than *process* information to assess what is needed; often they overreact to stimuli and may become aggressive easily. The challenge in trauma therapy is to work with patients who have diminished capacity of intellectual functions, including language.

• I made some suggestions of possible ways of working with this group of patients informed by the neurobiology of trauma.

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PTSD (ICD-11)

Essential Features:

Development of characteristic symptoms following exposure to an extremely threatening or horrific event or series of events.

Re-experiencing of the Traumatic Events:

- Intrusive recollections of the event(s) as images, thoughts or perceptions. Dissociative flashbacks (images, sounds, smells and tactile sensations associated to the trauma).
  - Nightmares
- Intense psychological distress when reminded of the trauma
- Physiological reactivity on exposure to cues that resembles /symbolises the trauma or parts of it.

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PTSD

Hyperarousal:
A state of perceived current threat in the form of hypervigilance (with irritability, insomnia, anger) or an enhanced startle reaction. The symptoms must also last for several weeks and interfere with normal functioning.

Avoidance:
Marked internal avoidance of thoughts and memories or external avoidance of activities or situations reminiscent of the traumatic event(s). Inability to recall important parts of the trauma; feelings of detachment towards others and numbness.

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COMPLEX PTSD (ICD-11)
(FORMERLY: ENDURING PERSONALITY CHANGE AFTER CATASTROPHIC EXPERIENCES)

Symptom Pattern
Core symptoms of PTSD (re-experiencing in the present, avoidance, hyperarousal)

Plus
Persistent and pervasive impairments in:

- **affective functioning**: Affect dysregulation, heightened emotional reactivity, violent outbursts, tendency towards dissociative states when under stress

- **self functioning**: Persistent beliefs about oneself as diminished, defeated or worthless; pervasive feelings of shame, guilt

- **relational functioning**: Difficulties in sustaining relationships or feeling close to others.

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Dissociative Continuum

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CORTICAL VS SUBCORTICAL PROCESSING

Le Doux found that the memories of fearful experiences involve at least 2 neuronal organisations:

1) An implicit emotional memory system (associated with amygdala)

2) A declarative or explicit memory (linked with hippocampus) associated with conscious recollection.
   Both usually operate simultaneously and in parallel but the functioning can be dissociated. *(Le Doux 1995)*

In severely traumatised subjects accessing the cognitive functioning is very difficult as frontal cortex functioning is reduced and the more prominent levels of emotions, such as anger/fear dominate the presentation.

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CORTICAL VS SUBCORTICAL PROCESSING

Accessing these emotions at the level of intervention in therapy is a challenge. This is also relevant in child parts work where at times the arousal level takes over the more functioning accessible apparently normal part of the personality (ANP) (Nijenhuis et al, 2004)

The lower automatic level of processing of emotions can highjack the system before a more complex system (more cognitive) can be connected.
Maturation of the brain and attachment

Right hemisphere growth spurt just around birth => in the limbic system

The attachment pattern influences the development of the limbic and cortical segments in the right hemisphere

The processing stays trapped at the subcortical level

The antidote: stimulating integrative processes

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HUMAN BRAIN

In the course of evolution, the human brain has developed 3 interdependent parts:

1. **BRAINSTEM AND HYPOTHALAMUS** (primarily associated with the regulation of internal homeostasis (e.g. regulation of hormones)

2. **LIMBIC SYSTEM**, in charge with maintaining the balance between the internal world and the external reality (oral and genital function; parental care; audio vocal behaviour and play)

3. **NEOCORTEX**, responsible for analysing and interacting with the external world. (primarily oriented to the external world; reasoning strategies to attain personal goals, making decisions, weighing a range of options and predicting outcomes of our own actions; also deciding which stimuli is useful and which is not)

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HUMAN BRAIN

Together the 3 systems control a range of regulatory functions:

1. INTERNAL VEGETATIVE FUNCTIONS: rhythms of rest/sleep and activity, feeding, reproductive cycles…

2. CONTROL RELATIONSHIPS WITH THE OUTSIDE WORLD: assessing novelty (analysed against the previously stored knowledge), danger, gratification, selection of what is needed and discard what is not relevant.

3. LEARN FROM EXPERIENCE: the organism needs to be able to engage in routine tasks without being distracted by irrelevant stimuli…

4. social function of the brain allows to engage in complex social systems.

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OPTIMAL AROUSAL ZONE OR WINDOW OF TOLERANCE: feelings and reactions are tolerable; we can think and feel simultaneously; our reactions adapt to fit the situation.

SIGNS OF HYPERAROUSAL: overwhelm, panic, impulsivity, hypervigilance, defensiveness, feeling unsafe, reactive, racing thoughts, anger or rage.

SIGNS OF HYPOAROUSAL: numb, “dead,” passive, no feelings, can’t think, disconnected, shut down, “not there,” can’t defend.

AUTONOMIC AROUSAL MODEL [OGDEN, MINTON & PAIN, 2006]
“Therapy is not simply method and technique, at the heart of it all is the spirit of our work”

Ron Kurtz (body-centered psychotherapist)

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MARY AND THE ROSE OIL

- 50 year old Australian married woman

- Mother of 3 children (ages 10, 12 and 16)

- Physically, emotionally and sexually abused by mother from birth to age 18. Abuse included force-feeding until age 7; being fed on her own vomit; hit with stick on her legs.

- In her teens, suffered from anorexia and required 2 short admissions in hospital due to this problem.

- Self harm: superficial cuttings around knee area for a number of years, also superficial cuttings in her wrists and taking small overdoses of her regular medication.

- OCD: compulsive cleaning of her house for up to 9 hours a day.

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Referred to the TSS for 2nd opinion.

Apart from 2 admissions in her teens, no further contact with mental health services until maturity. At the time of her referral to our unit, she had been an inpatient for 2 years due to dissociative fugues.

8 sessions of EMDR triggered current situation: abreaction in one of the EMDR sessions, since then has stopped minor self harm but started severe self harm while in dissociative fugue.

Several services involved in her care: psychiatric team, A&E, surgeons, police, helicopters.

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CLINICAL PRESENTATION

• Dissociative fugues: disappears unaware of what she does or where she is, finding herself in the middle of nowhere, in the countryside, with deep cuts in her legs.

• As a result of this she had part of her leg amputated, had MRSA infection; surgeons concerned they may need to amputate leg or that she may die in one of her dissociative fugues.
SUMMARY OF PREVIOUS TREATMENTS

• Inpatient admissions for eating disorder in teens
• Psychoanalytic Psychotherapy, twice a week for a number of years (in her 40s)
• EMDR, 8 sessions (in her 40s)
• Ongoing inpatient treatment due to high risk of accidental death due to self harm (2 years by the time she was referred to TSS)
• Psychotropic medication at the time of referral included: antipsychotics, antidepressants, benzodiazepine, anticonvulsants.

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3 sessions (of 2 h each), due to severe dissociative episodes.

Major trigger during assessment: when asked about her appetite, she changed her presentation, becoming childlike, aggressive and wanting to scratch the psychiatrist’s face. The use of rose oil brought her back to her adult self within seconds.

The interview continued using rose oil to prevent further dissociative episodes.

Diagnosis made: DID.
TREATMENT RECOMMENDATIONS

Rose oil as part of her treatment:

Used by the patient on strap around mobile phone. This stopped most dissociative fugues.

Used in the inpatient unit by nursing staff:
- reduced the use of IM tranquilisers
- reduced restrictions by nursing staff
  (both methods were used to prevent self-harm).

Used during therapy sessions to ground her and prevent/reduce dissociative episodes

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TREATMENT AT THE TSS

An equivalent of 3 years, weekly therapy sessions

Modalities of therapy: interwoven Sensorimotor psychotherapy, informed by the Structural Dissociation Model and Lifespan Integration.

The fine attunement between therapist and patient was essential. Modifications of protocol were needed due to levels of dysregulation as well as transferentie issues.

Frequency of sessions according to coping and integrative capacity of patient

Medication as essential part of treatment: antidepressants and Pregabalin.
outcome

Patient began activities outside her home: yoga and jogging.

While in therapy: 2 major dissociative fugues with severe self mutilation. 1st, when care coordinator died suddenly. 2nd, when mother (perpetrator) contacted patient through facebook (1st contact since illness began)

By the time of discharge: patient had no dissociative fugues for almost 3 years.

Medications on discharged: the same.

The use of grounding oils, used regularly as well as regular grounding techniques.

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outcome

At discharge point:

- patient had made new friends,
- was able to go to social gatherings and holidays with family,
- Taking college courses, including jewellery. She excelled in making jewellery.
- Planning to get own small business with one of her friends and sell jewellery in local markets.
- Looking forward to new family life as children had left home and husband retired.
- In her own words: “I have a life”

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Best treatment

Prevention
Second best treatments

• Assessment: holistic approach.
• Co-morbidity
  • Clinician has to be knowledgeable “enough” of neuroscience behind the clinical conditions as well as of the treatment offered. It is not enough to say “I did not know the patient was complex”
• Treatment offered (modalities), length and practical issues (travel, resources, safety). Rehabilitation: address this from the beginning (diet, exercise, drugs, isolation, day structure)
• Pets.
• Multifactorial issues to consider
  - attachment issues
    • type, number of traumas and severity of abuse
    • Genetic factors
    • Social circumstance (isolation; instability, relationships)
    • Biological factors: nutrition, IQ, substance misuse
    • Unknown factors, look for the unpredictable ones
Second best treatments, different modalities:

• Some possibilities:

  • Internal Family Systems
  • Lifespan Integration
  • Sensorimotor Psychotherapist
  • Ego State Therapy
  • Dialect Behaviour Therapy
  • Psychodynamic Psychotherapy
  • other...

• Individual vs Group therapy
“The overwhelming question in neurobiology today is the relationship between the mind and the brain”

Crick & Koch (the problem of consciousness)

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Further understanding/work is needed

- some of our patients are also perpetrators.

- Educating children and families essential.

- Further research into vulnerability factors and resilience (individual as well as social)

- The treatment of the victim, should not exclude the treatment of the perpetrator.
To observe the human being in front of us is fascinating.
To work with their pain is a privilege
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