

Dissociation, Somatization, and Other Challenging Presentations of PTSD

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Objectives

- Describe how individuals with PTSD may present with dissociation and somatization.
- Understand rationale for not immediately excluding individuals with PTSD and dissociation or somatization reactions from evidence-based treatments for PTSD.
- Identify methods to address dissociation and somatization PTSD reactions within evidence-based PTSD treatment.

Consultations on Dissociation/Somatization in PTSD

My patient dissociates/has a somatic response to trauma triggers:

- *Is this PTSD or something else?*
- *How can I keep my patient from having this reaction in session?*
- *Is my patient appropriate for an evidence-based psychotherapy (EBP) for PTSD?*
- *Is EBP treatment harmful?*
- *Should I refer my patient to a higher level of care?*

Consultations on Dissociation/Somatization in PTSD

My patient dissociates/has a somatic response to trauma triggers:

- *Managing this is tiring.*
- *I've been working with my patient for years with no improvement.*
- *I'm burning out.*
- *I want to provide an EBP, but I don't know where to start.*
- *My patient doesn't seem ready for PTSD treatment.*
- *I'm not ready to provide PTSD treatment.*

Dissociation & Somatization

- Controversy about separating the classification of dissociation and somatization disorders (e.g., North, 2015; Saxe et al., 1994)
 - Both may occur in response to severe stress
 - Both have traditionally been viewed as forms of escape from stress
 - Theorists and clinicians often explain and treat similarly
 - Both originated from hysteria diagnosis

Indian Journal of Psychiatry, January 1986, 28(1), pp. 47-49

DSM-III DIAGNOSTIC CATEGORIES FOR ICD-9 HYSTERIA: A STUDY ON 103 CASES

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SUMMARY

Rediagnosing 103 ICD-9 Hysteria cases on DSM-III, the authors found Conversion Disorder and Atypical Dissociative Disorder to be the most common diagnosis. Somatization Disorder was diagnosed only in 8.7 per cent of cases. Twenty-nine per cent cases received double diagnoses. Limitations of using DSM-III on Hysteria patients are mentioned and a suggestion is made to include a new category of 'Simple Dissociative Disorder' in the DSM-III.

Introduction

Diagnostic and Statistical Manual, III

4th Edition of American Psychiatric Association

I. M. S. Hospital, New Delhi, between July 1982 and September 1983 were screened for the diagnosis of Hysteria under ICD - 9, made

Dissociation & Somatization within PTSD

- Within PTSD, conceptualize dissociation and somatization as trauma reactions
 - Not typically DSM-5 dissociative disorders or somatic symptom disorders
- PTSD assessment impact
 - May underreport PTSD symptoms – may mislabel or fail to recognize internal states (alexithymia)
- PTSD treatment impact
 - May interfere with new learning and trauma processing in therapy, maintaining PTSD symptoms

Dissociation & PTSD

- **Dissociation**: “An experienced loss of information or control over mental processes that, under normal circumstances, are available to conscious awareness, self-attribution, or control, in relation to the individual’s age and cognitive development.” (Cardeña & Carlson, 2011, p. 251)
 1. Loss of continuity in subjective experience with involuntary and unwanted intrusions into awareness or behavior
 - *PTSD B3*: Dissociative reexperiencing/flashback
 2. Inability to access information or control mental functions or behaviors; gaps in awareness, memory, or self-identification
 - *PTSD D1*: Dissociative amnesia
 - Blanking out, gaps in awareness
 3. Experiential disconnectedness; may include distortions in self- or environmental perceptions
 - *PTSD Dissociative Subtype*: Depersonalization or derealization

Dissociation & PTSD

- 40-73% of individuals exposed to trauma will experience dissociative states during or after the trauma
 - Sharp rise followed by a gradual decline over time
(Carlson & Dalenberg, 2009; Martinez-Toboas & Guillermo, 2000; Saxe, et al., 1993)
- Correlations between dissociation and PTSD symptoms, $r_s = .45-.91$
 - Symptoms move together during treatment (Carlson et al., 2012)
- Dissociative subtype of PTSD prevalence – 6% to 45%; $M = 20\%$
(Hansen, Ross, & Armour, 2017)

Dissociation & PTSD Consultation Descriptions

- “losing chunks of time was evident in my office”
- “hard to tap into emotionality due to dissociation”
- “not able to stay present in sessions”
- “dissociation often looks like under-engagement”
- “during treatment, she dissociated and heard her perpetrator’s voice”

Dissociation & PTSD conceptualizations

- Operant conditioning learned response
 - Dissociation can protect during intolerable, inescapable experiences
 - Dissociation (e.g., loss of memory) leads to a drop in anxiety, which increases the likelihood of future dissociation (even when no longer needed)
 - Dissociation serves as an avoidance/escape behavior
- State-dependent learning (peritraumatic dissociation)
 - If an individual dissociated at the time of the trauma, the individual may also dissociate (returning to the same state) when reminded of the trauma
- Overmodulation of emotion - Neurobiological research
 - Depersonalization/derealization associated with greater activity in frontal cortex areas that are involved in inhibiting brain areas that coordinate fear responses (i.e., limbic system/amygdala; Schiavone et al., 2018)

Somatization & PTSD

- **Somatization: the presentation of medically unexplained, or insufficiently explained, physical symptoms (somatoform symptoms)**
 - Gastrointestinal (vomiting, abdominal pain, nausea, bloating, diarrhea)
 - Pain (extremities, back, joint, head)
 - Cardiopulmonary (shortness of breath, palpitations, chest pain, dizziness)
 - Conversion/pseudo-neurological (difficulty swallowing, loss of voice, deafness, loss of vision, loss of consciousness, seizure/convulsions, paralysis, muscle weakness)
 - Sexual (genital pain, menstrual irregularities)
- **Somatization PTSD Symptoms**
 - B3: Dissociative reexperiencing (sensory intrusions)
 - B5: Physiological distress to trauma reminders

Somatization & PTSD

- Research on examining somatization and PTSD is sparse
 - Incidence of co-occurring [medically explained] physical health problems
 - Construct definition and assessment challenges
- PTSD over 3x more likely to have abridged somatization
 - 24.7% with PTSD vs 8.2% without PTSD; no sex differences (Andreski et al., 1998)
 - Abridged somatization: endorsement of 4+ sx's males/6+ sx's females (Escobar et al., 1989)
- Impact of somatization
 - Increased healthcare utilization
 - Impaired patient-provider relationships

Somatization & PTSD Consultation Descriptions

- “diagnosed with psychogenic non-epileptic seizures (PNES)”
- “strong body memories and was in physical pain in session”
- “grabbed his neck and said he felt like he was being choked again”
- “vomiting in session”
- “episodes of blurred vision”
- “loses ability to talk - can only whisper”; “speaks in tongues”
- “wheelchair bound due to unexplained paralysis”

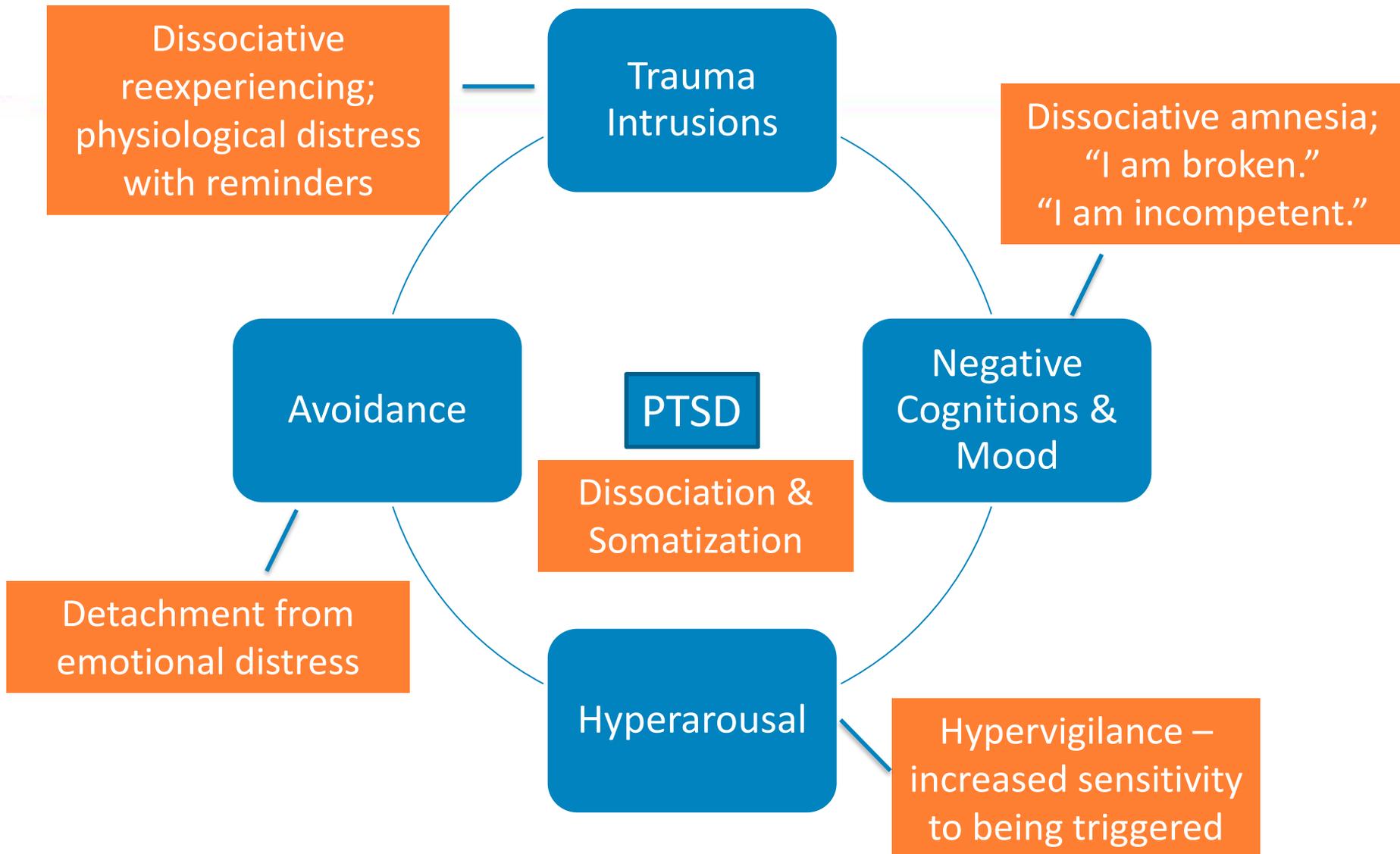
Somatization & PTSD Conceptualization

- Operant conditioning learned response
 - Somatic reactions may remove the individual from emotional pain (perhaps also gaining emotional support), relieving distress, and increasing likelihood of future somatization
 - May be modeled
 - Somatization serves as an avoidance/escape behavior
- State-dependent learning
 - When faced with trauma reminders, the individual may display a somatic response of the same physical state that occurred at the time of the trauma
- Communication of extreme distress (alexithymia)
 - Somatization may provide a means of communication for expressing difficult emotions
 - Emotions are converted into physical symptoms

Transcultural Considerations

- Dissociation and somatization reactions are more frequently reported from non-Western, developing societies (Escobar, 2004)
 - Sometimes framed as rather exotic culture-bound syndromes
- Philosophical mind-body dualism, prevalent in Western societies, may have led to concept of somatization and separation of mental health from "medical care" (Fabrega, 1990)
- Attend to potential biases and consult
 - Dissociation or somatization as an inferior way to express with emotions
 - Historical association with hysteria: potential gender bias

Dissociation & Somatization within PTSD



PTSD Treatment for Dissociation/Somatization

My patient dissociates/has a somatic response to trauma triggers:

- *How can I keep my patient from having this reaction in session?*
- *Is my patient appropriate for an evidence-based psychotherapy (EBP) for PTSD?*
- *Is EBP treatment harmful?*
- *Should I refer my patient to a higher level of care?*

PTSD Treatment for Dissociation/Somatization

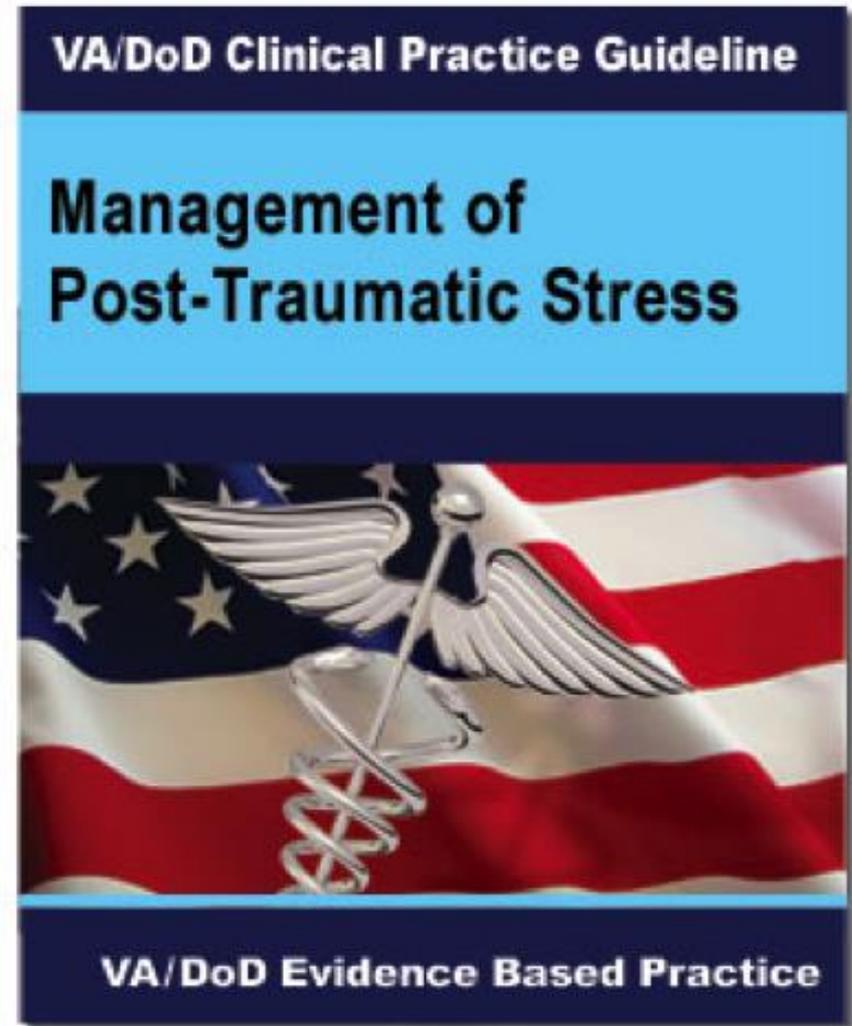
- **Dissociation and somatization are not immediate exclusions to evidence-based PTSD treatment**
 - Recommended manualized PTSD treatments are gradual: Address motivation/avoidance/coping within treatment
 - Can always alter treatment plan if needed
- **No need to avoid dissociation or somatization trauma reactions**
 - Assess the reactions to help form a case conceptualization, inform the treatment plan, and motivate for treatment
 - We would expect trauma reactions to reduce with PTSD treatment

PTSD Treatment for Dissociation/Somatization

- Develop a **shared response plan** for reactions in treatment:
 - Teach **grounding** to orient to the present moment (Kennerley, 1996),
 - Attention to sensory input, an image, or object – intended to stabilize
 - Consider active, in session, grounding
 - Choose meaningful methods, consider motivation-oriented grounding
 - Decide if touch is okay
 - Identify a contact person/caregiver – telemental health
 - Develop plan collaboratively
 - Debrief, reformulate, and reassess
 - Return to treatment: Do not allow reaction to stop the session
 - “Conquer the seizure” (L. Myers: PNES & PE)
 - Increase confidence/competence
 - Response plan should help to facilitate - not avoid - PTSD treatment

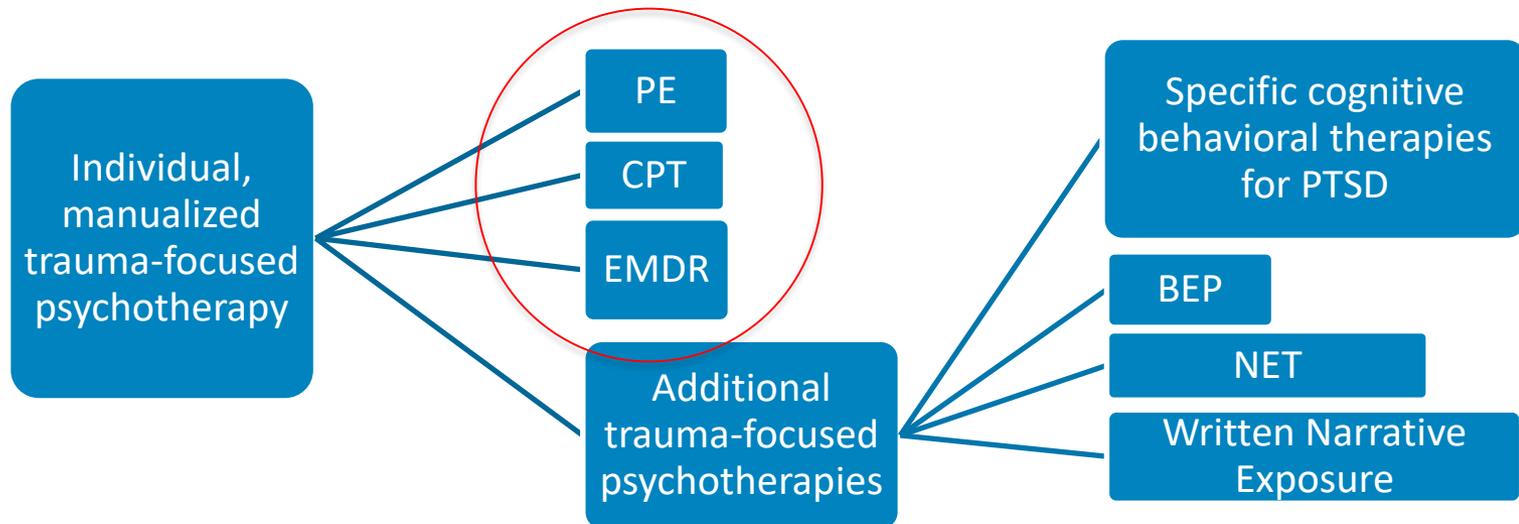
VA/DOD Clinical Practice Guideline

Department of Veterans Affairs
& Department of Defense
(VA/DoD) Clinical Practice
Guideline for the Management
of Posttraumatic Stress
Disorder and Acute Stress
Reaction (2017)



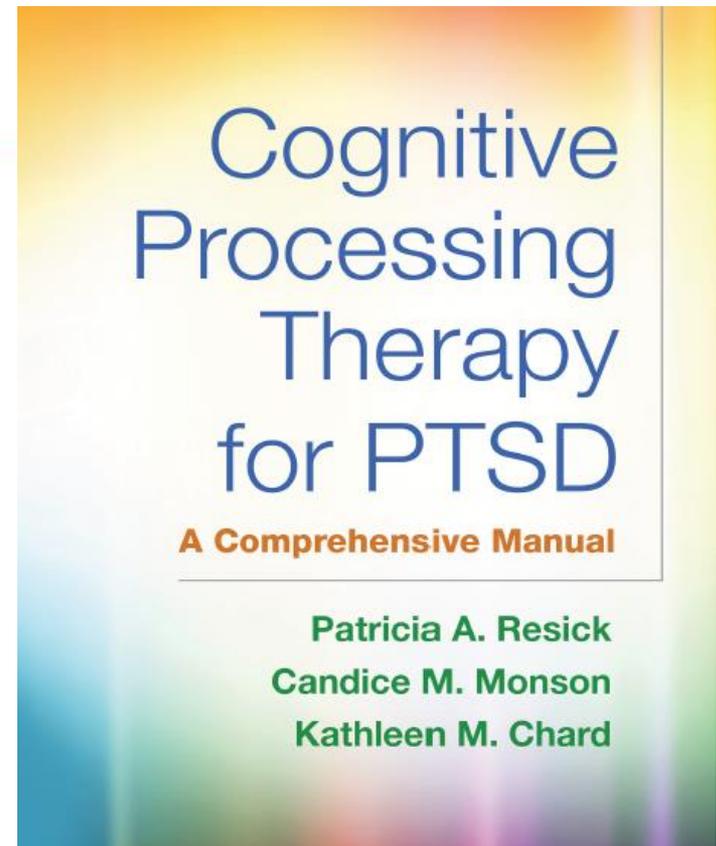
Trauma-Focused Evidence-Based Psychotherapies

***We recommend* individual, manualized trauma focused psychotherapies that have a primary component of exposure and/or cognitive restructuring to include Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), specific cognitive behavioral therapies for PTSD, Brief Eclectic Therapy (BEP), Narrative Exposure Therapy (NET), and written narrative exposure.**



Cognitive Processing Therapy (CPT)

- **Cognitive Theory:** The experience of traumatic events distorts beliefs and judgements. PTSD attributed to becoming “stuck” in the natural process of recovery.
- Cognitive-focused techniques are used to help patients move past “stuck points” and progress toward recovery
- May be provided with a written trauma account (CPT+A)



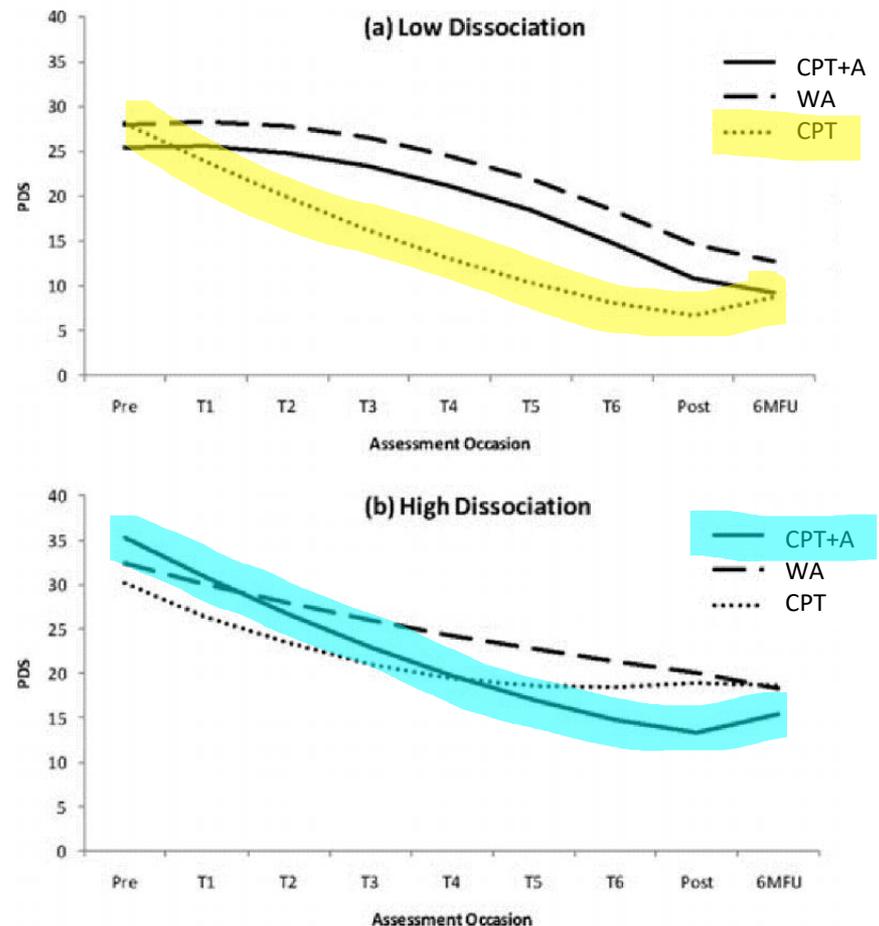
Resick, P. A., Monson, C. M., & Chard, K. M. (2017). *Cognitive processing therapy for PTSD: A comprehensive manual*. New York, NY: The Guilford Press.

Cognitive Processing Therapy (CPT)

- Dissociation and somatization reactions are not exclusionary
 - Therapists should assess reactions and generally proceed with CPT
 - Consider grounding prior to initiating CPT if unable to stay focused or if potential harm associated with reaction
- CPT Psychoeducation
 - Dissociation and somatic complaints are described as common reactions/avoidance of external reminders, preventing processing of the trauma that is needed for recovery
- Include any dissociation-/somatization-related stuck points on the Stuck Point Log. e.g.,
 - “Because I dissociated/froze during the trauma, that means I wanted it.”
 - “Feeling nausea or pain when I remember the trauma means I’ll never get better.”

Cognitive Processing Therapy (CPT)

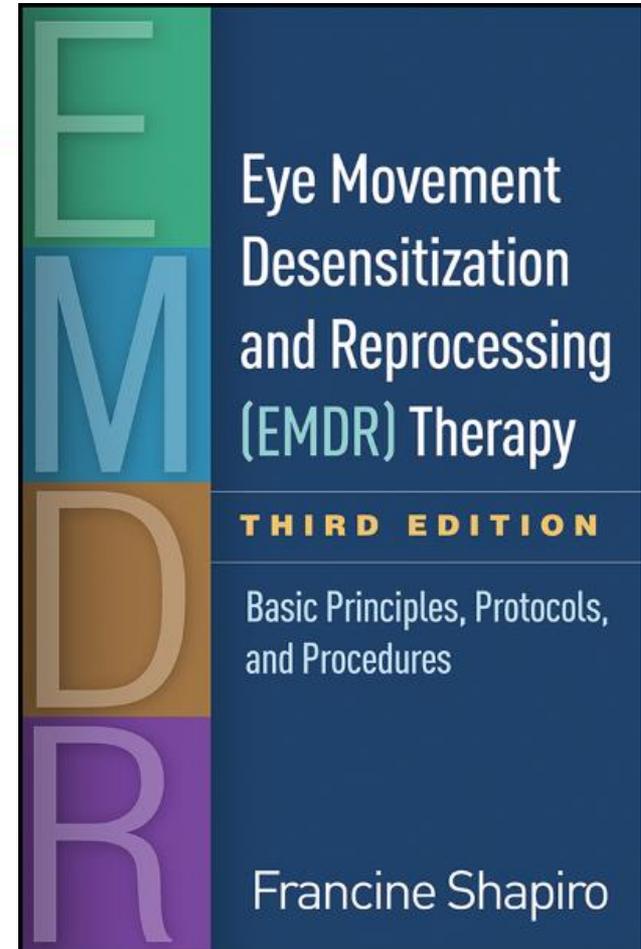
- Resick et al. (2012), comparing CPT, CPT+A, and WA
 - Women with low pretreatment dissociation responded best to CPT (no written account)
 - Women with high pretreatment dissociation responded best to CPT+A (with written account)
- CPT+A may organize narrative and increase engagement with trauma memory, facilitating cognitive therapy



Resick, P. A., Suvak, M. K., Johnides, B. D., Mitchell, K. S., & Iverson, K. M. (2012). The impact of dissociation on PTSD treatment with cognitive processing therapy. *Depression and Anxiety, 29*(8), 718–730.

Eye Movement Desensitization and Reprocessing (EMDR)

- **Adaptive Information Processing model:** If the information related to a traumatic event is not fully processed, the initial perceptions, emotions, and distorted thoughts will be stored as they were experienced at the time of the event
- Bilateral stimulations (e.g., eye movements) serve as dual attention stimuli, allowing clients to attend to both external and internal stimuli
- EMDR described as integrating psychodynamic, cognitive behavioral, experiential, physiological, and interactional therapy components



Shapiro, F. (2017). *Eye movement desensitization and reprocessing (EMDR) therapy: Basic principles, protocols and procedures*. (3rd ed.). New York, NY: Guilford Press.

Eye Movement Desensitization and Reprocessing (EMDR)

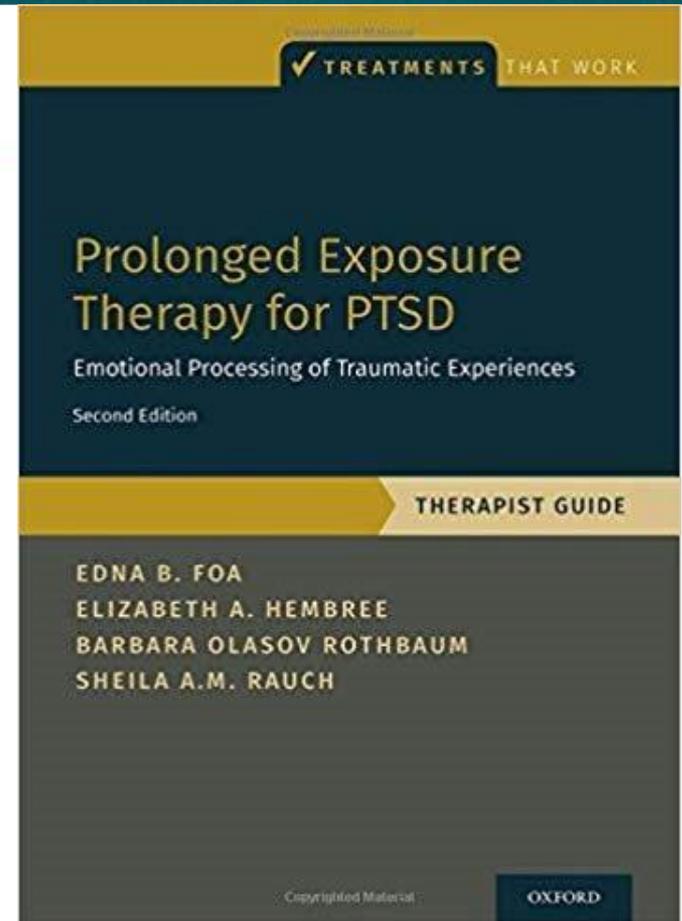
- Should not avoid or delay EMDR due to dissociation or somatization
 - Dissociation and somatization are expected trauma reactions that we would expect to resolve as PTSD is treated
- Routinely assess if client is able to maintain dual awareness of the trauma memory and what is happening in session
 - If unable or unwilling to maintain enough dual awareness to progress in treatment, not a good candidate (yet) for EMDR
- Empirical support for dissociation and somatization
 - E.g., case studies with phantom limb pain (Schneider et al., 2007)

Eye Movement Desensitization and Reprocessing (EMDR)

- Phase 4 (Desensitization and reprogramming)
 - Therapist routinely asks where emotion/distress is noticed in the body
 - Somatization and dissociation are expected, particularly if peritraumatic
 - Reactions are treated similarly to any other change reported by the patient during reprocessing
- Phase 6 (Body scan)
 - Opportunity to see if negative bodily distress related to memory is resolved
 - Body distress may be targeted for further reprocessing
- Clinicians may use EMDR strategies to increase the patient's access to memory
 - Modified protocols and specific training possible, particularly for new dissociation or separate dissociative disorders

Prolonged Exposure (PE)

- **Emotional processing theory:** Activation of the trauma memory allows for processing of emotions, corrective reorganization of the memory, and reduces overgeneralization of triggers
- Avoidance works in the short-term to reduce distress but maintains PTSD symptoms in the long-term
- CBT - Addresses 3 factors that maintain PTSD
 - *In Vivo Exposure* - Avoidance of external trauma situations
 - *Imaginal Exposure* - Avoidance of trauma thoughts and images
 - *Exposure Processing* - Unhelpful thoughts related to the trauma



Foa, E. B., Hembree, E. A., Rothbaum, B. O., Rauch, S. A. M. (2018). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences, therapist guide.*(2nd ed.) New York, NY: Oxford University Press.

Prolonged Exposure (PE)

- Dissociation/somatization not routinely excluded from PE
 - Therapist should assess if reaction is impacting therapeutic learning
- Hagenaars, van Minnen, and Hoogduin (2010)
 - Dissociative symptoms (emotional numbing, depersonalization, and general tendency to dissociate) were not predictive of poor outcome or dropout
 - Patients reporting high levels of numbing had better outcomes than patients with lower levels of numbing.
- Myers et al. (2017, 2018) – psychogenic nonepileptic seizures (PNES)
 - PE reduced the number of PNES and improved PTSD; maintained over time
 - No PE protocol modifications; incorporated log to track seizure frequency

Prolonged Exposure (PE)

- PE is individualized by design
- Modifying in vivo exposure
 - Break down targets into smaller (lower SUDS) steps
- Modifying imaginal exposure (overengagement strategies)
 - Help stay grounded to present
 - Create distance from trauma memory while maintaining emotional engagement level conducive to learning

Other treatment considerations

- Higher level of care (outpatient vs residential)
 - Consider if unable to progress in treatment plan due to constraints of outpatient treatment (i.e., 60-90 min weekly sessions)
- Increase frequency of contact – particularly for high avoidance
 - Massed treatment (more than 1x/week)
 - Check-ins between session (peer support)
- Bridge gaps in awareness during session
 - Record sessions, listen for homework
 - Written – not only verbal - material
- Utilize treatment team approach
 - Consult with treating providers outside of mental health
 - Incorporate loved one/caregiver

Other treatment considerations

- **What about a stepped or phased treatment?**
 - Minimal research to date examining phased treatment
- Cloitre, Petkova, Wang, & Lu Lassell (2012)
 - Skills Training in Affective and Interpersonal Regulation (STAIR); Narrative Storytelling (NST); Supportive Counseling (SC)
 - 3 conditions: STAIR/NST, SC/NST, STAIR/SC
 - Level of dissociation had no impact on PTSD outcomes
 - High dissociation group
 - STAIR/NST resulted in better dissociation outcomes
- Van Minnen et al. (2016) – EMDR & PE
 - “Patients with the dissociative subtype of PTSD do benefit from trauma-focused treatments without a pre-phase of emotion regulation skill training and should not be excluded from these treatments”

Other treatment considerations

- Other VA/DOD CPG recommended approaches:
 - Non-trauma-focused PTSD therapies
 - Pharmacotherapy
- Whole health/Complementary approaches, for example:
 - Yoga
 - Meditation
 - Somatic Experiencing
- Skills-based therapies, for example:
 - Dialectical Behavior Therapy (DBT)
 - STAIR

Other Challenging Presentations/Diagnostic Complexity

- Dissociation vs psychosis
 - Flashback vs psychotic hallucination
- Dissociation vs underengagement
 - Numbed out vs amotivated/anhedonic
- Comorbid somatic symptom disorder or dissociative disorder
 - Differential diagnosis and treatment planning
- Seeking to dissociate
 - Address as safety behavior/maintaining PTSD
 - Use motivational strategies

Measurement-based care - Assessment

- PTSD Assessment:
<https://www.ptsd.va.gov/professional/assessment/overview/index.asp>
- Dissociation Assessment:
 - Dissociative Subtype of PTSD Scale (DSPS)
 - Dissociative Experiences Scale (DES)
 - Multidimensional Inventory of Dissociation
- Somatization Assessment:
 - Beck Anxiety Inventory (BAI) – somatic response items
 - Hamilton Anxiety Rating Scale (HAM-A) – somatic response items
- Log of dissociation/somatization reactions

Resources

- ISSTD – International Society for the Study of Trauma and Dissociation (<https://www.isst-d.org/>)
- NCPTSD - PTSD Research Quarterly
 - The Dissociative Subtype of PTSD: An Update of the Literature (2018)
 - https://www.ptsd.va.gov/publications/rq_docs/V29N3.pdf
- NCPTSD – PTSD 101
 - The Dissociative Subtype of PTSD (Lanius) – 1 hr free CE credit
 - https://www.ptsd.va.gov/professional/continuing_ed/dissociative_subtype_ptsd.asp

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**Any question about PTSD.
We're ready to help.**

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