Suzette Boon, Kathy Steele & Dolores Mosquera. A Coruña, 2018

Dissociative, Psychotic or both?

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DID/ ASDD example 1 *or* a psychotic or schizophrenia spectrum disorder?

- Because of the presence of psychotic or psychotic-like symptoms in dissociative identity disorder (DID) and other specified dissociative disorder(OSDD) there is often diagnostic confusion with psychotic or schizophrenia spectrum disorders.
- Patients with DID (and less often with OSDD) frequently get diagnoses in the psychotic or schizophrenia spectrum (and sometimes it is vice versa)
- Treatment however is very different and medication for their psychotic-like symptoms has very little effect for patients with DID or OSDD.
- Thus, it is very important to train clinicians in the assessment of dissociative disorders and in differential diagnosis

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Why are DID or ASDD difficult to diagnose

- Lack of consensus as to what are dissociative symptoms
- High comorbidity with other psychiatric disorders and personality disorders
- In dissociative disorders the cluster of (pathological) dissociative symptoms is usually ***not*** the presenting problem, so patients may be misdiagnosed when they present with other psychiatric (or psychotic-like) symptoms
- Lack of training (or insuffcient) in diagnosis and treatment of dissociative disorders in psychiatry and psychology trainings.

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Overlapping symptoms in DID, ASDD and psychotic disorders or schizophrenia spectrum disorders

- Auditory (voice hearing, and command hallucinations) visual and tactile hallucinations;
- Symptoms of paranoia
- Trauma- related delusions
- Other first rank Schneider symptoms
- There may be a flat affect and little or no emotion visible

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Symptoms that may overlap phenomenologically in DID and ASDD and psychotic disorders

- Alterations of consciousness (absorption, depersonalization, derealization; concentration and or memory problems)
- Sometimes long psychiatric history with different diagnoses in particular in complex cases with more diagnoses
- (Sometimes) a trauma history and posttraumatic stress symptoms

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Different Concepts of Dissociation

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Different theoretical concepts of dissociation

-Dissociation a symptom on a continuum from "normal to pathological" (a.o Putnam, 1986)

-Dissociation a *pathological* symptom *always referring to division of self* (no continuum) a.o Van der Hart, Nijenhuis & Steele, 2006, see also Boon & Draijer, 1993)

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Normal dissociation on a continuum

Symptoms based on narrowing and lowering of consciousness, e.g.,

- "A reduction of awareness of his or her surroundings" (ASD; DSM-IV, p. 432)
- "My sense of time changed--things seemed to be happening in slow motion" (PDEQ; Marmar et al., 1998)
- "Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them (DES; Bernstein & Putnam, 1986)

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Changes in consciousness and awareness that may be part of narrowing or lowering of consciousness* (

-Absorption and imagination, daydreaming

- Problems with concentration, mild trance like experiences
- Mild depersonalization and derealization

* These symptoms are reported by patients with dissociative disorders but also very regularly by patients with other psychiatric disorders and the: "normal population"

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	Pathological psychoform dissociative symptoms	Pathological somatoform Dissociative symptoms
Negative	Amnesia (for everyday life); fugue states Depersonalization (out of body experiences) Derealization (not recognizing friends, surrounding) "loss" of " talents" or capacities (as may happen in a dissociative organisation of self)	'Conversion' symptoms : loss of hearing, vision, speech, smell, taste, strength in arms legs, paralysis Loss of sensation e.g feeling of pain, hunger, thurst , temperature etc); "I am just a head" (no connection with body)
Positive	Intrusions of dissociative parts; (Schneider's first rank symptoms) Intrusions of flashbacks, or traumatic memories	Pain, tics, unvoluntary movements non-epileptic seizures; Sensoric perceptions; Intrusions of sensations related to current behavior of dissociative part (e.g feeling that legs are moving but it is not you who is moving your legs) or traumatic experience of part

Dissociative Organization of Personality (VanderHart, Nijenhuis & Steele, 2006; Steele, Boon & Van der Hart, 2018)

- Basically two types of dissociative parts of the personality
- Part(s) with functions in daily life
- Part(s) "stuck in trauma time".Their function is to hold traumatic feelings, sensations, cognitions and memories. However these last parts sometimes also have (limited) functions in daily life

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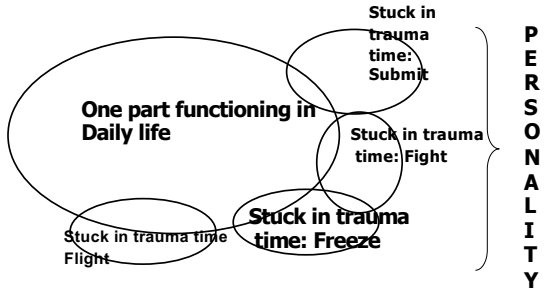
First organization, one part functioning in daily life



See: Nijenhuis, Van der Hart, & Steele (2001)
Adaptation Boon, 2018

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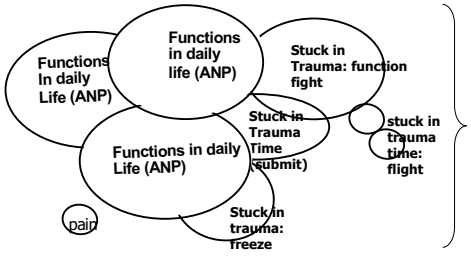
More complex organization: several parts functioning in daily life



Nijenhuis, Van der Hart, & Steele (2001)
Adaptation, Boon, 2018

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First Rank Symptoms of Schizophrenia common in DID

Voices commanding, commenting, arguing, crying (often heard inside head)

Made feelings, impulses, actions

Thought withdrawal or insertion

Hallucinations (auditive, visual, tactile related to traumatic memories or flashbacks)

Delusions (related to trauma)

Feeling that the body is controlled by someone else

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"psychotic" intrusions (of dissociative parts) in a person's executive functioning or sense of self

- DID and ASDD are *multiple reality disorders* (Kluft, 1991). Often several realities (different dissociative parts) cooccur or compete with each other in the same moment:
  - *"I know I am crazy, I have these strange thoughts suddenly popping up in my mind, they feel so real and yet like they are totally not mine"*
  - *"I sometimes see bloody hands coming towards me, trying to grab me, I know it is not happening but it is so frightening… so hard to tell myself it's not happening, it' s not real"*

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Intrusions (of dissociative parts) in a person's executive functioning or sense of self

- *Since yesterday, I have all the time the feeling that little insects are walking all over me, biting me, eating me. It's scary and I am itching. If I look I don't see them but then I have to turn my arm, I am convinced they must be at the back. But they are not so it must be my fantasy..I feel so ashamed, I am such a crazy person with weird fantasies. Over the years it comes and goes*
- *I got scared in the bus last week, there was shouting and a fight. I suddenly saw my arm pushing the button to stop the bus and my legs starting to walk. It didn't feel like my arms or my legs. It was so strange*
- *Even though I have been very succesfull at work, there are always voices telling me I am stupid, no good, not worth living. Deep inside I feel they are right. That outside me is just a facade*

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Intrusions (of dissociative parts) in a person's executive functioning or sense of self

- These "different realities" can be very confusing for the part functioning in daily life
- Events within that inner world that are accorded historical reality and which sometimes intrude into ongoing experiences, and/or impact ongoing experiences from behind the scenes (Kluft, 1998)
- Sometimes events in the inner world can be misperceived as events in external reality (a part stuck in trauma time is convinced being abused now)
- In most patients there are parts that can correct distorted reality, but they are not always present or accesible

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Intrusions (of dissociative parts) in a person's executive functioning or sense of self

- Sometimes, "distorted reality" may take over the awareness and consciousness of a DID patient without being able to correct the thought, sensation, hallucination
- If this happens, it usually doesn't last long (minutes to hours) (e.g. a partner looks like or changes in the original perpetrator
- In most cases distorted reality can be corrected and this is an important focus of therapy (learning to distinguish here and now from then and there

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Intrusions (of dissociative parts) in a person's executive functioning or sense of self

- And.. If the person is unaware of the link with trauma history or
- Unaware (or very avoidant) of amnesia or shameful dissociative experiences it becomes hard to assess a dissociative disorder
- Finally there is not just one concept of psychosis

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Symptoms that differentiate DID and ASDD from psychotic disorders

In psychotic disorders:

-Cluster of pathological dissociative symptoms is lacking in particular **amnesias; fugue states**

-If there are memory problems the description of the memory problems differs from DD patients. There may be memory problems related to absorption and depersonalization, or day dreaming

-no dissociative organization of self thus no evidence for the existence of dissociative personalities

-no dissociation during interview, no stress or tension related to interview

- Quality and prevalence of first rank symptoms differs

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Schizophrenia and psychotic disorders

-Depersonalization/derealization may be present often during psychotic episode;

-Schizophrenic patients report more negative symptoms

-Reality testing not (always)intact

-"As-if " quality of hallucinations not present/content of hallucinations different, sometimes bizar

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Differentiating Auditory hallucinations in DID from those in Schizophrenia

- Dorahy et al (2009) compared auditory hallucinations of schizophrenic patients with and without child maltreatment and DID patients
- DID voice experience looks different from schizophrenia voice experience.
- -Voice hearing in DID was more likely to:
  - Start before 18
  - Hear constantly
  - Hear both internally and externally
  - Hear more than 2 voices
  - Hear both child and adult voices

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	DID and ASDD	Psychosis/ schizophrenia
Depersonalisation/dereali-sation; absorption; imagination	Present in some form	Quite common in particular during psychotic phase
Somatoform dissociation	Very common	uncommon
Amnesia: time-loss (blocks of time missing); fugues, disremembered behaviors; unexplained possesions	Present in DID	absent
First rank symptoms	Present (**different quality**) Often as-if quality; Reality testing intact in at least in one part of personality "Multiple coexisting realities"	Present during psychotic episode Reality testing **not** in tact During psychotic episode Single reality (content more bizar and delusional explanation)

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	DID and ASDD	Psychosis/ schizophrenia
Negative symptoms of Schizophrenia Loss of initiative; lack of emotions; emptiness	Absent but.. Behavior of some parts may be misperceived as a negative symptoms	Present in schizophrenia not in all psychotic disorders
Dissociative parts (or evidence of extistence of parts)	present	absent
Presentation	Avoidance; shame; numb Difficulty talking about dissociative symptoms; Intrusions of parts during assessment; Dissociation during assessment	No fear, shame. Can talk freely about dissociative symptoms; No dissociation during assessment

Cluster of dissociative symptoms in a patient who previously has been given the diagnoses of psychosis, schizophrenia, borderline personality disorder and PTSD

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Conclusions 1

- Differentiating DID and ASDD from psychotic and schizophrenia spectrum disorders is important as treatment differs very much.
- Differentiation is not always easy. At a (superficial) phenomenological level there is overlap in symptoms in particular in first rank symptoms of schizophrenia (voice hearing, hallucinations)
- Sometimes a part functioning in daily life is "overwhelmed" by an intrusion of a sensation of a part stuck in trauma-time and for some time convinced (like that other part) of that reality without being able to correct it.

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Conclusions 2

- Patients with dissociative disorders may minimize or may not even be aware of (some of) their dissociative symptoms such as amnesia and the dissociative organization of their personality. In those cases making a differential diagnosis is even more difficult
- Carefull assessment of dissociative symptomatology is paramount

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The End

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