Psichiatria e Psicoterapia (2019) ***38****, 3,* 195-213

PSYCHIATRIC CONSULTATION AND DISSOCIATIVE DISORDERS: WHY IT IS SO IMPORTANT TO KNOW PATHOLOGICAL DISSOCIATION

Frau Costanzo

Introduction

One realizes by studying the history of dissociation that many recent findings were already known a hundred years ago. The first theoretical formulations of Freud gave importance to trauma as an important life event in the development of psychopathology. In his work "Studies on Hysteria" written with Breuer in 1895, he describes some case histories of women with dissociative disorders and in different cases, sexually abused. For many reasons Freud repudiated the seduction theory (for an in-depth study of the reasons see Ernest Jones's biography of Freud,1953).

In the introduction of his paper Birken (1988) claimed: "Freud's repudiation of the seduction theory in favour of the Oedipus complex, long regarded as a key episode in the early history of psychoanalysis, has recently become the subject of intense debate". Leaving aside the debate around the reasons for Freud's theoretical change and whether he actually abandoned his initial theory (Lothane 2001), what is certain is that the reality of childhood trauma was no longer considered important in the genesis of psychopathology. In this way he repudiated clinical realities of both abused children and adult survivors of childhood abuse (Ross 1989).

After 1910 there was a decline in the diagnosis and study of multiple personality disorder (MPD) (Putnam 1989). Freud's change of position was certainly one of the main reasons for the disinterest in this mental health disorder. No less important for his discredit was the fact that MPD was considered an artefact, i.e. an interaction between a naïve diagnostician and a hysterical patient (Ross 1989).

Furthermore, patients with multiple personality disorder began to be called schizophrenics. Many diagnoses of schizophrenia were made by shifting the focus of attention on biological damage to the detriment of traumatic origin. Rosenbaum (1980) documented that as the concept of schizophrenia began to gain ascendency among clinicians, the concept of DID markedly decreased, a change that likely occurred because schizophrenia and DID have some similar symptoms (Ross 1989, Kluft 1987). Since then the term "schizophrenia" introduced by Bleuler in 1908, made clinicians forget the concept of dissociation. Bleuler's work (1950) represented, on the one hand, the peak of interest in the link between dissociation and psychosis, on the other hand it decreed the disappearance of dissociation. With its insistence on the organic basis of schizophrenia, the Swiss psychiatrist accelerated the loss of interest in dissociative disorders linked to trauma and the beginning of the medicalization of schizophrenia. Medicalization assumed a central role in the second half of the twentieth century with the rise and dominance

Sottomesso Marzo 2019, accettato Luglio 2019

of the neo-Kraepelinian biological paradigm. It highlighted a clear separation between various mental disorders, the biological and often genetic bases, and the discontinuity between "normal" and "abnormal" functioning (Klerman 1978).

Since the early 1980s, there has been a resurgence of interest in DID and research into dissociation and Dissociative Identity Disorder (DDI) has been growing (Sutcliffe and Jones 1962, Carlson 1981, van der Hart and Dorahy 2009, Dorahy et al. 2010).

Despite this advancement in scientific knowledge that led to the definition of effective treatments for dissociative disorders (Dorahy et al. 2014, Brand et al. 2009, Brand et al. 2012, International Society for the Study of Trauma and Dissociation 2011), the medical model of psychic illness continues to influence the approach to psychiatric disorders by considering pharmacological intervention as primary and limiting psychotherapeutic intervention in complex dissociative frameworks (APA 2016, Malla et al. 2015, Ross 2004).

In the first part of the paper I will describe the evolution of the concept of dissociation and the emergence of neo-Kraepelinian model. In the second part I will try to illustrate what, in my opinion, are the limits of medical evaluations that do not take into account the dissociative mechanism underlying psychiatric pathology. The purpose of this article is to highlight a way of proceeding that considers the achievement of the therapeutic alliance as a priority issue within the framework of the integrated treatment of dissociative disorders.

Pierre Janet and the concept of “désagrégation”

The paradigm based on dissociation has its foundations in the work of the French psychologist Pierre Janet. In his first clinical studies he described hysterical psychosis as a type of "daydream" during which the subject cannot differentiate between dream elements and normal perception (Janet 1901, Van der Hart et al. 1989).

In his studies with hysterical patients, Janet established that so-called “waking dreams” were related to traumatic experiences. According to Janet (1894), a psychosis could be considered hysterical if its dissociative nature could be established. He defined the main aspects that characterized hysterical psychosis (Witztum and Van der Hart 2008):

- The psychosis would include dissociative phenomena;
- The psychosis itself would be a dissociated mental state;
- There had to be a splitting or doubling of the mind;
- The presence of subconscious phenomena;
- The expression of altered states of consciousness;

Janet claimed that hysterical psychosis could develop progressively (Janet, 1901). Initially a certain sequence of images (the re-enactment of traumatic events) dominates the consciousness during a hysterical attack. Over time, traumatic content could intervene during the intervals between hysterics, turning hysteria into a chronic psychosis (Van der Hart et al. 1993, page 3). Due to high hypnotizability, Janet believed that hysterical psychosis could be treated with psychotherapy. He considered hypnotherapy the main treatment in these cases (Van der Hart et

al. 1989).

As Heim and Buhler (2006, page 115) summarize in their paper, Janet claimed: “The trauma induced emotion is a pathological phenomenon that leads to exhaustion of the individual, that is, a weakening of her or his psychological energies, or mental tension and force. This weakening of mental tension and force causes a diminution of psychological synthesis, thereby facilitating the formation of fixed ideas. This process is called désagrégation or dissociation”.

Hysterical psychosis, as defined by Janet, may today be considered dissociative psychosis. Van der Hart et al. (1993) have shown that many of these cases suffered from the adult consequences of real childhood trauma.

Although the concept of hysterical psychosis was the subject of attention in the late 1800s and early 1900s, something changed after 1910. According to Rosenbaum (1980) the decline of the multiple personality disorder known today as dissociative identity disorder (DDI) was due to the introduction of the term "schizophrenia" which replaced that of "dementia praecox". In his article he described how there was a decline in the number of reports of multiple personality disorders from 1910. In the probable attempt to highlight the underlying mechanism of dementia praecox and other psychiatric disorders, except for manic-depressive cases, Bleuler introduced the term of schizophrenia. He described this underlying pathological process as a splitting of personality. Bleuler claimed that all cases diagnosed as hysterical psychoses by other psychiatrists differed in no ways from other schizophrenics (for an analysis about the historical concept of schizophrenia see Moskowitz 2008). However, the main effect of renaming "dementia praecox" as "schizophrenia" or "split mind disorder" was to have absorbed many patients with DDI within organic brain syndromes.

In his book Ross (1989, page 39) wrote:

“There has been an ideological dichotomy in psychiatry over the last 80 years, which is not resolved. Initially, the Freudians were on one side, and the “biological” psychiatrists were on the other. The unitary Freudian camp has since been replaced by a welter of diverse schools. According to rumor, some biological psychiatrists have a very strong desire to be accepted as respectable medical scientists and never to be mistaken for psychoanalysts. The reciprocal morbid phobia is also in place.”

Thirty years later, there was more scientific evidence on the effectiveness of psychotherapy. Psychiatrists took far greater consideration of psychotherapy with complex disorders but just as then most cases support a reductionist biological model (Moncrieff 2013). What has certainly not changed is the difficulty of many psychiatrists to make an accurate diagnosis between the two groups of illnesses: organic brain syndromes and dissociative disorders. These have different etiologies, treatments and prognosis. As they were thirty years ago, in many cases of complex dissociative disorders patients are hospitalized and diagnosed as schizophrenics, treated only with antipsychotic drugs and in many cases with ECT (Hutton et al. 2013; Leiknes et al. 2012; Fosse and Read 2013).

Kraepelin and the neo-Kraepelinian model of mental disorders

Bleuler worked closely with Freud and was conditioned by the Janetian ideas about dissociation. On the contrary Kraepelin was deeply rooted in German academic culture. Unlike Bleuler, Kraepelin's ideas of Dementia Praecox were less influenced by psychology. He was firmly convinced that this was a brain disease linked to a brain autointoxication. He argued that dissociation was irrelevant to diagnostic conceptualization (Ross 1989).

Moreover, the model on which the author based his concept of Dementia Praecox was that of General Paresis of the mentally ill, also called *Dementia Paralitica*. General Paresis was very widespread in Europe in the early part of the nineteenth century. It was a terminal condition that combined psychotic symptoms with paralysis and ultimately death. Based on that Kraepelin defined a new theoretical model for mental disorders and in particular for "dementia praecox" (Jablensky 1995, Moskowitz 2011). In the last forty years the classification of mental disorders has been dominated by this approach, followed mainly by a group of American psychiatrists identified as *neo-Kraepelinian*. This "movement" revised the diagnostic system of psychiatric disorders in 1970, achieving its goal with the publication of the DSM-III in 1980. The basic idea was to create a more reliable diagnostic system than the previous ones. In reality the neo-Kraepelinians were motivated by the belief that these disorders were of a medical nature like any other (Moskowitz 2011, page 350).

The neo-Kraepelin model defined two central aspects (Klerman 1978):

a) there is a clear distinction between mental disorders and normality and it is possible to define a clear boundary between these two;
b) the study of mental disorders has to be based fundamentally on neurobiology;

Neo-Kraepelinian paradigm about clear genetic or biological bases for schizophrenia and other mental disorders has not been scientifically supported; there is no evidence that diagnoses are strictly separated from each other and from normal experience (Ross 2016, Ross and Ross 2018, Moskowitz 2011). Furthermore psychotic symptoms have been recognized as being common to various disorders, as well as schizophrenia, and their presence in a large portion of the population without any diagnosis of mental disorder (Van Os et al. 2008).

The historical decline of the concept of dissociation initiated in the first decade of the 1900s was followed by the subsequent shift towards a medical reductionist model of mental illness. The discovery of antipsychotic drugs allowed a rapid resignation policy in many psychiatric hospitals, significantly shifting the cost/benefit balance of schizophrenia therapy and other psychiatric disorders. This led the public health system to change direction: the administration of psychotropic drugs was far less expensive than any other psychotherapy treatment (Moncrieff 2013).

The Neo-Kraepelin model has based its research on a biological and genetic idea of mental disorders. At present this paradigm has not been supported (Moskowitz 2011, Ross 2016, Read et al. 2013). Despite the fact that numerous research data has demonstrated the long-term deleterious effects of psychotropic drugs (Gøtzsche 2015, Longden and Read 2016) and there is no evidence of the theoretical model based on chemical imbalances (Council for Evidence-based Psychiatry

2014), the central paradigm of psychiatry has not undergone major changes. Pharmacological intervention is always considered the treatment of choice for psychiatric disorders (Read et al. 2014, Read et al. 2004, Read 2008).

Pharmacology and dissociative disorders

The purpose of this article is to argue the importance of psychological evaluation in defining dissociative functioning before proceeding with any other drug treatment. For more information on the most appropriate drug therapy with patients with DDI and cPTSD I suggest the guidelines of the International Society for the Study of Trauma and Dissociation (2011) and the articles of Loewenstein (1991a, 1991b, 2005). The guidelines of the International Society for Trauma and Dissociation (2011) recommend paying close attention to therapeutic boundaries and to the active lines of communication between the treatments, especially when the psychiatrist is not the primary therapist. The patient should have only one clinician involved and the primary therapist should be responsible for all psychotherapy emergencies.

It becomes necessary in the treatment of patients with DDI and cPTSD to have a regular exchange of significant information between treatment team members. For this reason, the psychiatrist should always be in contact with the main therapist and with the team. It is recommended to monitor pharmacotherapy considering individual psychotherapy and group psychotherapy where this is provided for. The patient, the psychotherapist and the psychiatrist should be involved in discussing the continuation or discontinuation of medication, trying to define a subsequent therapeutic objective once the patient has achieved good stabilization.

Loewenstein (2005) highlights how the pharmacological therapy of patients with DDI and complex PTSD depends on the evaluation of the symptoms that one or more parts present. These may vary depending on how the parts relate to each other and to the outside. According to the description of symptoms that are found across most or all alternate identities, he describes the psychological aspects of psychopharmacologic interventions in DID. The author highlights some particular points in the pharmacotherapy of DDI:

a) the importance to maintain communication between psychiatrist and psychotherapist by sharing voice mail, email or brief phone calls;
b) give the patient a more realistic vision of the pharmacological treatment and of his efficacy;
c) paying attention to patients with strong wishes for medications as a solution to all problems and to patients who may have phobic reactions or feelings of loss of control when psychotropic medication are proposed;

As Loewenstein (2005, page 668) writes:

> "Psychopharmacology for the patient with DID must be understood in the context of the total treatment of the patient. In DID treatment, psychopharmacologic interventions are primarily adjunctive and empirical in nature, as no double-blind, placebo-controlled studies have been performed to study any psychopharmacologic agent or medication regimen for DID."

He writes again:

> "The majority of problems, symptoms, and difficulties in DID are most efficaciously addressed psychotherapeutically, hypnotherapeutically, or both, not with medications. Nonetheless, medications, if properly conceptualized and administered, may have a significant beneficial adjunctive role in DID treatment."

In my opinion, the points highlighted by Loewenstein deserve further investigation. In particular, I believe that it is crucial to set the pharmacological treatment after having defined a general idea about how DDI parts work and the psychological process in the general dissociative disorders. The pharmacological intervention cannot be separated from contact and agreement with the patient's internal system. It cannot precede the therapeutic alliance formation. If that is what happens (i.e. there is no agreement or medications are imposed to the patient) then it could be iatrogenic.

First contact with dissociative disorders

The following cases illustrate the error very often committed by psychiatrists in setting up a pharmacological treatment without evaluating dissociative functioning.

Case 1

Patient 1 is an 18 years old male. He was first admitted to a Psychiatric Service at the age of 13 with a diagnosis of anorexia nervosa. The clinical picture in addition to the eating disorder was characterized by a compromise of the emotional and relational sphere. After his first hospitalization the diagnosis was changed to Obsessive and Compulsive Disorder. During the 2 years characterized by 6 hospital admissions and one period of 6 months in a therapeutic community, the patient showed a serious conflict with his mother. He showed physical aggressiveness alternated with moments of great emotional closeness. During this period he presented a psychiatric symptomatology that was aggravated: the affective dysregulation increased, there was a reduction in the care of himself and an increase in social withdrawal up to the point of mutism. At the discharge from the last admission the patient's diagnoses were of unspecified schizophrenia spectrum and other psychotic disorders, obsessive-compulsive disorder, autism spectrum disorder and other specified trauma/stress related disorder.

I made a diagnosis of Other Specified Dissociative Disorder (OSDD) based on a clinical interview and the later Dissociative Disorders Interview Schedule (DDIS) results. Among the various symptomatological manifestations, one in particular was the cause of the difficulties during psychotherapy: passive negativism (a symptom of the DSM-5 diagnosis of catatonia, characterized by the patient's tendency to refuse to carry out orders or simply react when given instructions) had increased for several months. There was resistance in every attempt to get in touch with him, which manifested itself in the mutism. Sixteen months after the start of psychotherapy, he achieved greater integration and contact with a dissociated child part, the

patient described the reasons for his dysfunctional behavior, particularly during hospitalization.

Negativism and mutism as volition disorder are considered predominantly in schizophrenia frameworks. In the DSM-5 they are two of the catatonia symptoms, a condition that may be associated with other mental disorders. Two other symptomatological manifestations of the patient, probably connected to this state, were the extreme postural rigidity and the presence of grimacing (one of the symptoms described in the DSM-5 category of catatonia). In fact, these manifestations may have originated from dissociated emotional experiences, in the absence of autobiographical memories of traumatic events (Freeman and Garety 2003). They could be explained with the emergence of one dissociated part.

The aspect that I want to highlight, as described later by Patient 1, is the attempt by the hospital team to have the patient take a pharmacological treatment at all costs. This increased the negativism and prolonged the hospitalization with negative consequences for the therapeutic path. The pharmacological evaluation was carried out without knowing the patient's internal system and consequently by reinforcing the dissociative mechanism. In the first months of therapy the patient used to remain silent for long time during the sessions and when he interacted he did so by briefly nodding his head or uttering only a few words. The interviews were very demanding and I had to control a strong feeling of powerlessness due to the impossibility of interacting verbally with him.

After a careful evaluation of his clinical record and psychiatric history I was able to formulate a hypothesis on the psychopathological mechanism in place and try to build the therapeutic alliance on the basis of these elements. The initial hypothesis was based on the non-verbal behavior of the subject during the sessions and assumed that his anger had been dissociated (the family history and the analysis of the various admissions corroborated this hypothesis).

The validation of this dissociated ego state was essential for building a successful therapeutic alliance (Watkins and Watkins 1997, Ross and Halpern 2009, Van der Hart et al. 2006). In order to validate this state of dissociated rage (Linehan 1993) I worked on two aspects: a) I focussed on regulating my mental state of impotence, which was determined by the difficulties in communicating with the patient; b) I made it clear during the sessions that I needed to understand from him what of my behaviour irritated him.

During the first two months I carried out a psycho-educational work on dissociative symptoms, while avoiding to come into contact with the emotional state, so as not to generate an increase in internal phobia (an aspect that occurred every time the discourse shifted towards a hypothetical emotion experienced by the patient). Small changes became evident in the psychotherapy sessions, for example when the patient implemented grounding strategies without verbalising the actions (for an in-depth study of these strategies and of psycho-education on dissociative symptoms see Boon et al. 2011). When we came on to discussing drug therapy, its role and the treatment of psychological disorders in general, the patient showed greater interest, which was revealed by a change in posture and verbal expression. For this reason I suggested that our therapeutic goal should be achieving a better understanding of what was happening to him, with the aim of interrupting the drug treatment in the future. In the following months I continued with grounding strategies and specific techniques to establish contact with the parties (Ross and Halpern 2009), talking about the functioning of the brain, and always highlighting the need

to hear from him if there was something annoying in our conversations. In the course of these sessions our therapeutic goal was also brought up and discussed again. After 5 months of therapy the patient's verbal communication started to improve and after 8 months his speech became normal, with a considerable reduction of response latency when answering questions.

In addition to the progress made with the verbal communication, during the rest of the therapy the patient saw a significant improvement in all symptoms described above in conjunction with the gradual steps in the integrative process. The therapy continued following the international guidelines on treatment of dissociative disorders (International Society for the Study of Trauma and Dissociation, 2011).

Case 2

Patient 2 is a 29 year-old female. She was hospitalized twice over a two-year period for 21 days each time. The main symptomatology concerned strong somatizations at cardiac and abdominal levels. The years before admission the patient was treated with a pharmacotherapy for an accumulation disorder (F42, APA 2013). She is discharged from the hospital with the diagnosis of psychosis NAS. Drug therapy initially includes an antipsychotic, subsequently accompanied by anxiolytics and an antidepressant. During the years prior to hospitalization and during admissions, patient 2 attributed the responsibility for her unease to medications. She alternates periods in which she refuses to take drug therapy to periods in which she consults several psychiatrists asking them to modify it.

I made a diagnosis of Other Specified Dissociative Disorder (OSDD) based on a clinical interview and the later Dissociative Disorders Interview Schedule (DDIS) results. In addition to criteria for a somatic symptom disorder, patient 2 presents Schnederian symptoms and other secondary characteristics associated with DID. The patient was removed from her parents at the age of 12. She went to a convent school where she spent all her adolescence until she reached the age of majority. In the anamnesis she also presents several episodes of physical abuse during the years of nursery school. Then the diagnosis of selective mutism was made and was followed by the service of child neuropsychiatry.

The event reactivating the dissociative mechanism concerns the moving of the family in a new apartment. The removal of home contents from one location to another location become a trigger for the child part. She acts checking behaviours and she presents somatizations. The latter can be considered traces of dissociated traumatic procedural memories that emerge at the highest levels of consciousness only through these somatic components (Ogden et al. 2006).

It was Briquet (1859) who gave importance to trauma as an etiological factor in hysteria. Defining the syndrome which then took its name, the author focused on the somatic aspects of hysteria. He claimed that the latter was caused "by the effect of violent emotions, protracted pains, family conflicts and frustrated love, on predisposed and hypersensitive persons" (Ellenberger 1970, page 142).

Also in this clinical case as in the first one the pharmacological treatment precedes the evaluation of the dissociative mechanism. In the first months of patient 2 therapy she has had

different dissociative crises, managed by the therapist with a specific intervention plan defined together with the family members. For this reason, it was possible to avoid other admissions. She was constantly complaining about somatizations that led her to consult various medical specialists and psychiatrists, expressing anger against the drugs to which she attributed the full responsibility for her illness. The patient was not accessible on a cognitive level, the level of amnesia was very high and I could not work with the child part. The only work possible was that of body regulation. After ten months of therapy an interesting phenomenon occurred. The parents decided to support her in the discontinuation of drug therapy. Within a week the somatizations were reduced and after 30 days patient 2 no longer presented this symptomatology. This clinical phenomenon can find an explanation within the theoretical model of dissociative disorders (Van der Hart et al. 2006, Ross and Halpern 2009, Janet 1901). In the first period of her parents' departure, which she could not see and hear for 6 years, the patient experienced a strong sense of helplessness. She cried constantly, tended to be alone in the room and experienced a strong sense of anger. The nun who was following her had decided that patient 2 should have taken an antidepressant. The patient at a later stage of therapy, after coming into contact with the child part, reports having unsuccessfully opposed her by not wanting to take this drug. I believe that she has connected the strong sense of helplessness and the rage resulting from the abandonment with the antidepressant that she was forced to take. Subsequently, with the reemergence of the dissociated emotional state the only explanation (locus of control) to her strong somatizations remained drug therapy.

A necessary step for the validation of this dissociated state linked to anger (Linehan 1993) was to help the patient to regain more mental control. As in the first case, the main objective was to create a therapeutic alliance which we founded on the patient’s conviction that the drug was the cause of her pain.

While supporting the patient on her path to scaling down the drug until a complete suspension of the pharmacological therapy (Breggin 2012), at the same time I suggested that we should assess whether her psychophysical state of illness actually depended on the drug and, if we found that this was not the case, I proposed to work together to reduce the intensity of her pain. As mentioned above, after stopping the drug treatment the symptomatology reduced progressively until it disappeared. Predictably, it re-emerged later at the onset of the dissociated state of anger. After that the symptoms never reached the same intensity nor was the patient hospitalised ever again and it became possible to work with different regulation strategies on the body state (Corrigan and Elkin-Cleary 2018).

Pathological process in dissociative disorders

Neurosciences are supporting the Janetian idea of désagrégation and the explanatory models of dissociative processes that are based on the Jacksonian concept of "mental functions organization" (Janet 1977, Schore 2009, Farina et al. 2005, Porges 2001). According to Jackson, the incarnated mind resulting from evolution of the species has the ability to integrate ever more complex levels with each other. According to an ever-increasing degree of complexity, the mind comes to represent itself after having integrated the activity of the lower components (Franz and

Gillet 2011, Horn et al. 2014, Buckner et al. 2008, Ey 1962).

In fact, many studies have shown the negative effects of early trauma, how victims of trauma have reduced connectivity between cortical and subcortical areas (Teicher et al. 2010, De Bellis 2010, Corrigan 2014, Reinders et al. 2014) and how trauma experienced in the early stages of life interferes with the emerging connections in the Default Mode Network (Daniels et al. 2011, Bluhm et al. 2009, Supekar et al. 2010).

According to the DSM-5, the essential characteristic of dissociative disorders is the disruption of the usually integrated functions of consciousness, memory, identity, emotion, perception, body representation, motor control and behavior (American Psychiatric Association 2013, Kingdon and Young 2007). In the same way according to the ICD-10: "the aspect shared by dissociative disorders is the partial or complete loss of the normal integration between memories of the past, awareness of identity, immediate sensations and control of body movements" (WHO 1992). Dissociative symptoms can potentially affect every area of psychological functioning.

The concept of "désagrégation" concerning the pathophysiology of dissociative disorders is starting to have important effects in the field of psychiatry with the increase of neuroscientific evidence regarding the impact of trauma on the brain. On the contrary, the theoretical model on psychiatric disorders based on chemical imbalances has not been supported (Council for Evidence-based Psychiatry 2014, Kingdon and Young, 2007, Lacasse and Leo 2005).

Giving priority to the pharmacological intervention could lead to an increase in the dissociative process/mechanism. For example, in dissociative patients' internal pathological system has organized itself into dissociated parts that hold thoughts, feelings, memories, and impulses that were intolerable for the individual. In DID getting rid of the voices or ignoring them, only creates more internal conflict (Mosquera and Ross 2016). Not recognizing the central dissociative process could lead the pharmacologist to try to get rid of auditory hallucinations, which in the DDI patient represent dissociated parts. Conventional interventions in psychiatry focus solely on symptom reduction (psychotic symptoms) through the use of medication (Romme and Escher 1989), not considering that turning this into the primary objective slows or interferes with the integration process. Moreover, many of these patients do not respond to antipsychotic therapy despite taking high doses of this drug (Ross 2015, Samara et al. 2015). The strategy used with dissociative patients who do not respond to antipsychotic is to increase the dosage (Mocrieff 2006a, 2006b). In addition to having long-term medical consequences (Geddes et al. 2000, Harrow and Jobe 2013, Tiihonen et al. 2009) this method interferes with emotional processing and psychotherapeutic treatment approach to the hallucinations (Romme and Escher 2000).

Treatment alliance as main objective in the integrated settings of therapy

For the complex DSM-5 dissociative disorders (Loewenstein 1991b), i.e., DID and Other Specified Dissociative Disorder (OSDD) (OSDD corresponds to DSM-IV DDNOS subtype 1b), as well as for other complex trauma-related disorders such as complex post-traumatic stress disorder (PTSD), the standard of care is phase-oriented treatment consisting of three phases: (1) safety, stabilization, symptom reduction, and skills training; (2) treatment of traumatic memories;

and (3) personality reintegration and rehabilitation (Chu 2011, Cloitre et al. 2012, International Society for the Study of Trauma and Dissociation, 2011).

The first phase as well as the other phases are based on the therapeutic alliance. This is the guiding thread not only for therapy with dissociative disorders but for the treatment of any other psychiatric disorder. It is the main indicator of improvement in psychotherapy (Ardito and Rabellino 2011, Horvath and Bedi 2002, Safran and Muran 2011).

According to Martin et al. (2000), we can consider three main variables to define the therapeutic alliance: a) an *affective bond* between patient and therapist, b) the collaborative nature of relationship c) an agreement on goals and tasks between the two. The development of an alliance is considered essential for the onset of client involvement in therapy (Warren 2001, Norcross 2018) and the clinician must be continually engaged in the monitoring and repairing of treatment alliance ruptures (Liotti and Monticelli 2014). Using data from the TOP DD study, a longitudinal naturalistic treatment of patients with dissociative disorders, Cronin et al. (2014) studied the importance of therapeutic alliance in predicting success in the treatment of this kind of disorder. The authors concluded that the strength of alliance was positively correlated with therapeutic outcome, representing a crucial variable in treatment for DD patients.

In the integrated settings where psychiatrist, psychotherapist and other professional figures collaborate together, not focusing on the therapeutic alliance with the patient can interfere with the work of the team. With the re-emergence of The Victim-Rescuer-Perpetrator triangle dynamic, the therapists can become part of the problem. The Victim-Rescuer-Perpetrator Triangle is a concept originally formulated by a transactional analyst (Karpman, 1968). It was later used to describe the functioning mechanism linked to the disorganized Internal Working Model: the representations of self and of attachment figures alternate rapidly in the role of victim, rescuer and perpetrator (Liotti 2006).

The Victim-Rescuer-Perpetrator is the main problem in DID and cPTSD. When there is more than one therapist and service involved, the internal division and ambivalence is often spread across the professionals involved in different aspects of care. It operates within the therapeutic relationship and in most cases, it is the cause of a therapeutic impasse or therapeutic failure (Ross and Halpern 2009). It is normal that the drama triangle can be activated in a multiple setting and this can be exploited on a therapeutic level. The problem is when the team does not place the construction and repair of the therapeutic alliance at the centre of the work (Ivaldi 2004, Liotti et al. 2008). Generally, this happens when patient is treated pharmacologically without considering functioning of dissociative parts and therefore without having established a minimum of alliance with the internal system (Romme and Escher 2000).

The therapeutic alliance as a primary goal can make it possible for the therapist to maintain contact with the internal system of the DID patient. In many of these cases, pursuing the therapeutic alliance means finding an agreement with the part that imitates the aggressor (perpetrator imitating part) opting initially to keep the dissociative mechanism active. As done by Janet in the treatment of the famous case of the delirious Achilles when he began to communicate with the devil who had possessed him (Janet 1894).

It is worth highlighting that therapy is a specific type of collaborative work done within the

boundaries of a social contract. In hospitalization, for example, the therapeutic agreement is regulated by a written contract that is made by the various professional figures involved in the treatment (Ross 1989, Ross and Halpern 2009). The contract is a good way to define limit-setting and working on the victim-rescuer-perpetrator dynamic using the cooperative motivational system (for the concept of motivational system see Liotti 2017, Cortina and Liotti 2014). In Italy the integrated settings involve different professionals working in the same mental health centre. It may involve psychotherapists who collaborate with mental health centres and treat patients with dissociative disorders in a private setting. In all these cases the victim-rescuer-perpetrator triangle dynamic can be activated and therapists have moved away from a stance of therapeutic neutrality and become part of the problem.

I describe two conditions that can generally occur with patients with complex trauma when co-therapy does not take into account the patient's dissociative mechanisms. In an integrated multiple setting involving the psychiatrist and the psychotherapist one can get stuck in the activation of the drama triangle when:

a) The patient presents in the first sessions a dissociated child part in need (for the concept of "part" see van der Hart et al. 2006, Ross 1989). The expectation of this part is that the therapist can somehow do the job and take on the patient's difficulties. Psychiatrist and psychotherapist can assume the rescuers role. The first passing the explicit or implicit message that pharmacotherapy may be the solution to its problems; the second one does not regulate the activation of the motivational system of care-giving (Liotti 2017). For this reason he lets himself be influenced by the patient's excessive requests, which may end up in some cases with the crossing of the therapeutic boundaries.
b) The patient presents an angry part in the session. This is the perpetrator part. She attacks both specialists. The psychiatrist prescribes medications without working on the therapeutic alliance. The therapist can also be represented as the perpetrator or unwittingly colludes with the client against the "bad" perpetrating psychiatrist. This could be a re-enactment of the non-offending parent and the offending parent. In both cases psychotherapist and psychiatrist get stuck in the drama triangle.

In both cases the relationship between the two therapists must be open and collaborative, and communication between them must be continuous, as long as the patient is made aware of their contacts (Farina and Rainone 2005). In case a) the psychiatrist should not generate unrealistic expectations about the drug therapy, highlighting its effects in the short and medium term; he should try to define a common goal based on the reduction of symptoms within a more complex therapeutic work. When the limits of the pharmacological intervention are clarified and the focus is put on the joint work, this will help regulating the activation of a dissociated child part, linked to the reactivation of the patient's internal operating model (Liotti 2006).

In case b) the two co-therapists find themselves in a situation more complicated than the previous one. A patient who manifests a state of anger in the session is likely to activate in the therapist a mental state that could lead him to become more easily entangled in the dysfunctional interpersonal scheme (Liotti and Monticelli 2014). His understanding of the dissociative

mechanism in place will keep the psychiatrist from making unilateral choices regarding the drug therapy and will induce him to work, first of all, on the emotional validation of the "dissociated part". Only later, when finding an agreement on the common goal, he will discuss the pharmacological option. The psychiatrist can then suggest that the patient shares the object of his anger with the main therapist, thus keeping the attention on this mental state. In the treatment of DID (where access to memory can vary depending on the level of amnesia) the technique of talking to one part through another (Steele et al. 2017, Mosquera and Ross 2016), if adopted by the co-therapist, can allow the main therapist to reconnect to the session and increase co-awareness between the parties.

In the case b) described above, these interventions could lead to different outcomes in the state of the patient, such as: 1) expressing anger in a non-rejecting and punitive context 2) having a cooperative relationship model. At the same time, they would provide to both therapists the chance to amend the errors of attunement (misattunement) inevitably made and would regulate the state of helplessness which normally emerges in the treatment of patients with these clinical histories.

The therapy relationship is not an equal relationship. The patient with DDI or cPTSD has grown up in a traumatic family environment. The therapeutic setting reminds the client of past unequal relationships in which he was abused. They have developed a complicated system of protectors, persecutors, and other personalities to deal with problems of trust and safety (Ross and Halpern 2009). This point should be kept in mind when specialists are working in the integrated settings. The figures involved in the treatment are continually faced with the reactivation of the drama triangle in the patient.

Conclusions

Since the early 1900s the dissociative disorder has undergone a decline and since the 70s the field of psychiatry has begun its path of medicalization (Moskowitz 2011, Moncrieff 2013).

Dissociative disorders are complex disorders that activate within the therapeutic setting specific dynamics related to traumatic family relationships. Patients who are victims of cumulative traumas have been sensitized to real or imagined acts of perpetration by therapists and they easily experience feelings of powerlessness and victimization. The victim-rescuer-perpetrator dynamic is continuously present at an implicit level ready to emerge and undermine the foundations of psychotherapy (Ross and Halpern 2009). Recognizing and dealing with this dynamic becomes necessary for the progress of treatment. In integrated-setting therapies it is important to consider this dynamic and this is the first step in order to set up an effective treatment. Pharmacological therapy cannot precede the evaluation of the internal functioning of the patient with dissociative disorder, in particular that with dissociative identity disorder. The risk is that different parts of the system develop different relationships with each professional, resulting in no one therapist or support service getting the whole picture.

I consider the therapeutic alliance a priority in being able to define with the patient which pharmacological treatment may be more appropriate. It becomes important to explore medications within the path and work with the parties. It has to proceed with the idea of easing

dysregulated psycho-physiological states and reducing the dosage as the person increases the level of integration. It is important to use medications as another resource to be defined and monitored with the patient (Breggin 2012). In summary, in co-therapy or multiple agency involvement I consider the following points to be important:

- Pharmacotherapy should have the function of a stabilizer that helps to get through the therapy. Medication as a stabilizer must be considered within the therapeutic process, giving absolute priority to the therapeutic alliance.
- Pharmacotherapy should be continuously monitored and adapted, with a focus on the therapeutic goal established between therapists and the patient.
- In a collaborative framework, the assessment of the dissociative disorder (as well as that of any other psychopathological disorder) and the definition of the dissociative process must precede the definition of the pharmacological treatment. Many dissociative disorders may not respond to the medication while maintaining the same symptomatology or may respond by showing less activation of the parts but the internal dissociated organization remains (Ross 2015).

Abstract

Keywords: dissociative disorders, psychiatric consultation, psychiatric medications, therapeutic alliance, co-therapies

Since the early twentieth century dissociative disorder has undergone a decline and since the seventies the field of psychiatry has begun its path of medicalization.
Dissociative disorders are complex disorders that activate within the therapeutic setting specific dynamics related to traumatic family relationships. Recognizing and dealing with it becomes necessary before defining any pharmacological treatment.
This paper aims to review some crucial issues on the history of dissociative disorders and medical model of mental disorders. The article wants also to highlight the importance of the therapeutic alliance specifically in the first contacts with dissociative patients, the main role of the psychotherapist in treating Dissociative Identity Disorders (DID) and it wants to suggest some strategies to cope with these patients in the integrated settings of therapy.

References

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders,* 5th ed. Author, Washington, DC.

American Psychiatric Association (2016). *Practice guidelines for the psychiatric evaluation of adults,* 3th ed. Author, Washington, DC.

Ardito R, Rabellino D (2011). Therapeutic alliance and outcome of psychotherapy: historical excursus, measurements, and prospects for research. *Frontiers in Psychology* 2, 270, 1-11.

Birken L (1988). From seduction theory to Oedipus complex: a historical analysis. *New German Critique* 43, 83-96.

Bleuler E (1950). *Dementia praecox or the group of schizophrenias*. International Universities Press, New York.

Bluhm RL, Williamson PC, Osuch EA, Frewen PA, Stevens TK, Boksman K, ….Lanius RA (2009).

Alterations in default network connectivity in posttraumatic stress disorder related to early-life trauma. *Journal of Psychiatry & Neuroscience* 34, 3, 187-194.
Boon S, Steele K, van der Hart O (2011). *Coping with trauma-related dissociation: Skills training for patients and therapists*. W. W. Norton & Company, New York.
Brand BL, Classen CC, McNary SW, Zaveri P (2009). A review of dissociative disorders treatment studies. *Journal of Nervous and Mental Disease* 197, 9, 646–54.
Brand BL, Myrick AC, Loewenstein RJ, Classen CC, Lanius R, McNary SW, Pain C, Putnam FW (2012). A survey of practices and recommended treatment interventions among expert therapists treating patients with dissociative identity disorder and dissociative disorder not otherwise specified. *Psychological Trauma: Theory, Research, Practice & Policy* 4, 5, 490–500.
Breggin P (2012). *Psychiatric drug withdrawal: A guidebook for prescribers, therapists, patients, and their families*. Springer, New York.
Breuer J, Freud S (1986). *Studies on hysteria*. Pelican Books, New York.
Briquet P (1859). *Traité Clinique et thérapeutique de l'hystérie*. Baillière, Paris.
Buckner RL, Andrews-Hanna JR, Schacter DL (2008). The brain's default network anatomy, function, and relevance to disease. *Annals of New York Academy of Sciences 3,* 1124, 1-38,
Carlson ET (1981). The history of multiple personality in the United States: I. The beginnings. *American Journal of Psychiatry* 138, 5, 666–668.
Chu JA (2011). *Rebuilding shattered lives: Treating complex PTSD and dissociative disorders* (2nd ed.). John Wiley & Sons, Hoboken, New Jersey.
Cloitre M, Courtois CA, Ford JD, Green BL, Alexander P, Briere J, Herman JL, Lanius R, Stolbach BC, Spinazzola J, Van der Kolk BA, Van der Hart O (2012). The ISTSS expert consensus treatment guidelines for complex PTSD in adults http://www.istss.org.
Corrigan FM (2014). The clinical sequelae of dysfunctional defense responses: dissociative amnesia, pain and somatization, emotional motor memory, and Interoceptive loops. In Lanius U, Paulsen S, Corrigan F (eds) *Neurobiology and treatment of traumatic dissociation: toward an embodied self*, pp. 153-172. Springer Publishing Company, LLC, New York.
Corrigan FM, Elkin-Cleary E (2018). Shame as an evolved basic affect. Approaches to it within the Comprehensive Resource Model (CRM). *Medical Hypotheses*, 119, 91-97.
Cortina M, Liotti G (2014). An evolutionary outlook on motivation: Implications for the clinical dialogue. *Psychoanalytic Inquiry* 34, 8, 864–899.
Council for Evidence-based Psychiatry (2014). Unrecognized facts about modern psychiatric practice http://cepuk.org.
Cronin E, Brand BL, Mattanah JF (2014). The impact of the therapeutic alliance on treatment outcome in patients with dissociative disorders. *European Journal of Psychotraumatology* 5, 1, 1-9.
Daniels JK, Frewen P, McKinnon MC, Lanius RA (2011). Default mode alterations in posttraumatic stress disorder related to early-life trauma: a developmental perspective. *Journal Psychiatry Neuroscience* 36,1, 56-59.
De Bellis MD (2010). *The neurobiology of child neglect*. In Lanius, R, Vermetten E, Pain C (eds) *The impact of early life trauma on health and disease: the hidden epidemic*, pp. 123-133. Cambridge University Press, New York.
Dorahy MJ, van der Hart O, Middleton W (2010). The history of early life trauma and abuse from the 1850s to the current time: how the past influences the present. In Lanius R, Vermetten E, Pain C (eds) *The impact of early life trauma on health and disease: the hidden epidemic,* pp. 3-12. Cambridge University Press, New York.
Dorahy MJ, Brand BL, Sar V, Krüger C, Stavropoulos P, Martinez-Taboas A, Lewis-Fernandez R, Middleton W (2014). Dissociative identity disorder: An emprical overview. *Australian and New Zealand Journal of Psychiatry* 48, 5, 402-417.
Ellenberger H (1970). *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry.* Basic Books, New York.
Ey H (1962). Hughlings Jackson's principles and the organo-dynamic concept of psychiatry. *America*

Journal of Psychiatry 118, 673–682.
Farina B, Ceccarelli M, Di Giannantonio M (2005). Henri Ey's neojacksonism and the psychopathology of disintegrated mind. *Psychopathology* 38, 5, 285-290.
Farina B, Rainone A (2005). Una pratica senza teoria. In Liotti G, Farina B, Rainone A (eds) *Due terapeuti per un paziente,* pp. 3-18. Laterza, Roma.
Fosse R, Read J (2013). Electroconvulsive treatment: hypotheses about mechanisms of action. *Frontiers in Psychiatry*, 4, 94, 1-10.
Freeman D, Garety PA (2003). Connecting neurosis and psychosis: The direct influence of emotion on delusions and hallucinations. *Behaviour Research and Therapy* 41, 8, 923–947.
Franz AE,, Gillet G (2011). John Hughlings Jackson's evolutionary neurology: a unifying framework for cognitive neuroscience. *Brain* 134, 10, 3114–3120.
Geddes J, Freemantle N, Harrison P, Bebbington (2000). Atypical antipsychotics in the treatment of schizophrenia: systematic overview and meta-regression analysis. *The British Medical Journal* 321, 7273, 1371-1376.
Gøtzsche P (2015). *Deadly Psychiatry and Organized Denial*. People's Press, Copenhagen.
Harrow M, Jobe TH (2013). Does long-term treatment of schizophrenia with antipsychotic medications facilitate recovery? *Schizophrenia Bullettin* 39, 5, 962-965.
Heim G, Buhler KE (2006). Psychological trauma and fixed ideas in Pierre's Janet conception of dissociative disorders. *American Journal of Psychotherapy* 60, 2, 111-129.
Horn A, Ostwald D, Reisert M, Blankenburg F (2014). The structural-functional connectome and the default mode network of the human brain. *Neuroimage* 15, 102, 142-151.
Horvath AO, Bedi RP (2002). The alliance. In Norcross JC (eds) *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients, pp. 37-69.* Oxford University Press, New York.
Hutton P, Weinmann S, Bola J, Read J (2013). Antipsychotic drugs. In Read J, Dillon J (eds) *Models of Madness. Psychological, Social and Biological Approaches to Psychosis*, pp. 105-124. Routledge, New York.
International Society for the Study of Trauma and Dissociation (2011). Guidelines for treating dissociative identity disorder in adults, third revision. *Journal of Trauma and Dissociation* 12, 2, 115-187.
Ivaldi A (2004). Il triangolo drammatico: da strumento descrittivo a strumento terapeutico. *Cognitivismo clinico* 1, 2, 108-123.
Jablensky A (1995). Kraepelin's legacy: Paradigm or pitfall for modern psychiatry? *European Archives of Psychiatry and Clinical Neuroscience* 245, 4/5, 186-188.
Janet P (1894). Un cas de possession et l'exorcisme modern. *Bulletin de l'Université de Lyon* VIII, 2, 41-57.
Janet P (1977). *The mental state of hystericals*. University Publications of America, Washington DC.
Janet P (1901). *The Mental State of Hystericals. A study of mental stigmata and mental accident*. G. P. Putnam's sons, New York, London.
Jones E (1953). *Sigmund Freud: Life and work* (Vol.1). Hogarth Press, London.
Karpman SB (1968). Fairy tales and script drama analysis. *Transactional Analysis Bulletti 7*, 39–43.
Kingdon D, Young A (2007). Research into putative biological mechanisms of mental disorders has been of no value to clinical psychiatry. *British Journal of Psychiatry* 191, *4,* 285-290.
Klerman GL (1978). The evolution of a scientific nosology. In Shersow JC (eds) *Schizophrenia: Science and Practise*, pp. 99-121. Harvard University Press, Cambridge.
Kluft RP (1987). First-rank symptoms as a diagnostic clue to multiple personality disorder. *American Journal of Psychiatry* 144, 3, 293–298.
Lacasse JR, Leo J (2005). Serotonin and depression: a disconnect between the advertisements and the scientific literature. *Public Library of Sciences Medicine* 2, 12, 1211-1216.
Leiknes KA, von Schweder LJ, Hoie B (2012). Contemporary use and practice of electroconvulsive therapy worldwide. *Brain and Behavior*, 2, 3, 283-345.
Linehan M (1993). *Cognitive-behavioral treatment of borderline personality disorder*. Guilford Press, New York.
Liotti G (2006). A model of dissociation based on attachment theory and research. *Journal of Trauma and*

Dissociation 7, 4, 55-73.
Liotti G (2017). Conflicts between motivational systems related to attachment trauma: key to understanding the intra-family relationship between abused children and their abusers. *Journal of Trauma and Dissociation* 18, 3, 304-318.
Liotti G, Monticelli F (2014). *Teoria e Clinica dell'alleanza terapeutica*. Raffaello Cortina Editore, Milan.
Liotti G, Cortina M, Farina B (2008). Attachment theory and multiple integrated treatments of borderline patients. *Journal of The American Academy of Psychoanalysis and Dynamic Psychiatry* 36, 2, 295-315.
Loewenstein RJ (1991a). Rational psychopharmacology in the treatment of multiple personality disorder. *Psychiatric Clinics of North America 14*, 3, 721–740.
Loewenstein RJ (1991b). An office mental status examination for complex chronic dissociative symptoms and multiple personality disorder. *Psychiatric Clinics of North America* 14, 3, 567–604.
Loewenstein RJ (2005). Psychopharmacologic treatments for dissociative identity disorder. *Psychiatric Annals* 35, 8, 666-677.
Longden E, Read J (2016). Assessing and reporting the adverse effects of antipsychotic medication: A systematic review of clinical studies, and prospective, retrospective, and cross-sectional research. *Clinical Neuropharmacology* 39, 1, 29-39.
Lothane Z (2001). Freud's alleged repudation of the seduction theory revisited: facts and fallacies. *The Psychoanalytic Review* 88, 5, 673-723.
Malla A, Joober R, Garcia A (2015). "Mental illness is like any other medical illness": a critical examination of the statement and its impact on patient care and society. *Journal of Psychiatry & Neuroscience* 40, 3, 147-150.
Martin DJ, Garske JP, Davis K (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. *Journal of Consulting and Clinical Psychology* 68, 3, 438-450.
Moncrieff J (2006a). Why is it so difficult to stop psychiatric drug treatment ? It may be nothing to do with the original problem. *Medical Hypotheses* 67, 3, 517-523.
Moncrieff J (2006b). Does antipsychotic withdrawal provoke psychosis ? Review of the literature on rapid onset psychosis (supersensitivity psychosis) and withdrawal-related relapse. *Acta Psychiatric Scandinavica* 114, 1, 3-13.
Moncrieff J (2013). *The bitterest pills. The troubling story of antipsychotic drugs*. Palgrave Macmillan, New York.
Mosquera D, Ross CA (2016). A psychotherapy approach to treating hostile voices. *Psychosis* 9, 2, 167-175.
Moskowitz A (2008). Association and dissociation in the historical concept of schizophrenia. In Moskowitz A, Schafer I, Dorahy MJ (eds) *Psychosis, trauma and dissociation: Emerging perpesctives on severe psychopathology,* pp. 35-50. Wiley-Blackwell, London.
Moskowitz A (2011). Schizophrenia, trauma, dissociation, and scientific revolutions. *Journal of Trauma and Dissociation* 12, 4, 347-357.
Norcross JC (2018). Psychotherapy relationship that work III. *Psychotherapy* 55, 4, 303-315.
Ogden P, Minton K, Pain C (2006). *Trauma and the body: a sensorymotor approach to psychotherapy*. Norton, New York.
Porges SW (2001). The polyvagal theory: phylogenetic substrates of a social nervous system. *International Journal of Psychophysiology* 42, 2, 123-146.
Putnam FW (1989). *Diagnosis and treatment of multiple personality disorder*. Guilford Publications, New York.
Read J (2008). Schizophrenia, drug companies and the internet. *Social Science & Medicine* 66, 1, 99–109.
Read J, Mosher L, Bentall R (2004). *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia*. Brunner-Routledge, Hove, NY.
Read J, Dillon J, Lampshire D (2014). How much evidence is required for a paradigm shift in mental health ? *Acta Psychiatric Scandinavia* 129, 6, 477-481.
Read J, Haslam N, Magliano L (2013). Prejudice, stigma and "schizophrenia": the role of bio-genetic ideology. In Read J, Dillon J (eds) *Models of Madness: Psychological, Social and Biological Approaches*

to Schizophrenia, pp. 157-178. Routledge, London, New York.
Reinders ATS, Willemsen ATM, den Boer JA, Vos HPJ, Veltman DJ, Loewenstein RJ (2014). Opposite brain emotion-regulation patterns in identity states of dissociative identity disorder: A PET study and neurobiological model. *Psychiatry Research Neuroimaging* 223, 3, 236-243.
Romme M, Escher S (1989). Hearing voices. *Schizophrenia Bulletin 15*, 2, 209–216.
Romme M, Escher S (2000). *Making sense of voices – a guide for professionals who work with voice-hearers*. Mind Publications, London.
Rosenbaum M (1980). The role of the term schizophrenia in the decline of diagnoses of multiple personality. *Archive of General Psychiatry* 37, 12, 1383–1385.
Ross CA (1989). *Multiple Personality Disorder. Diagnosis, clinical feature and treatment*. John Wiley & Sons, New York.
Ross CA (2004). *Schizophrenia. Innovations in diagnosis and treatment.* The Haworth Maltreatment and Trauma Press, New York, London, Oxford.
Ross CA (2015). How effective are antipsychotic medications? *Ethical Human Psychology and Psychiatry 17*, 3, 176–183.
Ross CA (2016). Extreme exaggeration of the results of genetic research on schizophrenia. *Psychosis* 8, 2, 186-187.
Ross CA, Ross AW (2018). Misleading use of heritability estimates in schizophrenia genetics. *Psychosis* 11, 1, 90-91.
Ross CA, Halpern N (2009). *Trauma model therapy: A treatment approach to trauma, dissociation, and complex comorbidity*. Manitou Communications, Richardson, Texas.
Safran JD, Muran JC (2011). Repairing Alliance Ruptures. *Psychotherapy* 48, 1, 80-87.
Samara MT, Leucht C, Leeflang M, Anghelescu IG, Chung YC, Crespo-Facorro B, …Leuch S (2015). Early improvement as a predictor of later response to antipsychotics in schizophrenia: A diagnostic test review. *The American Journal of Psychiatry* 172, 7, 617-629.
Schore AN (2009). Attachment trauma and the developing of right brain: Origin of Pathological Dissociation. In Dell P, O'Neil JA (eds) *Dissociation and Dissociative Disorders: DSM-V and beyond*, pp. 107-141. Routledge, New York.
Steele K, Boon S, van der Hart O (2017). *Treating trauma-related dissociation: A practical, integrative approach*. W. W. Norton & Company, New York.
Supekar K, Uddin LQ, Prater K, Amin H, Greicius MD, Menon V (2010). Development of functional and structural connectivity within the default mode network in young child. *NeuroImage* 52, 1, 290-301.
Sutcliffe JP, Jones J (1962). Personal identity, multiple personality, and hypnosis. *International Journal of Clinical and Experimental Hypnosis* 10, 4, 231-269.
Teicher MH, Rabi K, Sheu Y, Seraphin SB, Andersen SL, Anderson CM, Choi J, Tomoda A (2010). Neurobiology of childhood trauma and adversity. In Lanius R, Vermetten E, Pain C (eds) *The impact of early life trauma on health and disease: the hidden epidemic,* pp. 112-123. Cambridge University Press, New York.
Tiihonen J, Lönnqvist J, Wahlbeck K, Klaukka T, Niskanen L, Tanskanen A, Haukka J (2009). 11-year follow-up of mortality in patients with schizophrenia: A population-based cohort study (FIN11 study). *Lancet* 374, 9690, 620-627.
Van der Hart O, Brown P, van der Kolk B (1989). Pierre Janet's psychological treatment of posttraumatic stress. *Journal of Traumatic Stress* 2, 4, 379-395.
Van der Hart O, Dorahy MJ (2009). History of the concept of dissociation. In Dell PF, O'Neil JA (eds) *Dissociation and the dissociative disorders: DSM-V and beyond*, pp. 3–26. Routledge, New York.
Van der Hart O, Nijenhuis E, Steele K (2006). *The Haunted Self: Structural dissociation of the personality and the treatment of chronic traumatization*. Norton, New York.
Van der Hart O, Wiztum B, Friedman B (1993). From hysterical psychosis to reactive dissociative psychosis. *Journal of Traumatic Stress* 2, 4, 365-378.
Van der Kolk B, van der Hart O (1989). Pierre Janet and the breakdown of adaptation in psychological trauma. *American Journal of Psychiatry* 146, 12, 1530-1540.

Van Os J, Linscott RJ, Myin-Germeys I, Delespaul P, Krabbendam A (2008). A systematic review and meta-analysis of the psychosis continuum: Evidence for a psychosis proneness – persistence – impairment model of psychotic disorder. *Psychological Medicine* 39, 2, 179-195.

Warren CS (2001). Negotiating the therapeutic alliance: a relational treatment guide. *Psychotherapy Research* 11, 3, 357-359.

Watkins JG, Watkins HH (1997). *Ego states: Theory and therapy*. Norton, New York.

Witztum E, van der Hart O (2008). Childhood trauma in psychotic and dissociative disorders. In Moskowitz A, Schafer I, Dorahy MJ (eds) *Psychosis, trauma and dissociation: Emerging perpesctives on severe psychopathology*, pp. 23-24. Wiley-Blackwell, London.

World Health Organization (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. WHO, Geneva, Switzerland.

Costanzo Frau
Psychotherapy Service and Research on Trauma & Dissociation, Cagliari

Corrispondenza
E-mail: psicoterapiaricercatd@gmail.com