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Defining Psychosis, Trauma, and Dissociation

Historical and Contemporary Conceptions

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Prior to considering the range of potential relationships between trauma, dissociation, and psychosis, to which the rest of this book is dedicated, it is important to spend some time considering how these terms have been used over time, and the advantages and disadvantages of each. In this chapter, we review the etymology and historical uses of the terms *psychosis*, *trauma*, and *dissociation*, emphasizing current popular uses. Each term has been used in a range of ways, some more problematic than others. While only limited effort has been expended in defining *trauma* in recent years, and hardly any effort has been expended for *psychosis,* the definition of *dissociation* has received considerable attention in the literature, with a number of different definitions proposed (see Dell & O'Neil, 2009 and Nijenhuis & Van der Hart, 2011, for extended discussion of this issue). Following an overview of current uses of these terms, we present our recommendations as to how they might be most usefully employed. The authors of other chapters in this book are not bound by our recommendations, but the following discussion should allow the reader to carefully consider the use of these concepts throughout this volume and elsewhere.

Consideration of the meaning of the terms *psychosis*, *trauma*, and *dissociation* illuminates several tensions. The most prominent involves the relation between the person and the world, including other individuals. The question is whether any of our terms of interest can be adequately defined by reference to *only* the person or *only* the world. For example, the disturbances seen as part of *psychosis*, such as *delusions*, have long been considered to reside in the individual. However, we will consider here whether the concept *psychosis* can really be used without reference to other persons. Likewise, *trauma* is increasingly being seen as a specific event or events to which an individual is exposed, but attempting to locate the meaning of this term in the 'outside world' without reference to an individual's *interpretation* of the specific spatiotemporal context, appears fraught with difficulty (Nijenhuis, 2017). A second, related, tension involves the grounding of these concepts in real life experiences. By definition, *trauma* requires exposure to a challenging event, which is central to its meaning. In contrast, *psychosis* has often been seen as behaviour or language that fundamentally cannot be understood – is

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incomprehensible. But if psychotic symptoms, such as delusions, actually arise from challenging life events in ways that *can* be understood, does that then make them *not* psychotic? These issues will be explored below.

Psychosis

Etymology and Historical Conceptions

Severe forms of psychological and behavioural dysfunction have been recognized since ancient times, leading to the development of concepts such as 'insanity', 'mania', and 'dementia'. The term 'psychosis' was introduced as an alternative term in the mid-nineteenth century by the Austrian physician Ernst von Feuchtersleben (Beer, 1995). In his 1845 book (von Feuchtersleben, 1845) *Lehrbuch der Ärztlichen Seelenkunde* (translated into English as *The Principles of Medical Psychology*), von Feuchtersleben used the term 'psychosis' – derived from the Greek 'psyche' for 'mind or soul' (literally, '*animating spirit*'), followed by the Latin suffix '-osis' for 'abnormal condition' – to refer to an ailment where both the body *and* the soul were sick (i.e. a disease that affected 'the whole person'). His coinage was a response to the early nineteenth-century debate in German psychiatry between *Psychiker* and *Somatiker* – those who located mental disease in the 'soul' and those who located it in the 'body'. Feuchtersleben's new term was an attempt to mediate between these two groups and reconcile their opposing views.

Late nineteenth-century and early twentieth-century nosologies largely shared this conception of *personhood* as the primary locus of psychoticism (and schizophrenia). For Kraepelin, for instance, Dementia Praecox involved a 'destruction of personality' (Berrios & Hauser, 1988) and Bleuler (1949) maintained that

> A schizophrenic … is not … a sick personality due to alterations in single psychological functions. Quite to the contrary, we notice in him single altered functions because his personality as a whole is sick (p. 288).

As the twentieth century developed, two divergent major trends could be recognized. In Europe, and particularly England, Kraepelin's narrow concept of schizophrenia/dementia praecox held the day, but in the United States a much broader conception was in use. The latter was influenced by Bleuler's notion of disturbed associative processes as central to schizophrenia and Freud's view of psychosis as a defect in 'reality testing'. These conceptions were common in settings where psychodynamic thinking was dominant, such as the psychiatric community in the United States in the mid-twentieth century (Andreasen, 1989). Here, the boundaries of the concepts *schizophrenia* and *psychotic* were wide, with 'borderlines states' argued to manifest 'reality distortion' in subtle ways.

These conceptions figured heavily in the first American classificatory systems, the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-I, APA, 1952) and the DSM-II (APA, 1968); the latter added the condition that psychosis had to 'interfere grossly with an individual's capacity to meet the ordinary demands of life' (APA, 1980, p. 368). By the late twentieth century, the corresponding

international diagnostic system, the International Classification of Diseases (ICD), was defining psychosis in a similar way. For example, the ICD-9 (WHO, 1977) defined 'psychoses' as mental disorders in which 'impairment of mental function has developed to a degree that interferes grossly with insight, ability to meet some ordinary demands of life or to maintain adequate contact with reality' (p. 410). Level of functioning, however, was not emphasized in the DSM-III (APA, 1980) or DSM-III-R's (APA, 1987) definitions of 'psychosis', perhaps because the revised diagnosis of *schizophrenia* now required evidence that current level of functioning was 'markedly below' previous levels. The DSM-III defined 'psychotic' as a 'gross impairment in reality testing' (APA, 1980, p. 367) while the DSM-III-R added '… and the creation of a new reality'[1] (APA, 1987, p. 404). The presence of specific psychotic symptoms was considered 'direct evidence' of psychosis.

Current Conceptions

In the DSM-IV (APA, 1994), DSM-5 (APA, 2013), and the ICD-10 (WHO, 1992), the trend to emphasize psychotic symptoms in the conception of psychosis reached its apex. Here, psychosis is simply *defined* as the presence of certain psychotic symptoms. This is most clearly stated in the ICD-10 (WHO, 1992).

> 'Psychotic' has been retained as a convenient descriptive term …. Its use does not involve assumptions about psychodynamic mechanisms, but simply indicates the presence of hallucinations, delusions, or a limited number of severe abnormalities of behaviour, such as gross excitement and overactivity, marked psychomotor retardation, and catatonic behaviour (pp. 3–4).

Likewise, in the DSM-IV (APA, 1994), *psychosis* is defined by reference to the psychotic (or 'positive') symptoms of schizophrenia, with three versions (from narrow to broad): (i) delusions and hallucinations (experienced without 'insight'), (ii) delusions and hallucinations (with or without insight), and (iii) delusions, hallucinations, and disorganized speech or behaviour (Rudnick, 1997). 'Psychosis' is not even defined in the DSM-5 (APA, 2013), but 'psychotic *features*' are defined as delusions, hallucinations, and formal thought disorder (p. 827). Finally, the proposed ICD-11 (beta-draft) emphasizes, in addition to the psychotic/positive symptoms listed above, the first-rank symptoms of experiences of passivity and control ('the experience that one's feelings, impulses, or thoughts are under the control of an external force'; WHO, n.d.), by listing these as psychotic experiences separate from delusions (in the DSM-IV and DSM-5, such experiences are simply considered examples of 'bizarre' delusions).[2]

These changes reflect increasing concern in the psychiatric community over the last half century with the *reliability* of psychiatric terms, after research evidence revealed, for example, that the diagnosis of schizophrenia was being applied very differently by UK and US psychiatrists (Kendell et al., 1971). This emphasis on reliability and the consequent attempt to operationalize the definition of psychosis has led to an entirely circular definition; that is, being 'psychotic' now means 'having psychotic symptoms'. As such, 'psychosis' has simply become shorthand for specific psychotic symptoms such as delusions or hallucinations. This use of 'psychosis' adds little to the meaning of these terms, and is lacking in utility or validity.

While the official definition of the term psychosis is a tautological one, it is clear that the concept is used in a different way clinically. Heinimaa (2008) looked at the use of the words 'psychosis' and 'psychotic' in psychiatric practice, and concluded that these terms (along with psychotic symptoms such as 'delusions') relate to the concept of 'incomprehensibility'. This view in itself is not new, as Jaspers (1913/1963) argued more than a century ago that 'genuine' (in German, 'echte') psychotic delusions were 'psychologically irreducible' or 'not understandable' (p. 96). Heinimaa goes beyond Jaspers, however, in insisting that the concept of psychosis cannot be understood without recourse to the political and social context of diagnosis and treatment: '"Incomprehensibility", and consequently "psychosis", are *relational* concepts, and any attempt to read these relational events into individuals is doomed to fail' (Heinimaa, 2008, p. 50). Elsewhere, he notes that these terms are meaningless outside of their interpersonal context: 'Saying that something is incomprehensible is not an explanation at all, but just an expression of despair when our ordinary ways of comprehending people and situations elude us' (Heinimaa, 2003, p. 227).

In other words, the term psychosis is utilized by 'authorized' individuals when the speech or behaviour of a person under consideration cannot be understood (and when the observer has no simple explanation for their lack of understanding – e.g. believing the person is speaking a foreign language). To illustrate, the DSM-5 offers as psychotic symptoms '*grossly disorganized*' behaviour or '*disorganized*' speech. But what do these terms mean? Is the behaviour or speech *lacking* organization or does the observer/interviewer simply not *recognize* what that organization is? To put it differently, how can we determine that a symptom is unconnected with a person's life experiences if we are ignorant of their history or if they are unable (or unwilling) to make the connection for us? As is discussed in later chapters of this book (particularly Chapters 12 and 16), if someone is experiencing a flashback to a traumatizing experience while the observer is unaware of this (or if they are unaware themselves), their behaviour will most likely be labelled 'disorganized' and deemed to be psychotic.

Importantly, the term 'psychosis' (as well as 'delusional' and 'hallucinations') is often qualified by appending a prefix ('*quasi*-psychotic') or suffix ('psychotic-*like*') in situations where an apparent connection to an individual's life experiences *can* be made, making the content of the symptom seem *understandable* (Brewin & Patel, 2010). Under these circumstances, clinicians or researchers are often hesitant to use the term *psychosis* (an observation which supports the argument for its conceptual connection with 'incomprehensibility'). An analysis of the use of the term *pseudo-hallucinations* (Berrios & Dening, 1996) comes to a similar conclusion. Berrios and Dening (1996) describe pseudo-hallucinations as a 'joker' in a 'diagnostic game', which allows clinicians to 'call into question the genuineness of some true hallucinatory experiences that do not fit into a pre-conceived psychiatric diagnosis' (p. 761).

There is one final consideration. While this is rarely elaborated, in practice *psychosis* almost always is used to describe a *change* in a person's behaviour. Someone who was previously understandable has now become 'un-understandable'. The historical fact that psychosis meant a malady of the whole person leads to the recognition that the concept of psychosis cannot be understood without reference to the surroundings, the social world, and the world at large. As Parnas (1999) notes, echoing Freud (1924), 'From a phenomenological point of view, a fully developed psychotic syndrome signifies the emergence of a new organisational unity where a new order of meaningfulness has replaced the old one' (p. 27).

Proposed Conception

The current official meaning of the term 'psychosis' – having 'psychotic' symptoms – is clearly unhelpful to clinicians or researchers. And while our understanding of how 'psychosis' is used in practice – in an inherently interpersonal way to indicate non-comprehension – is no doubt accurate, such a formulation has limited utility. A lack of comprehension between persons can arise from a number of sources, and limiting the definition to this social contextual perspective would require us to refrain from using 'psychosis' whenever an explanation for a person's behaviour can be found. This does not seem to be ideal.

But how do we address the intertwining issues of self, meaning, and world in looking for a valid and more useful concept of psychosis? We can begin by going back to the original conception of 'psychosis', as an 'illness' of the whole person, adding that it occurs in the context of other relationships and the broader world. Acknowledging the validity of this historical interpretation, one way forward might be through an exploration of the concept of 'reality', as used in definitions of psychosis. Commonly used expressions include 'reality testing' or 'loss of contact with reality'. As usually interpreted, these expressions imply that reality is 'out side of the self' and can be 'tested' more or less accurately, or that one can maintain or lose contact with it. Such a positivistic view of the world is not compatible with contemporary constructivist philosophies – the recognition that the person and the world cannot so easily be dichotomized (Damasio, 1994), or that even such fundamental functions as perception are inherently relational. Janet, for example, insisted that perception is driven by the potential for action – we see what we are capable of acting on or responding to at the most basic level (Janet, 1935). Others have recognized this and spoken of a 'perception-motor action cycle' (Hurley, 1998).

So, if reality is not 'out there' to be assessed more or less accurately by us 'in here', how do we arrive at consensual views of 'reality' (i.e. how do we share meaning with others about the world)? In Chapter 23 of this book, Blizard offers this proposal for how reality testing (or what we would prefer to call 'reality *validation*') develops:

> From a developmental standpoint, the first modality is sensory cross validation: 'If I see it, can I touch, hear, smell, or taste it?' Next comes consensual validation: 'Did you see (hear, feel) what I saw?' Cognitive validation can take place internally, although it usually needs to be reinforced consensually: 'Did this event make sense, fit within my, your, or society's understanding of what is possible?' … Beyond simple, sensory cross validation, the capacity for reality testing depends on interaction with others. When the child's primary caregivers have circumscribed methods of reality testing or pervasively distorted perceptions of others, the child's basis for interpreting people will be similarly skewed …
>
> Familial denial of experiences, such as, 'That doesn't hurt', 'Your father would never do a thing like that', or 'That didn't happen, you just imagined it', may cause a child to doubt her own experience and accept the consensual [i.e. familial] version of reality.[3]

A potential useful heuristic model for applying these ideas to the concept of reality (and hence to 'psychosis') comes from Pierre Janet. Janet argued that humans ascribe a level of reality to internal or external events that could be conceptualized in terms of a

hierarchy. He included on this hierarchy various concepts, including thoughts, imagination, actions, and various states of the past, present, and future (Janet, 1928). The immediate future and recent past are usually accorded high levels of reality, and thoughts and ideas are usually accorded low levels. The highest level of the reality function (*la fonction du réel)* involves what Janet called *presentification*, the capacity to act in a fully focused and meaningful way in the present, integrating one's past experiences and future plans (discussed at length in Van der Hart, Nijenhuis, & Steele, 2006). Mental health requires presentification to be (usually) accorded the highest level of reality, so we can act in the present and effectively adapt with required action.[4] Anything that *weakens* the experienced reality of the present (e.g. chronic childhood invalidation of the reality of traumatizing experiences), or *strengthens* the experienced reality of thoughts or imagination (e.g. schizoid tendencies or schizotypal personality), could lead to psychological or functional impairment. Indeed, Janet argued that much of psychopathology could be conceptualized as a *mixing up* of levels of reality – for example, viewing the distant past as happening in the present, as occurs in post-traumatic disorders.

Janet's ideas can be usefully applied to the concept of psychosis. Psychosis could be conceptualized as occurring when internal experiences such as thoughts or imagination are accorded as much or more reality than the current moment. To clarify this notion, here is an illustration contrasting permutations of levels of reality arising from delusions, with milder and more transient aberrations.

A person living in city A has applied for a new job in city B, 500 kilometres away. After he applied for the position, but before hearing whether or not he was to be interviewed, he saw on a television program that one of City A's prominent sports teams had agreed to move to city B, an unusual event. The person might reflect on this and say to himself, not entirely seriously, 'That's interesting, I wonder if that might be a "sign" that I will get the job?' Many well-functioning people would not do this at all, and those who did (indulging in what we might call 'magical thinking'), would drop the thought fairly quickly and certainly not act on it in any way. Such a fleeting consideration would involve a transient increase in reality of a wished-for future.

In contrast, a person who was delusional might see that same TV story and decide that it meant not only that he was *going* to be offered the job, but that he had *already* been offered the job – but just not been notified in the usual way (perhaps because his mail had been stolen). Indeed, he might believe that the news story was specifically *meant* to give him that information (a delusion of reference). Further, he might be so convinced of the reality of this that he would leave his job in city A, move to city B, and arrive at the workplace where he had applied for a job, saying, 'When do I start?'

This is, of course, a highly simplified and somewhat unrealistic example (for example, delusions are often *not* acted on), but it does illustrate how Janet's 'hierarchy of reality' can inform our understanding of psychosis. It has the additional advantage of not excluding bizarre-seeming behaviour that *can* be linked back to a person's life. And it illustrates our position that psychotic experiences, such as delusions, may not be, in essence, different from the hopes and fears of all of us – they are only accorded a stronger level of reality and hence are more likely to drive actions.

Thus, we would argue that a useful adjunct to understanding the concept of *psychosis* as *relationally-based* would include both of the following: (i) the recognition that a considerable and relatively stable permutation in the 'hierarchy of reality' has occurred and (ii) that the person as a whole has been changed in a fundamental way – that their entire conception of themselves, other people, and the world has been transformed.

Trauma

Etymology and Historical Conceptions

For more than three centuries, the term *trauma*, derived from the Greek word for 'wound', has been used to describe physical wounds or bodily injuries. It wasn't until the late nineteenth century that trauma was first used to describe *psychological* injuries. According to Van der Hart and Brown (1990), the German neurologist Albert Eulenberg argued in 1878 that the existing concept of 'psychic (psychological) shock', referring to the after-effects of powerful emotions such as terror or anger, was better conceptualized as 'psychic *trauma*'. They note that Eulenberg 'regarded the "sudden action of vehement emotions" as an actual molecular concussion of the brain' comparable to cerebral concussions resulting from physical trauma (Van der Hart & Brown, 1990, p. 1691).

Though Eulenberg believed that overwhelming emotions could directly cause brain injury, most early uses of *psychological* trauma viewed physical injury as only a *metaphor* for psychological injury. But the experience of intense or 'vehement' emotions was central to the concept (Janet, 1889). By the late 1880s, *trauma* was widely used, particularly in the diagnosis of *traumatic neurosis* (introduced by Oppenheim, 1889). For example, Breuer and Freud, in their 1893 'Preliminary Communication on the Psychological Mechanisms of Hysterical Phenomena' (later incorporated into *Studies on Hysteria* (1895/1955), extended the concept of trauma from traumatic neuroses to hysteria:[5]

> In traumatic neuroses, the operative cause of the illness is not the trifling injury but the effect of fright – the psychical trauma. In an analogous manner, our investigations reveal, for many, if not for most, hysterical symptoms, precipitating causes which can only be described as psychical traumas. Any experience which calls up distressing affects – such as those of fright, anxiety, shame, or physical pain – may operate as a trauma of this kind … (p. 5–6).

Clearly, in this early formulation, Breuer and Freud recognize that an event by itself, without taking into account the range of individual reactions, cannot account for the symptoms – since 'any experience' theoretically, could 'operate as a trauma'. They then add, importantly, 'whether or not it does so depends naturally enough on the susceptibility of the person affected' (Breuer & Freud, 1895/1955, p. 6). The relevance of dissociation was also clearly recognized. A few sentences later, Breuer and Freud note, 'We must presume … that the psychical trauma – or more precisely the memory of the trauma – acts like a foreign body which long after its entry must continue to be regarded as an agent that is still at work …' (p. 6).

The first English use of the word *trauma* in a psychological sense came in William James' 1894 review of Breuer and Freud's 1893 'Preliminary Communication'. In his review, James states:

> Hysteria for them starts always with a shock, and is a 'disease of the memory'. Certain reminiscences of the shock fall into the subliminal consciousness, where they can only be discovered in 'hypnoid' states. If left there, they act as permanent 'psychic *traumata*', thorns in the spirit, so to speak. The cure is to draw them out in hypnotism, let them produce all their emotional effects, however violent,

> and *work themselves off*. They make then (apparently) a new connection with the principal consciousness, whose breach is thus restored, and the sufferer gets well (p. 199; italics in original).

Thus, in the late nineteenth century, the concept of psychological trauma and the concept of dissociation were inexorably linked.

Through most of the twentieth century, there was no urgent need to develop the concept of trauma, which was primarily used in the context of traumatic neurosis. However, with the introduction of the diagnostic category *Post-Traumatic Stress Disorder* (PTSD) in the DSM-III (APA, 1980), a precise definition of 'trauma' became more important. As PTSD could only be diagnosed *after* the experience of a 'trauma', the new term '*post*-traumatic' shifted the emphasis from trauma as a *reaction* to an event to trauma as the *event itself*. The definition of 'trauma' determined the potential limits of the PTSD category for the purposes of psychiatric treatment and, frequently, criminal and civil legal liability.

Contemporary Conceptions

From 1980 on, definitions of trauma included in the DSM diagnosis of PTSD (DSM-III to DSM-IV) emphasized exposure to an extreme event precipitating strong emotional reactions. Both of these components were considered important. So, the 1980 DSM-III described trauma as a 'psychologically distressing event that is outside the range of usual human experience' and was experienced with 'intense fear, terror, and/or helplessness'. While there was no attempt to define the type of event, it was stated that the 'precipitating stressor' could *not* be one that was 'usually well tolerated' by other members of one's cultural group.[6]

This definition was changed when it became apparent that symptoms of PTSD could develop in response to experiences that were certainly not 'outside' the range of 'usual human experience', such as domestic violence or rape. Other changes in the DSM-IV (APA, 1994) included describing the types of experiences that would qualify as a trauma, along with specifying the ways in which a person could be exposed to the relevant information. Qualifying events had to involve 'actual or threatened death or serious injury' or 'a threat to the physical integrity of oneself or others'. The person could have actually experienced the danger, witnessed another exposed to danger, or otherwise been 'confronted with' the traumatic event (presumably, for example, by being told of this by a third person). In contrast, the ICD-10 (WHO, 1992) declines to identify specific events, but defines trauma as 'a stressful event or situation of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone' (p. 120). In all of these definitions, however, strong emotional reactions or pervasive distress were required components.

This was no longer the case with the publication of the DSM-5 in 2013 (APA, 2013). In a dramatic change to the meaning of the word 'trauma', the DSM-5 authors dropped the 'emotional response' component of the PTSD trauma definition, arguing that it had 'no utility'. In the DSM-5 (APA, 2013), a traumatic event (also referred to as a 'traumatic stressor') is defined as one involving exposure to 'actual or threatened death, serious injury, or sexual violence' that a person him- or herself experienced, witnessed, or heard about (which, in most cases, would have to involve a 'family

member or friend' experiencing a violent or accidental death or risk of death; p. 271). The proposed ICD-11 PTSD criteria defines trauma as 'an extremely threatening or horrific event or series of events, and also does not refer to emotional reactions. A subtle but significant modification is found in the proposed criteria for complex PTSD, however, where it is noted that the event or events are '*experienced as*' extremely threatening or horrific.

Thus, over the past century-and-a-quarter, the definition of trauma has changed dramatically – from its conception as 'any experience' that produces distressing affects, to a description of specific events without reference to any emotional reaction.

Proposed Conception

As noted, the DSM-5 conceptualization of trauma reverses more than a century of tradition, decoupling the term trauma from its metaphorical binding to physical wounds. But is this really a problem?

There are good reasons in the conception of trauma to emphasize the subjective psychological response *over* the external event. For example, Carlson, Smith, and Dalenberg (2013) found that emotional losses, without any suggestion of physical threat or danger, such as the ending of an important relationship or the loss of one's home, could powerfully predict PTSD.

There is also a body of literature dating back two decades exploring persons' emotional responses to psychotic symptoms, such as paranoid delusions or abusive voices. Technically, according to the DSM-5 criteria for PTSD, such experiences would not qualify as a trauma. Nonetheless, researchers have found that psychotic patients meeting PTSD symptom criteria in response to psychotic symptoms were equally as distressed or functionally impaired as psychotic patients meeting PTSD criteria on the basis of a DSM-IV defined 'traumatic event' (Lu et al., 2011). They note that their findings are consistent with a number of other studies, and argue that they raise 'further questions about the scientific validity of the DSM-IV definition of traumatic event' (Lu et al., 2011, p. 73).

We would argue that the solution to this dilemma would be to firmly locate 'trauma' in the individual (as a 'wound'), or between the individual and the world, recognizing that an individual's history and characteristics can raise their risk of being traumatized; events, inherently 'subject-dependent and spatiotemporally embedded' (Nijenhuis, 2017, p. 49), would then be defined, as more or less 'potentially traumatizing'. This is the tack taken by Van der Hart et al. (2006) who review the literature on traumatizing events and conclude:

> Some events have more potential to be traumatizing than others. They include experiences that are intense, sudden, uncontrollable, unpredictable and extremely negative. Events that are interpersonally violent and involve physical harm or threat to life are more likely to be traumatizing than other kinds of highly stressful events such as natural disasters. Events that are not literally life-threatening but which include attachment loss and betrayal by an important attachment person also increase the risk of traumatization (p. 24).

Even though certain events are more likely to be traumatizing, there is considerable variation in how individuals react to these events; if someone successfully deals with an event that others might see as extremely stressful, that event cannot be viewed as

traumatizing for that person (Nijenhuis, 2015). Accordingly, one can conceptualize trauma as an individual's 'breaking-point' when faced with events that are, for him or her, personally overwhelming. As noted by military psychiatrist T. A. Ross (1941), 'All of us have our breaking-point. To some it comes sooner than to others' (p. 66). But a breaking-point, considered as a combination of individual factors and sensitivities to particular stressful events, should not be seen as purely quantitative in nature. The *meaning* of the potentially traumatizing event is always of great importance. As Nijenhuis (2017) notes, 'The meaning of the adverse event for the individual who lives it is necessarily co-dependent on the context of the current environment as well as on the embedded events that preceded it and *are anticipated to follow*' (p. 49). For example, Kilpatrick et al. (1989) describe a patient who did not develop PTSD in the months after she was raped, but only later after discovering that the rapist had previously raped other women, and had killed one of them. She was then forced to reconceptualize the *meaning* of the event as potentially life threatening (the event itself, of course, did not change), and developed PTSD.

Finally, this notion of trauma as a breaking-point highlights the inability to integrate the implications of an event into the existing conceptions of one's self and the world, recapitulating the historical linking of trauma and dissociation. In our opinion, to define trauma exclusively as an 'event' occurring 'in the world', without reference to an individual's inability to make sense of the experience, not only violates the essential historical meaning of the term, but renders it clinically useless – little more than a marker of extreme events.

Physical trauma continues to refer to a reaction to an injury, and we believe that psychological trauma should as well. Accordingly, following Nijenhuis (2015), we would define trauma as a 'biopsychosocial injury related to a particular dynamic and historical configuration of brain, body and environment … (whose) formal cause is a lack of integration of particular experiences/events … (which) manifests itself as a particular dissociation of personality' (p. 271). As such, the concept of trauma is intimately connected with the concept of dissociation, to which we now turn.

Dissociation

Etymology and Historical Conceptions

The term 'dissociation' comes from the Latin 'dis' (or 'apart') and 'sociare' (to 'join together' or 'associate') (OED, 2012). It was first used in the early fifteenth century to mean 'separate from companionship' (and, indeed, is still used this way, though more often as 'dis-associate'). The social use of the term predominated until the mid-nineteenth century, when it was adopted by chemists to describe the mechanism by which heat broke down compound substances into primary elements. Notably, chemists called the temperature at which the breakdown occurred a *dissociation point* – and recognized that it varied from compound to compound. It was only after dissociation was applied in social and chemical realms that it came to be used to describe *psychological* experiences. The earlier social and chemical meanings of dissociation, including the notion of a *dissociation point*, add important layers of meaning to the current psychological use of the term.

In nineteenth-century French psychiatry, dissociation referred to a division or compartmentalization of consciousness or personality – the latter term emphasizing that psychobiological phenomena beyond consciousness were involved. Some other terms in vogue at the time were *doubling of the personality*, *double consciousness*, *division of the personality*, and *psychological disaggregation* (Van der Hart & Dorahy, 2009). Pierre Janet, for example, used both *disaggregation* and *dissociation* interchangeably. Janet viewed dissociation as a major characteristic of the diagnostic category *hysteria* – a broad psychopathological category which today would include various trauma-related disorders, such as PTSD, various somatoform disorders, borderline personality disorder, and dissociative identity disorder. Janet clearly distinguished between *dissociation* and other disturbances of consciousness (i.e. narrowing of the field, or lowering of the level, of consciousness) that have, in recent years, come to be labelled dissociation. He states that 'when one doesn't notice something, doesn't make some associations with it, this is not "dissociation"' (1927/2007, p. 375). Incorporating dissociation as a division of the personality, Janet's definition of hysteria was:

> A form of mental depression [i.e. lowering of the integrative capacity] characterized by a retraction of the field of consciousness and a tendency to the dissociation and emancipation of the systems of ideas and functions that constitute personality (Janet, 1907, p. 332).

Contemporary Conceptions

Since Janet's time, two major conceptualizations of dissociation have been elaborated: a narrow and a broad one (Van der Hart & Dorahy, 2009). The narrow conceptualization, consistent with nineteenth-century views, regards dissociation as a division of consciousness or personality into relatively independent subsystems. For example, based on observations of acutely traumatized combat soldiers, Myers (1940) argued that dissociation pertained to a division between an *emotional* personality, fixated in trauma, and an *apparently normal* personality, focused on daily life challenges. Van der Hart et al. (2006) used Myers' terminology for their theory of *structural dissociation of the personality*, but modified it to refer to 'parts of the personality' instead of 'personalities', on the basis that each person has only one personality, however much it is divided or fragmented. The narrow conceptualization posits that dissociation of the personality gives rise to the manifest phenomena of dissociative symptoms (Dorahy & Van der Hart, 2007).

Since the 1980s, the narrow conceptualization of dissociation has been overshadowed and largely ignored in favour of a phenomenologically based broad conceptualization. In this broad view, dissociation is considered to be not only a lack of integration of psychological functions (itself already more inclusive than the narrow definition), but also a wide range of alterations in attention or consciousness. Such a definition obscures the careful distinction Janet made between dissociation as a *division* of personality and *alterations* of consciousness (cf. Steele, Dorahy, Van der Hart, & Nijenhuis, 2009).

We can see the increasing impact of this broad perspective in the progression of the definition of *dissociation* from the DSM-III (APA, 1980) to the DSM-5 (APA, 2013). In the former, 'dissociation' was defined (in the context of introducing the 'Dissociative Disorders' section), as 'a disturbance or alteration in the normally integrative functions

of identity, memory, or consciousness' (APA, 1980, p. 253). While such a broad definition would clearly allow for a range of experiences beyond those associated with a division of the personality, the definition became even broader in the DSM-IV (APA, 1994). Here, dissociation was defined as 'a disruption in the usually integrated functions of consciousness, memory, identity, or *perception of the environment*' (p. 477, italics added). The latter addition – a dramatic change from former definitions of dissociation – would clearly and explicitly include experiences of intense absorption in an event or derealization during a trauma, whether or not they were related to a division of the personality. And in the DSM-5 (APA, 2013), this definition was further broadened, to 'a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, *and* behavior' (p. 291, italics added).[7] Note that the use of 'and' (in our added italics) seems to imply that discontinuities must occur in *all* of these domains. This is clearly an error; it is likely that the editors meant to use 'or' or 'and/or', which would mean that disruptions or discontinuities in one or more of these domains could constitute 'dissociation' – clearly, a very broad definition, indeed (though, unlike the ICD-10 definition below, it does not include 'bodily sensations'). The ICD-10 definition (WHO, 1992) is broader than the DSM-IV, but narrower than the DSM-5; dissociation is a 'partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements' (p. 151). Nonetheless, all of the definitions above retained the notion of dissociation as a failure of integration, which is consistent with Janet's ideas.

We believe that these changes reflect two developments, one theoretical and one empirical. The 1970s and 1980s saw a number of important publications about dissociation. For our purposes, we highlight three. In the 1970s, the hypnosis researcher Ernest Hilgard began writing about his *neo-dissociation* theory, which culminated in the publication of his influential book, *Divided Consciousness: Multiple Controls in Human Thought and Action* (Hilgard, 1977). There he presented data on the *hidden observer* phenomenon – that, under hypnosis, some people (not otherwise demonstrating any pathology) can demonstrate a part of themselves not subject to post-hypnotic suggestions at the same time that another part enacts the suggestion (i.e. recognizing that their hand is placed in freezing cold water even as another part denies that the hand is cold). Thus, he argued for a *non-pathological* form of dissociation. Second, the *Dissociative Experiences Scale* (DES, Bernstein & Putnam, 1986) was published in the 1980s, and has been the most widely utilized dissociation instrument since then. The DES is explicitly based on a broad definition of dissociation, and includes many common alterations of consciousness and perception – including mild forms of absorption and depersonalization/derealization. Finally, an influential review of dissociation was published in 1991, arguing that disturbances of consciousness were common during traumatic (traumatizing) events, and deserved the label 'dissociation' (Spiegel & Cardeña, 1991). This was followed by the development of the *Peritraumatic Dissociative Experiences Questionnaire* (Marmar et al., 1994), which focused exclusively on alterations of consciousness and perception during very stressful events (including a sense of time lengthening or shortening, and objects appearing differently in shape or size), along with amnesia.[8] Thus, from the late 1970s through the early 1990s, the concept of dissociation was expanded to include (along with pathological divisions of the personality): (i) hypnotic-based divisions of awareness, (ii) common alterations of awareness, such as absorption, and (iii) alterations of consciousness and perception experienced during or directly

after a highly stressful event. Only the first maintained a focus on a division of the personality, but Hilgard argued that this was not necessarily pathological.

At the same time, the American Psychiatric Association was revising the psychiatric nosology nomenclature. The changes in the definition of dissociation coincided with the DSM-III and DSM-IV committees' explicit emphasis on assessment and reliability over validity. That is, the editors of the DSM-III, and later DSMs, were primarily concerned with how easily and reliably symptoms of a disorder could be assessed. They were only *secondarily* concerned with how valid that assessment information was. Most likely because alterations of consciousness and perception are easier to assess than the implied presence of a division of the personality, symptoms reflecting the former have been emphasized over the latter. But, it appears that this has led to an important loss of validity.

In our opinion, this broad definition has a number of shortcomings. First of all, it implies that functions can be dissociated from each other as if they existed in a psychological vacuum, that is, without being attached to some dissociative part of the personality with its own first-person perspective. Secondly, this definition allows for common and relatively normal alterations of consciousness such as *absorption* (a narrow intense focus of attention on specific internal or external stimuli), which appear unrelated to pathological forms of dissociation. Finally, the broad definition of dissociation includes alterations of perception and consciousness that characterize *derealization* and most forms of *depersonalization*,[9] which are very common during stressful events and occur in many non-dissociative mental disorders, particularly anxiety disorders. The meaning of *dissociation* from the beginning, in *all* senses (social, chemical, *and* psychological), as some sort of separation or division, has been lost in this broad conception.

The debate over the meaning of the term *dissociation* involves at least four related questions or tensions:

i) are transient alterations of consciousness, which do not appear to involve a division of the personality, dissociative (i.e. absorption, peritraumatic depersonalization, and derealization)?
ii) does intense absorption in an activity warrant the term dissociation (i.e. *normal* dissociation)?
iii) is dissociation exclusively trauma related (for example, are post-hypnotic suggestions that imply a division of personality *dissociative*)? and
iv) is dissociation best conceptualized as a *defence*, a capacity (i.e. related to hypnotizability), or a *failure of integration*?

In general, the broad interpretation of dissociation would answer these questions 'yes', 'yes', 'no', and *defence* (or *capacity*), while the narrow interpretation would, following Janet, consider dissociation to be a *failure of integration* (and only secondarily a psychological *defence* with adaptive value), and respond to the other questions in the opposite way (though the case of a transient division of the personality in hypnosis might be an exception).

Proposed Conception

While alterations of consciousness such as absorption, depersonalization, and derealization are common in persons with dissociative disorders, they are not limited to these disorders, as many persons have these experiences. Depersonalization and

derealization are common in a wide range of psychiatric disorders, and *absorption* frequently occurs outside of the context of dissociation of the personality (Steele et al., 2009). Indeed, it is difficult to see how alterations in consciousness such as absorption or most forms of depersonalization/derealization *in and of themselves* could lead to the development of dissociative parts of the personality or dissociative symptoms such as hearing voices. Research efforts such as those reported in Chapter 18 of this book suggest that high levels of dissociation are particularly associated with dual processing capacities, sometimes called *divided attention*. Thus, intense absorption in a particular event or occurrence, *in the absence of evidence for another stream of information processing*, is probably not predictive of dissociation.

In addition, there are significant differences in abuse histories and scores on dissociation measures between depersonalization disorder (DPD), characterized by chronic depersonalization and derealization (without evidence of a division of personality) and other dissociative disorders (Simeon, 2009). This has led some to argue that DPD lies closer to anxiety disorders than dissociative disorders (Baker et al., 2003).

Finally, some cognitive theorists have marshalled existing evidence to compellingly argue that alternations of consciousness involve fundamentally different mechanisms than divisions of the personality (Brown, 2006). While they argue that *both* should be called 'dissociation' (the former, *dissociative detachment*, and the latter, *dissociative compartmentalization*), a position we disagree with, they provide convincing evidence that the two do not deserve the same label.

Based on the above, we argue here for a return to the meaning of 'dissociation' as envisioned by Janet – a trauma-related division of the personality. This position has been articulated most fully by Van der Hart et al. (2006), in their concept of *structural dissociation of the personality* as a division of the personality. More recently, Nijenhuis and Van der Hart (2011) have proposed the following definition of structural or trauma-related dissociation (it is recognized that transient dissociation may occur *without trauma*, as in the case of hypnotic suggestion in susceptible individuals, for example). Trauma-related dissociation involves:

> a division of an individual's personality, that is, of the dynamic, biopsychosocial system as a whole that determines his or her characteristic mental and behavioural actions. This division of personality constitutes a core feature of trauma … (and) evolves when the individual lacks the capacity to integrate adverse experiences in part or in full … The division involves two or more insufficiently integrated dynamic but excessively stable subsystems … Each dissociative subsystem, that is, dissociative part of the personality, minimally includes its own, at least rudimentary, first-person perspective. As each dissociative part, the individual can interact with other dissociative parts and other individuals, at least in principle. (p. 418)

Phenomenologically, dissociation as a division of personality manifests in dissociative symptoms that can be categorized as *negative* (functional losses such as amnesia and paralysis, loss of certain skills such as driving a car) or *positive* (intrusions such as flashbacks or passive influence of other dissociative parts, such as voices commenting, thought withdrawal or insertion, or a sense that one's body is controlled by someone else). Both negative and positive dissociative symptoms can have mental and physical

manifestations. Mental, or *psychoform*, dissociative symptoms include hearing voices and feeling as though thoughts or emotions which do not belong to the person intrude into their mind 'out of the blue' (Schneiderian symptoms). Physical manifestations (i.e. dissociative *somatoform* symptoms) involve body experiences such as anaesthesia or tics, or somatic sensations related to trauma, such as vaginal pain from a past rape (Nijenhuis & Van der Hart, 2011; Van der Hart et al., 2006).

The DSM-5 definition of dissociation primarily relates to *psychoform* dissociative symptoms, not *somatoform* dissociative symptoms, and *positive* dissociative symptoms are often overlooked compared to *negative* dissociative symptoms. Consistent with this bias, while PTSD as a whole is not considered a dissociative disorder in the DSM-5, a *dissociative* subtype of DSM-5 PTSD has now been added, reflecting the core PTSD symptoms plus depersonalization/derealization (see Chapter 16 of this book). But the DSM-5 criteria themselves acknowledge that intrusion phenomena such as flashbacks are dissociative in nature (i.e. *positive* dissociation) and PTSD per se (not only a subtype of it) has been argued to be a dissociative disorder, as it manifests a division of the personality between one part 'stuck' in the trauma and another part that tries to function in daily life (Dorahy & Van der Hart, 2015; Nijenhuis, 2017; Van der Hart et al., 2006).

Thus, we would argue for a return to the original meaning of the term *dissociation*, as a trauma-based division of the personality, and that the various alterations of consciousness that have become subsumed under *dissociation* should be labelled in other ways.

Schneiderian Symptoms as Dissociation or Psychosis?

The first-rank, or Schneiderian, symptoms of schizophrenia are discussed in more detail in Chapter 4 and elsewhere in this book, but must be briefly discussed here, as they throw up an important point of tension between the concepts of dissociation and psychosis. In 1937, Kurt Schneider first proposed nine symptoms (later ten) to be highly predictive for the diagnosis of schizophrenia. After his book, *Clinical Psychopathology* was translated into English (Schneider, 1959), these symptoms became emphasized in the diagnosis of schizophrenia. From the DSM-III and ICD-9 on, they were considered core symptoms of schizophrenia, but have been found to be very common in dissociative disorders, particularly dissociative identity disorder (DID, see Chapters 4 and 12 in this book). Several of the symptoms are referred to as 'passivity phenomena', the experience that one's feelings, impulses, or thoughts are under the control of an 'external force' (for example, the symptoms of 'thought withdrawal' or 'thought insertion', which involve the sensation that some thoughts have been 'removed' from, or inserted into, one's mind). Apparently, Schneider considered these symptoms to reflect a permeability of the 'ego-world boundary' in schizophrenia (Koehler, 1979). However, in DID, they reflect the presence of one part or parts of the personality influencing another part of the personality; such attempts at influence are commonly reported by persons with DID (e.g. Kluft, 1987). The definition of these experiences as *necessarily* delusional (regardless of whether the 'external force' is given a delusional interpretation – as 'the devil', or 'the Secret Service', for example), and therefore psychotic, is highly problematic, as they may simply be accurate descriptions of experiences common in (indeed, *essential to*) severe dissociative disorders. That the same experience may be described as dissociative or psychotic reveals a fundamental tension between understandings of these two

concepts. Indeed, it implies that the current official definition of psychosis (or psychotic 'symptoms' or 'features') *requires* a definition of dissociation as *only* alterations in consciousness – a definition that eliminates a division of the personality from the realm of possibility. These problematic definitions of *psychosis* and *dissociation* are likely one of the reasons for the frequent misdiagnosis of persons with DID as suffering from schizophrenia (Putnam, Guroff, Silberman, Barban, & Post, 1986).[10]

Conclusion

The terms *psychosis*, *trauma*, and *dissociation*, central to the focus of this book, have all been used in a variety of ways over the centuries. We believe that the original, historically and contextually relevant, meanings of these terms, often far from their current usage, continue to be of substantial value. Here, we summarize the views we have presented, and argue for the resurrection of the original connotations.

Psychosis is the only one of the three terms which has always, and only, been applied to psychopathology and yet it is perhaps the most in need of rehabilitation. The original impetus for the introduction of the term was to carve out a middle ground between those who viewed mental disorders as a sickness of the body and those who located the abnormality in the mind or soul. Von Feuchtersleben insisted that it was both, that psychosis was a disorder of the whole personality, and that it was folly to attempt to reduce the pathology to brain dysfunction, or limit it to a disturbance of the mind. We are in great need of such a balanced perspective today, when severe psychopathology is often reduced to brain dysfunction.

Currently, researchers largely use 'psychosis' as shorthand for 'psychotic symptoms', with the former adding nothing to the meaning of symptoms such as delusions or hallucinations. This is particularly problematic as the symptoms designated as 'psychotic' include certain symptoms which appear dissociative and are more common in DID than in schizophrenia. As currently used, 'psychosis' is a signifier to others that the person in question is engaging in behaviour which appears meaningless and has no apparent connection to their lives. It indicates, in a sense, that they are less of a person than others in society – that they have lost an essential component of 'personhood', the capacity to engage in a meaningful dialogue with others. This classical conception of 'psychosis', where the presence of a morbid change in a person is assumed as the only way to explain dramatic changes in behaviour, emotional reactions, and thinking, still has relevance to our current use of the concept. We propose a way to develop this further, by using Janet's concept of a *hierarchy of reality* as a guide – namely, that psychosis results when individuals assign an inappropriately high level of reality to internal experiences such as thoughts and fantasies. This has the advantage of not forcing us to renounce the use of the term *psychosis* when a meaningful connection can be made between life experiences and bizarre behaviour.

Trauma and *dissociation* were first introduced and used in realms other than the psychological one – the former with regard to physical injuries and the latter to describe social or chemical divisions. Both of these original connotations are now in danger of being lost. Since the introduction of the compound term *post-traumatic* in 1980, the meaning of trauma has progressively shifted from the person's *reaction* to an extreme event to the event *itself*. Now, with the introduction of the DSM-5, the transformation

appears to be complete – trauma is defined as specific life-threatening events. We believe this to be a mistake. Research indicates that it is a person's inability to integrate the *meaning* of an experience that is essential to the nature of trauma. While some events, by their very nature, are potentially more traumatizing than others, individual factors are of great significance in determining who does, and who does not, react to extreme events with post-traumatic symptoms – or, as we would say, reacts with dissociation. Indeed, the simple definition of trauma as 'that which causes dissociation' is attractive, and has some merit.

Of all these terms, *dissociation* is the one which has been subjected to the most debate and has also suffered the greatest shifts in meaning. From its original roots as a division or separation in social or chemical domains, *dissociation* has come to mean a wide range of disturbances in consciousness, commonplace as well as pathological. The reasons for this shift are not entirely clear but, like trauma, this trend appears to have started a few decades ago and is accelerating. We argue that the current use of *dissociation* to describe alterations of consciousness such as absorption and derealization or depersonalization (excepting 'out-of-body' experiences) is historically inaccurate and poorly supported empirically. While all definitions of dissociation accept *divisions of the personality* as dissociation, the broad definition claims that common alterations in consciousness deserve the same title as these severe structural divisions of the personality. We believe, on both historical and empirical grounds, that the meaning of dissociation should revert to its historical roots, as a trauma-based *division* of the personality.

In order to understand the complex relations between psychosis, trauma, and dissociation, we must first have a clear picture of what these terms mean. We hope that the considerations laid out in this chapter provide a first step toward that goal.

Notes

1 Strikingly, the wording here is identical to Freud's (1924) conception of reality testing, as the creation of a new reality through the development of delusions.
2 Of note, the term 'negative psychotic symptoms' is increasingly being used (including in the proposed ICD-11) to refer to the negative symptoms of schizophrenia, such as 'flat' affect and avolition. This is a curious and illogical development and is not consistent with any recent proposed definition of psychosis.
3 One of the first to make a similar argument was Bowlby (1979, revised in 1985 and published in *A Secure Base*, 1988), in his remarkable paper 'On knowing what you are not supposed to know, and feeling what you are not supposed to feel'. There, he discusses a variety of ways in which parents may invalidate a child's reality, ranging from denial of experienced emotions to denial of witnessing a parental suicide. Other events, such as sexual abuse by a parent, are often not denied but simply never acknowledged on any level. Bowlby makes clear links between such experiences and subsequent severe psychopathology.
4 The rise of the gaming and online 'worlds', where 'actions' can have consequences, including in the 'real' world, complicates this issue and has clear implications for mental health, but is beyond the scope of this chapter.
5 In this, they were following Charcot and Janet, who expressed similar ideas previously or concurrently with Breuer and Freud (who acknowledged this). Freud, of course,

repudiated all of these ideas within a few years, with considerable consequences for trauma patients.

6 The relation between *trauma* and *stress* is a complex one that space will not allow us to explore here. Of note, the term *traumatic stress* is sometimes used, as though *trauma* simply indicated a very high level of *stress*. But this is clearly inadequate, as the individual *meaning* of an event is essential to the understanding of *trauma*. *Stress* is often used in an entirely *quantitative* way ('more' or 'less' stressful situations), but *trauma* cannot adequate be conceptualized in the same manner.

7 Curiously, the definition of dissociation in the DSM-5 glossary is somewhat different. Primarily emphasizing 'compartmentalization' without any reference to a division of personality, it describes dissociation as 'the splitting off of clusters of mental contents from conscious awareness' (p. 820).

8 As 'peri-' is a prefix meaning 'around' or 'surrounding', 'peritraumatic', like 'posttraumatic' implies that a 'trauma' is an event delimited in time.

9 Those forms of depersonalization characterized by separate observing and experiencing parts of the person (e.g., ego-observing phenomena such as 'out-of-body' experiences) are manifestations of a division of the personality, and therefore consistent with the narrow conception of dissociation.

10 The other main reason, of course, is that clinicians are not directed to consider DID as a differential diagnosis for schizophrenia. This is particularly problematic as the DSM-5 clearly recognizes – in its respective diagnostic sections – overlapping Schneiderian symptoms in schizophrenia and DID. Bizarre delusions, which until the DSM-5 were considered characteristic of schizophrenia, include *delusions of being controlled*, defined as a delusion in which 'feelings, impulses, thoughts or actions are experienced as being under the control of some external force rather than being under one's own control' (APA, 2013, p. 819). At the same time, in the dissociative disorders section, characteristic features of DID are reported to include the following: 'Strong emotions, impulses, and even speech or other actions may suddenly emerge, without a sense of personal ownership or control (sense of agency) … Alterations in sense of self and loss of personal agency may be accompanied by a feeling that these attitudes, emotions, and behaviours – even one's body – are "not mine" and/or are "not under my control"' (p. 293). Thus, on the one hand, these experiences are described as psychotic (delusional), while on the other hand, these same experiences are described as dissociative. Clearly, this could easily lead to a situation where a person's diagnosis depends primarily on which section of the DSM-5 their clinician is most comfortable with.

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