

The Necessity of Clinical Training in Trauma and Dissociation

Bethany L Brand

Psychology Department, Towson University, Towson, USA

Commentary

Few mental health professionals receive systematic training in the assessment and treatment of trauma related psychological problems, and even fewer about traumatized individuals who have dissociative reactions [1,2]. Information on childhood maltreatment and related topics such as dissociation is missing, inaccurate, or inconsistently presented in many current psychology textbooks [3-5], so students are often taught information about trauma and dissociation that is not evidence-based. The lack of accurate knowledge and training about trauma can have a negative impact on clinical practice. Many clinicians do not ask about trauma exposure and even when they do, many do not recognize the link between early traumatization and later psychopathology. One study found that 64% of patients reported they had experienced childhood sexual, physical, or emotional abuse, but only 20% had been asked about childhood abuse by mental health clinicians [6]. While 69% of the patients who had experienced childhood maltreatment believed there was a connection between maltreatment and their psychiatric symptom(s), only 17% of clinicians recognized this connection [7]. Without trauma-informed treatment, traumatized clients may not respond optimally and they may even be re-traumatized by the mental health system if they are labeled as “treatment resistant” because the treatment does not address the core issue of trauma; some may be misunderstood as fabricating or exaggerating their trauma history or symptoms. Furthermore, clinicians who are not trained in managing their own reactions to working with trauma survivors may be at heightened risk for vicarious traumatization [1].

The more traumas an individual has experienced, the greater the resulting symptom complexity exhibited is, including the greater the risk for dissociative symptoms [8]. Dissociation is “a disruption and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior” [9]. In particular, there is a lack of training and considerable misinformation about dissociative reactions to trauma [5,10,11]. Due to their lack of training and knowledge about dissociation, trainees and clinicians tend to overlook and/or misdiagnose dissociative reactions, leading many dissociative individuals to not get treatment. One study of youth found that those with dissociative disorders (DD) had the highest impairment of any of the disorders studied yet the lowest level (2.3%) of referral for mental health treatment [12]. A nationally representative sample of German youth and young adults found that those with DD were quite impaired, yet only 16% had ever received mental health treatment [13]. These studies demonstrate the importance of clinicians learning about assessing and treating dissociative reactions.

Dissociative symptoms can occur in the course of almost any psychiatric disorders, including mood disorders, anxiety disorders, psychotic disorders, and personality disorders. The Diagnostic and Statistical Manual of Mental Disorders ([DSM-5]; American Psychiatric Association [9]) now recognizes a dissociative subtype of post-traumatic stress disorder (PTSD), and dissociation are part of the criteria for acute stress disorder, borderline personality disorder, and panic disorder. The DSM-5 lists five dissociative disorders: dissociative identity disorder, dissociative amnesia (which also includes dissociative fugue), depersonalization/derealization disorder, other specified dissociative disorder (OSDD; formerly DDNOS), and unspecified dissociative disorder.

The most chronic DD, DID and DDNOS, are almost always comorbid with other disorders, which complicates both the clinical picture and differential diagnosis [14-17]. Patients with DID and DDNOS meet criteria for an average of 5-8 comorbid axis 1 diagnoses, with 75% meeting criteria for at least five [16,17]. In comparison, patients with mood or anxiety disorders met criteria for an average of 0-2 comorbid axis 1 disorders and patients with PTSD met criteria for an average of 4 comorbid axis 1 disorders [17].

The majority of patients with DID (up to 85%) do not manifest dramatic switching among dissociative self-states [18]. Rather, dissociative symptoms tend to be embedded in a mixture of mood, anxiety, somatoform, and trauma-related symptoms [14-17]. PTSD and treatment resistant depression are almost ubiquitous in the population. If clinicians are not aware of subtle clues in the history and mental status, dissociative symptoms can easily be overlooked due to more readily visible psychopathology. For example, reports of hearing voices are often assumed to mean the patient has a psychotic disorder, although the majority of patients with DID report hearing the voices of their dissociated self-states [19].

The treatment of severe, chronic DD requires a trauma-informed, staged approach to treatment that typically involves long-term psychotherapy and medications [20]. Space constraints limit this discussion but detailed descriptions are available [20-24]. Treatment that is consistent with expert guidelines for DD treatment is associated with improved functioning and symptomatology (International Society for the Study of Trauma and Dissociation) [20]. For example, Ellason and Ross [25] found that DID patients who remained in treatment showed significant improvements in depression, dissociation, PTSD and somatoform symptoms. A longitudinal, naturalistic study of 280 DID/DDNOS patients and their clinicians found that patients showed decreases in dissociation, PTSD, depression, distress, drug use, physical pain, self-harm, and hospitalizations, as well as improvements in adaptive behaviors such as socializing, attending school or volunteering during 30 months of treatment [14,26]. Therapists’ ratings indicated improved daily function and decreased suicide attempts. A stronger alliance predicted decreased symptoms of PTSD and depression, as well as improved functioning and decreased general distress [21].

Among inpatients who received trauma treatment for childhood sexual abuse, dissociation was the only significant predictor of poor outcome at discharge [27]. Jepsen and colleagues [28] found that the trauma patients who did not have a DD had less severe symptoms than

***Corresponding author:** Bethany L Brand, Psychology Department, Towson University, 8000 York Rd., Towson MD 21252, Tel: 410-704-3067; Fax: 410-704-5874; E-mail: BBrand@towson.edu

Received September 26, 2016; **Accepted** October 15, 2016; **Published** October 18, 2016

Citation: Brand BL (2016) The Necessity of Clinical Training in Trauma and Dissociation. *J Depress Anxiety* 5: 251. doi: [10.4172/2167-1044.1000251](https://doi.org/10.4172/2167-1044.1000251)

Copyright: © 2016 Brand BL. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

did the DD group before, during and after treatment. Although both groups demonstrated improvement in dissociative and other symptoms, DD patients were much more dysfunctional initially, took longer to show symptom improvement, and remained more symptomatic. Their amnesia and identity fragmentation did not improve; however, the trauma treatment they received did not specifically address dissociated self-states. The authors concluded that DD patients seem to require therapy that specifically addresses DD symptoms.

In summary, it is critical that clinicians are trained in the assessment and treatment of trauma-related reactions, and in particular, dissociative reactions. If dissociation and DD are not recognized, many of these patients will not be referred to psychotherapy, and even if they are referred, they are unlikely to optimally respond to treatment until the role of trauma in creating and maintaining their distress is addressed.

References

- Cook JM, Dinnen S, Rehman O, Bufka L, Courtois C, et al. (2011) Responses of a sample of practicing psychologists to questions about clinical work with trauma and interest in specialized training. *Psychological Trauma: Theory, Research, Practice, and Policy* 3: 253-257.
- Courtois CA, Gold SN (2009) The need for inclusion of psychological trauma in the professional curriculum: A call to action. *Psychological Trauma: Theory, Research, Practice, and Policy* 1: 3-23.
- Kissee JL, Isaacson LJ, Miller-Perrin C (2014) An analysis of child maltreatment content in introductory psychology textbooks. *Journal of Aggression, Maltreatment & Trauma* 23: 215-228.
- Letourneau EJ, Lewis TC (1999) The portrayal of child sexual assault in introductory psychology textbooks. *Teaching of Psychology* 26: 253-258.
- Wilgus SJ, Packer MM, Lile-King R, Miller-Perrin CL, Brand BL (2015) Coverage of child maltreatment in abnormal psychology textbooks: Reviewing the adequacy of the content. *Psychological Trauma: Theory, Research, Practice, and Policy* 8: 188-197.
- Lothian J, Read J (2002) Asking about abuse during mental health assessments: Clients' views and experiences. *New Zealand Journal of Psychology* 31: 98-103.
- Xiao CL, Gavrilidis E, Lee S, Kulkarni J (2016) Do mental health clinicians elicit a history of previous trauma in female psychiatric inpatients? *Journal of Mental Health* 1-7.
- Briere J, Dietrich A, Semple RJ (2016) Dissociative complexity: Antecedents and clinical correlates of a new construct. *Psychological Trauma: Theory, Research, Practice, and Policy* 8: 577-584.
- American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders*. American Psychiatric Publishing, Washington.
- Brand BL, Sar V, Stavropoulos P, Krüger C, Korzekwa M, et al. (2016) Separating fact from fiction: An empirical examination of six myths about dissociative identity disorder. *Harvard Review of Psychiatry* 24: 257-270.
- Dorahy MJ, Lewis-Fernández R, Krüger C, Brand BL, Şar V, et al. (2016) The role of clinical experience, diagnosis, and theoretical orientation in the treatment of posttraumatic and dissociative disorders: A vignette and survey investigation. *Journal of Trauma & Dissociation*.
- Ferdinand RF, Van der Reijden M, Verhulst FC, Nienhuis J, Giel R (1995) Assessment of the prevalence of psychiatric disorder in young adults. *Br J Psychiatry* 166: 480-488.
- Lieb R, Pfister H, Mastaler M, Wittchen HU (2000) Somatoform syndromes and disorders in a representative population sample of adolescents and young adults: Prevalence, comorbidity and impairments. *Acta Psychiatrica Scandinavica* 101: 194-208.
- Brand B, Classen C, Lanius R, Loewenstein R, McNary S, et al. (2009) A naturalistic study of dissociative identity disorder and dissociative disorder not otherwise specified patients treated by community clinicians. *Psychological Trauma: Theory, Research, Practice, and Policy* 1: 153-171.
- Dorahy MJ, Brand BL, Şar V, Krüger C, Stavropoulos P, et al. (2014). Dissociative identity disorder: An empirical overview. *Australian and New Zealand Journal of Psychiatry* 48: 402-417.
- Ellason JW, Ross CA (1996) Millon Clinical Multiaxial Inventory-II: Follow-up of patients with dissociative identity disorder. *Psychol Rep* 78: 707-716.
- Rodewald F, Wilhelm-Gößling C, Emrich HM, Reddemann L, Gast U (2011) Axis-I comorbidity in female patients with dissociative identity disorder and dissociative identity disorder not otherwise specified. *Journal of Nervous and Mental Disease* 199: 122-131.
- Spiegel D, Loewenstein RJ, Lewis-Fernández R, Şar V, Simeon D, et al. (2011) Dissociative disorders in DSM-5. *Depression and Anxiety* 28: E17-E45.
- Dorahy MJ, Shannon C, Seagar L, Corr M, Stewart K, et al. (2009) Auditory hallucinations in dissociative identity disorder and schizophrenia with and without a childhood trauma history: Similarities and differences. *The Journal of Nervous and Mental Disease* 197: 892-898.
- International Society for the Study of Trauma and Dissociation (2011) Guidelines for treating dissociative identity disorder in adults. *J Trauma Dissociation* 12: 115-187.
- Brand BL, Loewenstein RJ, Lanius RA (2014) *Dissociative identity disorder, Gabbard's treatments of psychiatric disorders*. American Psychiatric Association DC, Washington.
- Brand BL, Myrick AC, Loewenstein RJ, Classen CC, Lanius R, et al. (2011) 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, and Policy* 4: 490-500.
- Kluft RP (1989) Playing for time: Temporizing techniques in the treatment of multiple personality disorder. *American Journal of Clinical Hypnosis* 32: 90-98.
- Kluft RP (1999) An overview of the psychotherapy of dissociative identity disorder. *American Journal of Psychotherapy* 53: 289-319.
- Ellason JW, Ross CA (1997) Two-year follow-up of inpatients with dissociative identity disorder. *American Journal of Psychiatry* 154: 832-839.
- Brand BL, McNary SW, Myrick AC, Classen CC, Lanius R, et al. (2013) A longitudinal naturalistic study of patients with dissociative disorders treated by community clinicians. *Psychological Trauma: Theory, Research, Practice, and Policy* 5: 301-308.
- Jepsen EKK, Langeland W, Heir T (2014) Early traumatized inpatients high in psychoform and somatoform dissociation: Characteristics and treatment response. *Journal of Trauma & Dissociation* 15: 572-587.
- Jepsen EKK, Langeland W, Sexton H, Heir T (2013) Inpatient treatment for early sexually abused adults: A naturalistic 12-month follow-up study. *Psychological Trauma: Theory, Research, Practice, and Policy*.