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Dissociative Depression is Resistant to Treatment-As-Usual

Abstract

A new concept introduced by the author, the "dissociative depression" differs from primary depression in symptomatology, course, and treatment response. Being related to traumatization in childhood, dissociative depression tends to be chronic and is usually classified as treatment-resistant due to its limited response to biological interventions. Trauma-focused psychotherapy targeting dissociative psychopathology leads to positive results. However, such patients are usually undertreated in terms of effective psychotherapy and become recipients of long-term antidepressant prescription. The concept of dissociative depression is proposed to facilitate the identification of this large group of patients who suffer from their "no name" condition from the angle of official psychiatric classifications.

Opinion

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Introduction

As it occurs for schizophrenia, former subtypes of depressive disorder such as endogenous, reactive, neurotic, retarded, agitated, and anxious types lost their popularities over years. Major depression representing the full picture of depressive disorder and the disthymic disorder as milder and rather chronic types of the latter have been introduced to replace previous ones. However, albeit the rather vague concept of disthymic disorder, not all "major" depression is the same. In fact, depression can occur as the final common pathway of several psychiatric disorders. This paper is concerned with one potential subtype of depressive disorder which has been proposed by the author: "dissociative depression" [1,2].

Childhood trauma and resistance to treatment

Whereas the common biologically based treatment approaches to depression as proposed by the medical model of psychiatry usually have a good to excellent outcome for "primary" depression, many patients with depressive symptoms respond to medical treatment algorithms only poorly and must be considered as treatment-resistant in due course. A closer look at these patients makes apparent that they differ from those with a "primary" depressive disorder not only in response to treatment but also in symptomatology and pathogenesis. The majority of these patients have been living under lifelong environmental stress usually with an origin in early developmental years [3].

The adverse experiences ("traumas") of childhood reported by these patients take not rarely the scope of (sexual, emotional, or physical) abuse and/or (physical or emotional) neglect [4]. Some others are grown up in families which are "apparently normal" [5] only; i.e. they are subtly dysfunctional despite lack of an overt history of adversity. Among the latter group, adult interpersonal attachment problems prevail which have their origin in early childhood. Such families are usually characterized by affect dysregulation or narrow and rigid thinking styles which may also have traumatic origin. Dysfunctional communication styles of families (like e.g., pseudomutuality, marital schism, schizophrenogenic mother, double bind, high expressed emotion) which were once proposed to be a factor in the psychogenesis of schizophrenia, are in fact descriptive of dissociative patients' families [5]. A smaller percentage of patients report diverse kinds of childhood traumas other than childhood abuse and/or neglect such as repetitive painful invasive medical/surgical procedures enforced in childhood [6] or having grown up in extreme poverty.

Prevalence of dissociative depression

Dissociation is characterized by a disruption in one or more of the usually integrated functions affecting memory, consciousness, identity, emotions, body awareness, perception of the self and the environment, and sensorimotor abilities [7]. Chronic complex dissociative disorders such as dissociative identity disorder (DID) are increasingly considered to be post-traumatic syndromes closely related to childhood abuse and/or neglect [8]. Almost all of the patients with severe and chronic dissociative disorders, such as DID and its subthreshold forms are chronically depressed [9,10]. This means that the opposite is also true among patients with chronic depression. Namely, according to the data collected from a representative sample of women in the general population of a town in central Turkey (Sivas City), sizable proportions of women with a lifetime diagnosis of major depression (39.2%) and current major depression (41.3%) had a lifetime history of DSM-IV (American Psychiatric Association, 1994) dissociative disorder. In the same study, the lifetime prevalence of major depression was 31.7 % and current prevalence was 10.0 % [2].

Symptomatology of dissociative depression

Dissociative depression is characterized by irregularity of depressive mood. Individuals with dissociative depression tend to be younger than other depressive patients. The onset of depressive symptoms are described to be early in life; sometimes, even in early childhood. Rather than clear cut depressive episodes and subsequent periods of remission, a chronic course is presented. A study on Turkish women in the general population demonstrated that, in comparison to non-dissociative depression, those participants with concurrent

dissociation and depression had concentration difficulties, thoughts of guilt and worthlessness, suicidal ideas, and weight changes more frequently [2]. Women with dissociative depression reported passive influence experiences (resembling Schneiderian symptoms), borderline personality disorder criteria, suicide attempts and experiences of possession more frequently. Ideas of suicidality are persistent but usually kept under control by the patient despite their chronicity. The reason of suicidality cannot be well articulated by the patient compared to patients with primary depression. Affect dysregulation of the dissociative patient may resemble cyclothymia or bipolar II disorder. Mood change may occur instantly and may hold hours or even only a few minutes. Patients may describe this as an experience of being "down" or "up" without any reason suddenly. These changes may also be triggered by external cues.

Psychodynamics of dissociative depression

Recovery from dissociative disorder instantly relieves the depressive façade [12]. As a reason of this impairment, at least partly, re-integrated anger can be taken into consideration [13]. This anger is absorbed in the compartmentalized internal world of these patients. Continuous interruptions by mental intrusions and passive influence experiences originating from "within" cause the patient to be upset and undermines any hope for a better future for them, whereas their painful past intimidates their present. Difficulties in accessing memory beginning from daily mundane amnesias reaching to the scope of dissociative amnesia (sometimes covering traumatic periods and events) additionally interfere with an integrated sense of self. Once denied of their autonomous existence as children by their caretakers, these individuals continue to be prevented from being in leading role of their own life throughout adulthood either, this time captived by their internal world.

Arieti & Bemporad [14] underlined the role of the "dominant other" in the lives of depressive individuals. From the angle of view of psycho-traumatology, we may translate this concept to an "attachment to the perpetrator" and a "shift of locus of control" model as proposed by Ross [15,16]. Insecure attachment has been reported as an etiological factor of dissociative disorders [17,18]. Even in an abusive and/or neglectful environment, the child must develop attachment to the caretaker. This paradox leads to mental disconnection between traumatic information and feelings of safety in the presence of the abusive "caretaker". This problem of the attachment to the perpetrator can be acted out throughout life. The helpless child continues to identify with the aggressor and shifts locus of control in his or her "internal world". This illusion can be developmentally protective, however, it cannot be maintained in adulthood when one is increasingly exposed to "external" reality [15,16].

Whereas this internal world composed like a ghetto leads to the experience of perpetuated abuse inside, it also facilitates and maintains abusive relationships in the external world. This situation does not only end up in a depressive condition but also undermines healthy intimacy, causes social withdrawal, leads to psychological stagnation, and interferes with any hope for psychological change, progress, and maturation necessary to break the *circulus vitiosus* [19].

Chronic depression may be a façade which hides a chronic Post-Traumatic Stress Disorder (PTSD) with the classical symptom triad of numbing, intrusions, and hyperarousal. Others may suffer from affect dysregulation, creating unexpected mood fluctuations and disturbed subjective well-being and/or interpersonal relationships. There are those who are prone to alexithymia, including difficulty in identifying or expressing feelings and leading to frequent somatic complaints or alcoholism [20]. This composite syndrome has also been called as Complex PTSD [21]. Recently, a dissociative subtype of PTSD has been introduced [1,22] which may also overlap with the mentioned syndromes in some cases. Dissociation is usually involved as a common factor in these phenomena which cover a wide spectrum of trauma-related diagnostic categories [23,24].

Somatic dissociation and bodily complaints

One aspect of dissociation is the phenomenon of "medically unexplained" somatic symptoms [25,26]. Functional neurological (conversion) symptoms constitute those which are the ones closest to "psychological" dissociation. In the case load of a psychiatric clinic in central Turkey, among patients with functional neurological symptoms (most of them had psychogenic non-epileptic seizures), 47.4 % met lifetime diagnostic criteria of a DSM-IV dissociative disorder [27]. In a series of patients collected in a university clinic of a large metropolis (Istanbul) in Turkey, medically unexplained somatic symptoms differentiated patients with complex dissociative disorders from other psychiatric diagnostic groups [28]. As an evidence for universality of this phenomenon, there was no difference in somatic complaints between Turkish and Dutch patients with dissociative disorder except for the prevalence of psychogenic non-epileptic seizures (pseudo-seizures), which was more frequent among Turkish patients.

As compared to patients with conversion symptoms without a dissociative disorder, those who also met criteria of a dissociative disorder had more comorbid psychiatric disorders, childhood trauma, suicide attempts, and self-mutilating behaviors [27]. Standing in for general severity of the clinical condition, somatic complaints were related to higher suicidality among Turkish dissociative patients [29]. In an epidemiological study among women in Turkey, functional neurological symptoms were predicted by dissociative and depressive disorder implying the central role of dissociative disorder in the pathogenesis of these somatic symptoms [30].

Somatic dissociation is also related to developmental trauma [31]. There are preliminary data reporting separate relationships between different types of childhood trauma and somatic versus psychological dissociation [13]. While childhood trauma of omission type (neglect) seems to be related to somatic dissociation, childhood trauma of intrusive type (various types of abuse) seems to be related to psychological dissociation. Both types of dissociation end up in the common final pathway of depression. These data inspired a relationship of somatic dissociation to depression as a trait (lifetime diagnosis of depression), while psychological dissociation was elevated in

current depression in particular. There are studies on medically ill patients showing no relationship between childhood trauma and psychological dissociation while such relationship can be shown for somatic dissociation [32]. The question arises whether somatic dissociation represents a rather bodily "record" of traumatic stress which is separate from verbal or psychologically conscious processing and expression [21].

Conclusion

Treatment-resistant depressive phenomena and the frequently accompanying medically unexplained physical symptoms may have a post-traumatic origin usually covering dissociation as the basic element of psychopathology. Understanding the trauma-related origin of depressive conditions is important for clinicians who are exposed to treatment-resistant depressive patients. Dissociative depression, itself a common post-traumatic clinical condition, is a cause of resistance to "treatment-as-usual" of depressive disorder unless the psychopathology is addressed as such.

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