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Cumulative traumatization associated with pathological dissociation in acute psychiatric inpatients

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ABSTRACT

Clinical studies of patients with dissociative disorders and prospective studies of childhood trauma survivors show inconsistent findings regarding the relationship between childhood trauma and dissociation. This study aims to resolve this inconsistency by investigating how dissociation is related to parental dysfunctions, general psychopathology, childhood trauma, and adulthood trauma. Specifically, we focus on the role of cumulative traumatization in pathological and non-taxon dissociation. Eighty acute psychiatric inpatients were administrated standardized measures on dissociation, perceived parental dysfunctions, traumatizing events, and general psychopathology. Parental dysfunctions and trauma correlated with both types of dissociation and general psychopathology. When general psychopathology and parental dysfunctions were controlled, a unique link between trauma and dissociation remained significant. Moreover, the pattern of relationships differed for non-taxon and pathological dissociations. The effect of childhood but not adulthood trauma was significant on non-taxon dissociation. In contrast, an interactive model incorporating both childhood and adulthood trauma was the best model for explaining pathological dissociation. Childhood trauma is important for developing non-taxon dissociation, and adulthood trauma exacerbates its effects on the emergence of pathological dissociation. Cumulative traumatization from childhood to adulthood should be incorporated into the trauma hypothesis of pathological dissociation.

1. Introduction

Traumatizing events at early developmental stages including sexual and physical maltreatment prevail in patients with dissociative pathology. Dissociation refers to an experienced loss of information or loss of control over mental processes that under normal circumstance would be available to conscious awareness, self-attribution, or control (Cardeña and Carlson, 2011). Approximately 91% of the patients with DSM-III multiple personality disorder endured either sexual or physical abuse during childhood (Coons et al., 1988; Ross et al., 1989, 1990b; Boon and Draijer, 1993). Approximately 62–74% of psychiatric patients who were diagnosed with a dissociative disorder from a structured diagnostic interview reported childhood sexual, physical, or emotional abuse (Saxe et al., 1993; Modestin et al., 1996; Tutkun et al., 1998; Şar et al., 2000; Foote et al., 2006). In contrast, the rates in patients without a dissociative disorder were between 11% and 26%. Childhood relational trauma inflicted by close others may provoke conflict between approaching and avoidance towards the attachment figure, leading to a maladaptive regulation strategy that detaches from a reminder of the trauma memory (Terr, 1991; Freyd, 1994). Childhood trauma may be an antecedent for dissociative pathology (Dalenberg et al., 2012).

To clarify the role of childhood trauma in dissociative pathology, four prospective studies investigated the association between childhood trauma and dissociative experiences. Diverse samples including children from high-risk families (Ogawa et al., 1997), children from families referred to clinical home-visiting services (Dutra et al., 2009), survivors of childhood sexual abuse (Trickett et al., 2011), and those who had congenital anomalies and

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underwent traumatic medical procedures (Diseth, 2006) were followed from childhood or early adolescence to late adolescence or early adulthood. The results showed that dissociation correlated with traumatizing events, as measured at the same time period. Only one study documented that repeated traumatic medical procedures in early adolescence predicted dissociation in adulthood (Diseth, 2006), whereas the other three studies reported that traumatizing events in childhood did not predict dissociative experiences in adulthood (Ogawa et al., 1997; Dutra et al., 2009; Trickett et al., 2011). Instead, poor quality parenting behavior including the unavailability of psychological care and lack of affective involvement predicted the degree of dissociative experiences in early adulthood (Ogawa et al., 1997; Dutra et al., 2009).

The conflicting findings regarding the relationship between childhood trauma and dissociation raise three issues. First, parental dysfunctions may fully account for the association between childhood trauma and dissociation observed in the clinical studies. In addition to the prospective studies, dissociative symptoms were associated with perceived maladaptive parenting styles including intrusive discipline and control and the absence of care in the non-clinical (Modestin et al., 2002) and clinical samples (Modestin et al., 1996). More importantly, one study of trauma survivors showed that the effect of sexual abuse on dissociative symptoms became non-significant when family pathology was controlled (Nash et al., 1993, but also see Draijer and Langeland, 1999, and Tyler et al., 2004). Because childhood trauma covaries with parental dysfunctions (Bousha and Twentyman, 1984), parental dysfunctions may account for the association between trauma and dissociation (Merckelbach and Muris, 2001; Lynn et al., 2014). This finding could refute the trauma hypothesis. Alternatively, there may exist a unique effect of trauma on dissociation in the clinical sample, as the strength of the association between trauma and dissociation was higher in the clinical than the non-clinical samples (Näring and Nijenhuis, 2005).

Secondly, qualitatively different types of dissociation may exist and have differential relations with trauma (Putnam, 1995). Studies of dissociative experiences provided a clue to the distinction between non-taxon and taxon, or pathological, dissociation (Waller et al., 1996). Pathological dissociation, including depersonalization, severe gaps in awareness, and amnesia, appears to be malignant and severely interferes with occupational and social functions. Dissociative experiences indeed discriminate patients with a dissociative disorder from other clinical individuals without a dissociative disorder (Carlson et al., 1993). In contrast, non-taxon dissociation, such as absorption, imaginative involvement, and minor gaps in awareness, does not necessarily interfere with daily functions (Carlson, 1994). These types of dissociative experiences prevail in the non-clinical populations (Ross et al., 1990a). Non-taxon dissociative experiences may be a building block, but they are not sufficient for the development of pathological dissociation. Among the 28 items of the Dissociative Experiences Scale (DES), a widely used screening instrument (Bernstein and Putnam, 1986) and the scale used in the prospective studies (Ogawa et al., 1997; Dutra et al., 2009; Trickett et al., 2011), 20 items cannot effectively differentiate clinical patients with a dissociative disorder from non-clinical dissociative individuals (Waller et al., 1996). This instrument may assess non-taxon dissociation. The null relationship between childhood trauma and later dissociative experiences observed in the prospective studies may have arisen from using the DES in the studies.

Thirdly, in addition to childhood trauma, adulthood trauma may contribute to dissociative pathology. Prior research focused primarily on the effect of childhood traumatization on dissociation. Yet, one clinical study has shown that the clinical patients who underwent potentially traumatizing events in both adulthood and childhood had a higher dissociation score than those enduring traumatizing events in either childhood or adulthood (Lipschitz et al., 1996). Childhood trauma may lead to vulnerability to later stressors such as adulthood trauma. Thus, cumulative traumatization may be critical for the emergence of dissociative pathology. The importance of cumulative traumatization has been overlooked both in clinical studies (Coons et al., 1988; Ross et al., 1989, 1990b; Boon and Draijer, 1993; Saxe et al., 1993; Modestin et al., 1996; Tutkun et al., 1998; Şar et al., 2000; Foote et al., 2006) and in prospective studies (Ogawa et al., 1997; Dutra et al., 2009; Trickett et al., 2011). Adulthood trauma may prevail in dissociative patients in clinical studies, and the null results relating childhood trauma to later dissociation in the prospective studies may have arisen from not assessing adulthood trauma. Childhood trauma may be important, but adulthood trauma may sustain or exacerbate its effect on subsequent psychopathology including dissociation. If this is the case, a model including an interaction effect for childhood and adulthood trauma may increase the amount of explained variance in dissociation beyond the additive model with two independent effects for childhood and adulthood trauma.

The aim of the current study is to address the unresolved issues regarding the relationship between trauma and dissociation. A clinical sample of unspecified psychiatric inpatients was recruited because dissociation prevails in several psychiatric disorders, including psychotic disorders (Schäfer et al., 2006) and mood disorders (Oedegaard et al., 2008). We examined whether a unique link exists between trauma and dissociation that is independent from parental dysfunctions as well as from general psychopathology. Controlling for general psychopathology is necessary because clinical patients with dissociation were frequently polysymptomatic, with symptoms of anxiety–depression, paranoia–psychosis, and panic–phobia (Steinberg et al., 2005; Vogel et al., 2009). General psychopathology may be confounded with the link between trauma and dissociation, and trauma may not act as a specific factor in the genesis of dissociation (Lynn et al., 2014). The finding of a unique link beyond parental dysfunctions and general psychopathology would strongly support the important role of trauma in the development of dissociation. On the basis of our literature review, we hypothesize that cumulative traumatization may play a critical role in pathological dissociation but not in non-taxon dissociation. If that is the case, a model incorporating an interaction between childhood and adulthood trauma should better account for pathological dissociation than for non-taxon dissociation.

2. Methods

2.1. Participants

This study was approved of by the Institution Review Board at the National Taiwan University Hospital. Participants were recruited from two acute wards. One ward is for deficient reality testing or violent behaviors, primarily psychotic disorders and bipolar affective disorder (Ward-P); the other is for mood disturbances, anxiety, somatic complaints, or eating problems (Ward-N). Patients were eligible for this study if they were admitted for an acute psychiatric dysfunction (regardless of the clinical diagnosis but excluding organic brain syndromes) and if they were clinically stable after intervention. All participants, with their agreement, were referred to the principal researcher by four medical teams. Written informed consent was obtained after the procedure was explained.

Eighty-nine participants were approached: 54% were from Ward-P, and 46% were from Ward-N. Seventy-three percent were female. The average of age was 36 ± 12 years old. The primary clinical diagnoses of these participants included psychotic