Review Article

FUNCTIONAL DISSOCIATION, A CLINICAL SYNTHESIS OF DID AND PIERRE JANET'S PSYCHASTENIA

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Abstract

DID has its origins in the pioneering work of the physician and psychologist Pierre Janet (1859-1947), who put forward the notion of "dissociation of ideas and functions". This new concept was reworked a century later by O. van der Hart and his colleagues, who proposed the notion of "structural dissociation of personality" between at least two fragments with a sense of self: the ANP and the EP. Functional dissociation of personality is a new concept that we would like to introduce here, at the interface of DID and structural dissociation. This new diagnostic category provides very useful clinical details in psychotherapy practice because its prevalence is significant. Functional dissociation allows the clinician to produce a differential diagnosis with DID, which paves the way for a more appropriate treatment than DID for patients without structural dissociation of the personality. ***ASEAN Journal of Psychiatry, Vol. 23(2) January, 2023; 1-8.***

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Introduction

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Functional dissociation of personality is a new concept that we would like to introduce here, at the interface of DID and structural dissociation. This new diagnostic category provides very useful clinical details in psychotherapy practice because its prevalence is significant. Functional dissociation allows the clinician to produce a differential diagnosis with DID, which paves the way for a more appropriate treatment than DID for patients without structural dissociation of the personality.

Literature Review

The origins of DID: The dissociation of pierre janet

In the 18th century in Europe, the strange manipulations of F.A. Mesmer left no one indifferent, especially in France where he came to practice. Soon, in Paris, but also in the provinces, doctors or simply curious people tried to reproduce the same effects on their relatives or patients. This period saw a great development of hypnosis, and its therapeutic properties were soon discovered. An additional progress was made when doctors like Deleuze made the connection between magnetic trances and the symptoms of hysteria, the disease of the century that no one could yet explain.

While mesmerism or hypnosis sessions flourished in all regions, a revolution took place in people's minds when J.M. Charcot, the great neurologist of the Salpêtrière (Paris, France), reproduced these experiments himself and

succeeded in demonstrating that the trances of his hysterical patients were due to "ideas": at that moment, the parisian Academy of Sciences decided to take an interest in the link between hysteria and hypnosis.

It was in this atmosphere of enthusiasm for these new discoveries that the career of a young professor of philosophy, Pierre Janet, began. He volunteered to treat hysterical patients at the hospital in Le Havre (Normandy, France) and was the first to understand the relationship between hysterical attacks and hypnosis. According to him, hysterical and highly hypnotizable patients suffer from a dissociation of ideas and functions. More importantly, this dissociation is of traumatic origin. This fundamental discovery was published in his doctoral thesis in psychology, Psychological Automatism (recently translated into English).

In this work (and several earlier research articles) Janet (1889) explains for the first time that violent emotions, unbearable events, have the power to split the personality into two parts, a part that remains apparently normal (though depressed), and a part that is not accessible to consciousness, which contains the traumatic event and all its psycho-sensory-motor characteristics, also possessing the memory of the event [1]. This memory was thus recorded, but by detaching itself from the ego and from the individual's normal memory, it became subconscious (Janet coined the term).

The model created by Pierre Janet allowed him to explain, by grouping them together, numerous pathologies and behaviors that clinicians had not seen before him, such as: catalepsy, somnambulism, hysteria, automatic writing and speech, the behavior of mediums and spiritists. According to him, these manifestations can be explained by the intrusion into the subject's consciousness of dissociated parts of his personality: he will give more details in his doctoral thesis [2].

In formulating the modern model of traumatic dissociation, Janet also indicated a treatment aimed at reunifying the dissociated personality. This treatment would become the gold standard of DID treatment a century later [3]: the three-phase treatment, stabilization, reduction of traumatic memories, strengthening of the personality. Another major advance brought by the great clinician is to have explained hypnosis: according to him, this practice allows access to the traumatic memories of the patients, so that they can be reduced and above all, reintegrated into the normal personality and personal biography of the subjects. It follows that once the personality has been reconstituted, patients cease to be hypnotizable: it should be noted that since Janet, this definition of hypnosis is no longer widely used.

Schizophrenia, the dissociative continuum, and new critiques

Bleuler's schizophrenia and the dissociative continuum*:* In 1903-1904, E. Jung, who had just graduated from medical school, came to attend Janet's classes at the Collège de France and became very interested in the mechanism of dissociation, namely a failure of the subject's capacity for synthesis. He called this process a "loosening of associations". Back at the Burghölzli clinic, under the direction of E. Bleuler, the two doctors elaborated together a new vision of Kraeplin's dementia praecox. In his 1911 work, Bleuler defined schizophrenia as a disorder originating in a loosening of associations leading to a "Spaltung", which translators would eventually associate with Janet's dissociation [4,5].

The "dissociation" at work in schizophrenia met with worldwide success, and the entire international clinic soon adopted this new nosographic entity: Schizophrenia became the most studied psychiatric pathology of the 2h century, on all continents. However, the success of this model was at the expense of the dissociation of what Jung had already called "the French school": little by little, Janet's "dissociation of ideas and functions" was forgotten (even in his own country), and, as A. Moskowitz reminds us in 2005, the very term dissociation became irremediably associated with the schizophrenic process.

It was not until the 1960s and 1970s that psychology researchers took a renewed interest in the mechanism of dissociation. Researchers such as Spiegel and especially Hilgard proposed a new model of dissociation independent of schizophrenic disorders [6,7]. Hilgard called his theory neo-dissociation. According to this new approach, dissociation is a state of modified consciousness that takes place on a continuum that goes from normal to pathological. Altered states of consciousness such as absorption or day-dreaming are manifestations of normal, everyday dissociation, while the most intense cases can be considered pathological, such as dissociative fugue or, of course, multiple personalities.

It is by considering these innovative works that the main manual of world psychopathology, the DSM (Diagnostic and Statistical Manual) of the American Psychiatry Association, decided in 1980 to integrate dissociative troubles, of which the most representative at the time is the MPD (Multiple Personalities Disorder). Due to poor training of clinicians in this new disorder, it was renamed DID (Dissociative Identity Disorder) in 1994 in the DSM-IV version. Thus, the DSM nosography gives credit to the work of Pierre Janet, but without citing him. It should also be noted that for Janet, dissociation is traumatic in nature and does not exist in a "normal", non-pathological form.

Critics of neo-dissociation*:* The introduction of dissociative disorders in the DSM-III and their revision in the DSM-IV brought the concept of dissociation out of decades of neglect. Indeed, these publications encouraged hundreds of clinicians around the world to engage in research on dissociation and dissociative troubles. However, several authors were quick to note the limitations of the new definition [7]. One of these limitations is, for example, the identification of depersonalization and derealization as dissociative symptoms. As van der Hart and Dorahy note, these two concepts were also created by Pierre Janet, the author of the modern formulation of the concept of dissociation [8]. It turns out that for Janet, depersonalization and derealization are characteristic of depression, especially its severe forms with doubts, obsessions or compulsions. For these authors, the two symptoms should therefore be excluded from the dissociative picture.

This is why van der Hart, Steele and Nijenhuis produced a reference manual in 2006, The Haunted self, proposing a new vision of dissociation based on the early work of Pierre Janet: Structural Dissociation of the Personality (SDP). In this scheme, which has since been confirmed by functional brain imaging studies, a traumatic shock produces a fragmentation of the personality into two or more dissociated parts of the self. Primary dissociation produces an Apparently Normal Part of the personality (ANP) and an Emotional Part of the personality (EP), secondary dissociation produces one ANP and several EPs, and finally tertiary dissociation produces several ANPs and EPs. Each Emotional Part (EP) has its own sense of self, is inaccessible to the subject's normal consciousness, and is amnesiac of the other dissociated parts. According to the authors, the dissociative disorder thus defined encompasses not only DID, but also PTSD and other disorders of traumatic origin.

Structural Dissociation (SDP) is therefore a very serious disorder, with many comorbidities. The treatment recommended by the authors is also based on the work of Janet and describes the same three phases (stabilization, reduction of traumatic memories, reinforcement of the personality), while providing more practical details. Of course, the therapeutic arsenal may also include effective psychotropic medications, which Janet was not aware. Overall, the DID disorder currently categorized in the DSM-V corresponds well to the structural dissociation of van der Hart and colleagues, with the exception of the depersonalization/derealization symptoms, which are considered non-specific by these authors

For example, the presence of several alternating personalities is sometimes known by patients, and often reported by their relatives. The same is true for amnesia, which the patient generally

ends up noticing, for example when he finds his belongings in a place where he has no memory of having put them himself. A very old disorder also illustrates, quite well, the convergence between the SDP model and the DSM diagnostic categories, namely dissociative fugue: the patient suddenly finds himself in a place (possibly very far from home), without knowing how he got there. The dissociative fugue thus illustrates the switch between ANP and EP or between several amnesic EPs.

One problem: did patients are not just any patients

The severity of dissociative disorders such as DID or D-PTSD (PTSD of a dissociative nature introduced to the DSM-V in 2013) poses many challenges for identification and diagnosis [8,9]. Indeed, as the dissociated parts are amnesiac of each other, many times the patients themselves are unaware of what they are suffering from, and more often report other more common disorders. Depression, suicide attempts, phobias, insomnia, persistent pain or eating disorders remain the main causes of consultation for dissociative patients. It is therefore the practitioner's responsibility to detect the dissociative disorder beyond the patient's testimony, which is not easy. Most often, it is by comparing the patient's testimony with that of his or her relatives that the diagnosis can be inferred. In particular, the switch between ANP and PE or between multiple PEs is extremely difficult to observe in the consulting room [10]. This is because switches occur in the presence of specific triggers related to the subject's trauma, and these triggers are rarely present in the quiet, small office setting. According to some authors, patients consult mainly for distressing intrusions that alter their quality of life [11]. However, according to these studies, these unpleasant intrusions are tens of times more frequent than switches between dissociated parts of the personality.

It follows from these observational difficulties that cases of DID are primarily diagnosed in the hospital, and in a contingent manner. Panic attacks, violent outbursts, fugues with amnesia, or suicide attempts, for example, usually bring patients to the hospital for diagnosis and observation. Once DID or D-PTSD is diagnosed, these patients are followed in the day hospital and usually receive medication to help stabilize their condition: community practitioners do not see them again, or only at the end of their hospital follow-up. As a result of these situations, no more than 1.5% of patients in the city have DID or D-PTSD [12], whereas nearly 10% of them have DID or D-PTSD in medical facilities [13].

And yet, city offices are often visited by patients with symptoms apparently very close to structural dissociation. Thus, among the symptoms most often reported in the office, patients mention being divided, feeling torn between several parts of their personality, and even hearing an inner voice, either desired (as an advisor, for example) or - more often - unwanted (negative or threatening intrusion). An extremely important clue is that in all these frequent cases, the patient is fully aware of his or her divisions. He is the first to know the different parts of his personality, and the incompatible demands they make on him on a daily basis: rare are the cases of pathological amnesia, and the possible memory disorders observed remain within the range of normality. Today, these patients are poorly diagnosed and often undergo various treatments (psychological or drug) for many years, with no results. This is why it seemed interesting to us to relate these numerous clinical cases to a new diagnostic category, functional dissociation.

Functional dissociation: approach and origins

Symptomatology of functional dissociation*:* Several decades of practice in urban psychotherapy have taught us that many patients could be grouped together by the similarity and frequency of their characteristic symptoms: a functional dissociation. This new diagnostic category, based on field experience and long practice, would help both patients to better recognize their disorders and practitioners to better identify them in order to propose the most appropriate treatment [14]. Functional

dissociation can present itself with these characteristics:

1. Functional dissociation presents the same symptoms as structural dissociation: the patient feels fragmented, dissociated, and experiences several personality states all in conflict with each other,
2. During a functional dissociation, the ANPs and EPs remain conscious of each other, and no amnesia is observed between them,
3. Functional dissociation can be treated in the same way as structural dissociation (three-phase treatment), but more rapid treatments also exist.

Fragmentation of the ego, consciousness, or personality is indeed the symptom most often witnessed by patients in the city [15]. The patient painfully experiences these internal divisions, these contradictory tendencies, and is unable to resolve them alone. Their entire daily life is affected by this and, very often, it is impossible for them to make up their mind: they live for months or even years in indecision, doubt or ruminations. Of course, this functional fragmentation of the personality is most often accompanied by depression and other common disorders (insomnia, phobias, anxiety.): cognitive and behavioral disorders generally accompany functional dissociation.

The clinical picture is thus one of great suffering, not only psychological but often also physical/physiological, because the somatic symptoms are numerous (especially pain, but also motor, respiratory, dermatological and digestive disorders). It should be noted that because of the symptomatological proximity between structural and functional dissociation, the distinctions made by Van der Hart and his colleagues remain relevant, and the disorders can therefore be classified as psychoform and somatoform, positive and negative (Van der Hart et al., 1989). However, to avoid confusion, it will be preferable to speak of f-ANP and f-EP for the dissociated parts in a functional dissociation (rather than ANP and EP, as in a structural dissociation).

A pathology rooted in history*:* If functional dissociation is a pathology that is very characteristic of the beginning of the 21st century, where everything goes faster and faster, requiring individuals to adapt extremely quickly, it has analogies with disorders already identified at the beginning of the 20th century. In addition to being the father of modern dissociation, Pierre Janet had also conceptualized the notion of psychastenia. Similar to our current depression, Janet's psychastenia shares many properties with functional dissociation. Obsessions, doubts and ruminations are obviously part of it. Thus, the clinical picture is very similar, but one characteristic distinguishes them: for Janet, psychasthenia is a severe disorder with a mostly negative prognosis [16]. Among his clinical cases, the great practitioner shows that few patients manage to recover their health permanently. Most of them are forced to remain under observation for the rest of their lives, and have to return to the clinician regularly (from a few months to a few years). For Janet, this fatality could have several causes, including family heredity, a serious previous illness, persistent life difficulties, or as he liked to recall the inadequacy of the therapeutic approaches of his time.

The prognosis of functional dissociation is quite different: on the contrary, this pathology can be completely cured, sometimes in only a few sessions. How can this difference be explained? It goes without saying that the two nosographies are not absolutely identical: if doubts and ruminations are often part of the clinical picture, let us remember that the main property of functional dissociation is this fragmentation of the personality, this unbearable dissociation that patients complain about. Thus, identifying the patient's f-ANP and f-EP from the very first session allows the treatment to be drastically optimized. By making the right diagnosis, the clinician allows the treatment to be faster and more effective. Furthermore, the mobilization of several therapeutic tools that did not yet exist in

Janet's time obviously contributes to the success of the treatment.

The presence of dissociations at the heart of the personality had also been identified by a great theorist of human sciences: Gregory Bateson. At the end of the 1950s, the famous anthropologist, leader of the Palo Alto School, undertook to model Bleuler's schizophrenia using concepts from the world of communication (then just emerging). Surrounded by the first computer scientists and several psychiatrists, he conceptualized the notion of "double-bind" [17]. For him, dissociation or schizophrenia, therefore it can be explained by the fact that the child receives contradictory messages from his parents. For example, a father or mother constantly demands affection, but physically rejects the child when she/he approaches. The notion of double bind has many analogies with functional dissociation, as f-ANP and f-EP closely embody the paradoxical injunctions highlighted by Bateson and his colleagues. It differs, however, in one major aspect.

The main difference between Bateson's double bind and functional dissociation lies in the fact that a large number of patients present more than two dissociated parts. While some clinical cases have only one f-ANP and one f-EP, more often patients have several f-EPs. All these dissociated parts emit contradictory and incompatible signals. Often embodied by imaginary characters or by relatives from the patient's childhood, these functionally dissociated parts make daily life unbearable for the subjects by demanding behaviors that are impossible to reconcile. Bateson's double-bind has not had the posterity it deserved in the psychiatric field: one reason is perhaps this limitation to two paradoxical injunctions. Why not three, four, or more? In reality, our long clinical experience tells us that contradictory messages are often more numerous than two, which is why, within the functional dissociation model, we propose to integrate the notion of double bind (Bateson), but also triple-bind, quadruple-bind and finally n-uple-bind. These multiple constraints perfectly illustrate the functional dissociation of patients into as many f-EPs as insurmountable paradoxical injunctions.

Treatment approach for functional dissociation

The symptoms of functional dissociation touch on the cognitive, behavioral and social spheres, and generally integrate numerous sensorimotor or somatic manifestations in the broad sense. This is why the treatment offered to patients must itself include all the therapeutic facets likely to respond to these complex problems [18]. Historical therapies, which were based primarily on speech, have already demonstrated their limitations in cases of traumatic dissociation such as DID or D-PTDS. Similarly, their relevance remains modest in cases of functional dissociation: indeed, most patients already have a long history of drug or psychotherapeutic attempts that have ended in repeated failure. From this point of view, the most suitable approach is a semi-verbal or non-verbal approach, based fundamentally on the relationship between the body (and the brain) and the mind.

Previous work Mayer has allowed us to present the TICE© (Integrative Mind-Body Therapy), an approach that has been developed and completed over the past several years, the result of a long practices [15]. TICE© is part of the integrative psychotherapies that mobilize deep physiology and neurology to act directly at the source of the problems. Several studies have shown that similar approaches, such as EMDR, Brain spotting, or CBT, bring significant relief to patients. This type of approach is called bottom-up because of its anchoring in the patient's neurophysiology: by allowing direct access to the subcortical areas of the brain, the seat of emotions and traumatic memories, an integrative mind-body approach is the most suitable tool for treating functional dissociation in depth. New developments in the TICE©, which has already been validated for a long time, already allow us to think that, more specifically, a limbic focus therapy, or limbic therapy, is particularly indicated for the treatment of dissociative disorders, and in particular of functional dissociation. Integrative therapies with a neurophysiological approach, of which the TICE© and limbic therapy are part, have the particularity of preserving the patient's total

freedom: being non-verbal (or semi-verbal), they do not induce any suggestion, and allow the patient to freely choose his or her own path to recovery. This "hypnosis without hypnosis," as I have previously called it Mayer [16], brings out the f-EPs from the first session. The f-EPs are stuck in the trauma past and unable to extract themselves from it: by identifying the neurophysiological states associated with each of them, an integrative therapy (and in particular TICE© and limbic therapy), has the immediate effect of releasing the energy trapped in the past and making it available to the patient to relearn how to live again without anxiety, pain and insurmountable doubt [17,18].

Functional dissociation is often based on a faulty relationship with the past: during the practical sessions, the patient is invited to feel the parts of his or her body that are related to his or her physical or psychological suffering, within a benevolent and protective alliance. Focusing on the here and now mobilizes the autonomic nervous system and creates an opening to move beyond the traumatic past [19,20]. From this point of view, the polyvagal theory of S. Porges can be an effective ally: by activating the ventral vagal pathway to the detriment of the dorsal vagal pathway, the patient's social behavior will be able to overcome both attachment disorders and developmental disorders. In the end, the treatment of functional dissociation produces a result similar to that of structural dissociation: the patient's f-EP is integrated with the f-ANP, and the whole forms a unified personality, stronger, and capable of forming new life projects [21-23].

Conclusion

The notion of functional dissociation is the result of a long clinical experience and several decades of psychotherapy practice. Close to Pierre Janet's psychasthenia and Bateson's double-bind, this new notion also achieves a synthesis of the concepts of dissociation formed by Janet and then Van der Hart and colleagues. By accrediting these great predecessors, functional dissociation aims at better specifying the diagnosis of all patients, thus allowing the practitioner a more efficient approach and the patient, a deeper and faster recovery. We hope that the concept of functional dissociation will help both patients and clinicians to implement these therapeutic resources for well-being.

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