

UNRESOLVED PROBLEMS IN THE THEORY OF STRUCTURAL DISSOCIATION

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Introduction

The theory of structural dissociation is designed to account for complex dissociative disorders and posttraumatic stress disorder (PTSD) (Nijenhuis 2014; Van der Hart, Nijenhuis, & Steele 2005, 2006). With a minor modification, it could account for a much wider range of psychopathology (Ross 2013). There are several unresolved problems in the theory as recently enunciated by Nijenhuis (2014) that require further attention.

Additionally, Nijenhuis faces a problem concerning the audience for his philosophical analyses of the foundations of structural dissociation theory, the reasons why PTSD should be classified as a dissociative disorder, while depersonalization-derealization disorder (DD) should not, and related matters. For some clinicians, these logical arguments will seem like arcane medieval theology; they will not persuade those clinicians of anything, and may make them believe that structural dissociation is of “philosophical” interest but not of any clinical interest. Clinicians have been Nijenhuis’ primary audience, so this is a problem in and of itself. However, it is not a logical problem with the theory, so will not receive further consideration here.

The problems to be addressed in the present paper are:

1. How rudimentary can an emotional personality (EP) be and still qualify as structural dissociation? Do all cases of PTSD have an EP?
2. Should only structural dissociation be regarded as true dissociation? If yes, should dissociative amnesia be classified as a dissociative disorder?
3. Is depersonalization-derealization disorder (DD) an example of structural dissociation?
4. What other disorders could be based on structural dissociation?

Although there are a variety of philosophical problems that are relevant to the theory of structural dissociation and its foundations (Nijenhuis 2014), the primary approach here will be pragmatic and clinical.

1. How rudimentary can an emotional personality (EP) be and still qualify as structural dissociation?

According to the theory of trauma-driven structural dissociation of the personality, the primary configuration in PTSD and complex dissociative disorders is the existence of an apparently normal personality (ANP) and a dissociated emotional personality (EP). The ANP maintains executive control most of the time and carries out daily adult functions. The EP spends

most of its time not in executive control, but takes over intermittently when there is a switch of executive control, which occurs in dissociative identity disorder (DID) during periods for which the ANP has amnesia. In PTSD, the EP can take full executive control during a flashback in which orientation to the present is lost, and the person is in a full reliving of prior trauma. An EP is a psychological structure that is a separate, dissociated biopsychosocial subsystem of the whole person, with its own sense of subjective selfhood.

The EP holds the feelings and memories of the trauma and the mammalian defensive reactions related to it, including fight, flight, and freeze or tonic immobility. Rather than full switches of executive control between the EP and ANP, there can be intrusions into the ANP from the EP. Such intrusions can include thoughts, feelings, memories, partial motor control, or any other psychic phenomenon. Inversely, there can be withdrawals out of the ANP into the EP, resulting in amnesia, conversion symptoms, numbing and related symptoms.

The theory of structural dissociation fits DID perfectly; about that there is no controversy in the literature. Several questions arise, however: 1) how rudimentary can an EP be and still qualify as an EP? 2) how would the differentiation between the most rudimentary EP and the most complex, non-EP dissociated part of the self be made, either clinically or in research studies? And, 3) why is it essential to the theory that EPs have a subjective sense of selfhood?

Nijenhuis (2014, p. 79) states that an EP must have a sense of subjective selfhood, which he defines in terms of a number of philosophical properties of an EP, that it has: a first person perspective (FPP); a quasi-second person perspective (QSPP); a second-person perspective (SPP); and a third-person perspective (TPP). The FPP is the basic sense of self-existence; the QSPP is a second-order sense of sense involving I-me-mine relationships; the SPP is an I-you relationship where the other person is perceived as a human being; and the TPP involves perceiving the other person as more of an inhuman object for abuse or neglect. In full DID, an EP can have all these perspectives concerning both outside people and other EPs and ANPs.

In order to establish that an EP has these properties, one would have to engage it in conversation, and the EP would have to be capable of forming complete sentences; simple repeated phrases would not be sufficient. In full DID there are often EPs and ANPs whose existence is unknown early in therapy, both to the therapist and the ANP participating in the therapy. This is not a diagnostic problem if at least one full ANP and one full EP has been identified, which is always the case by definition if the diagnosis is DID.

In any other disorder, however, such as simple PTSD, the therapist may not have had direct contact with an EP because the EP is in executive control only during full flashbacks or abreactions. In this situation, the therapist cannot establish that the EP has the properties required by Nijenhuis' definition, therefore the therapist cannot establish that the PTSD is a dissociative disorder based on structural dissociation. This doesn't make any practical difference because the DSM-5 criteria for PTSD (American Psychiatric Association, 2013) don't require the presence of structural dissociation, but it is a problem for the theory.

In cases of PTSD where an EP has not been encountered, a therapist could assume the existence of an EP based on the symptoms, but this would be tautological. The more serious problem, however, is, what is the threshold for a dissociated part qualifying as an EP? Nijenhuis requires the existence of an EP in all cases of PTSD so that PTSD qualifies as an example of

structural dissociation. But how could one establish, clinically or in a research setting, that this is true in all cases of DSM-5 PTSD?

Clinically, in simple PTSD, a person having a flashback does not identify himself by a different name or age, does not claim to have different hair color, a different gender, to be non-human, or to experience the features of a full EP such as one encounters in DID. Presumably we can agree, then, an EP in a case of simple PTSD is more rudimentary than a fully formed EP in DID. But this does not answer the threshold question: how rudimentary can an EP be and still qualify as an EP? An additional problem is the fact that the DSM-5 criteria for PTSD do not require flashbacks: would a case of DSM-5 PTSD without flashbacks be based on structural dissociation? If yes, how could the structural dissociation be demonstrated?

The Nijenhuis (2014) definition of an EP seems to require a threshold that cannot be proven empirically in a research setting. Nor can the threshold problem be resolved clinically in many cases. This is not just a minor technical detail, or a quibble, because Nijenhuis requires a threshold for the definition of an EP in order to maintain specificity for the theory of structural dissociation:

If it would be said that agoraphobia includes dissociative parts, few mental disorders would not be dissociative. The concept of dissociative parts thus needs constraints to serve specificity. The best delimiter is the requirement that dissociative subsystems of the personality involve their own FPP, QSPP, SPP and TPP, because it is this phenomenon that distinguishes patients with dissociative disorders from mental healthy individuals, patients with other mental disorders, and patients with 'ego-states' (p. 79).

It is unclear what the difference is between an *ego state* and a rudimentary EP. One could argue that unless it is a rudimentary EP, a part of self should not be called an ego state. This is the threshold problem, and Nijenhuis does not appear to have solved it.

In any case, why is specificity an important requirement of structural dissociation theory? I can see that Nijenhuis might not want to be accused by skeptics of over-generalizing his theory, but what if structural dissociation does occur broadly throughout the DSM disorders? Why should we not allow that theoretically? Indeed, Ross (2013) has argued that dropping the requirement that all dissociated parts of self must meet the *FPP, QSPP, SPP and TPP* criteria, broadens and deepens the theory of structural dissociation, unifies the extensive comorbidity common in DID into a single structure and process, leads to an integrated treatment plan for a broad range of symptoms, and is consistent with Occam's razor, or the principle of parsimony. If the theory was broadened in this way, then the threshold problem would disappear. A dissociated part of self that held an impulse, affect, thought, sensation or perception could still intrude into the ANP, therefore flashbacks in simple PTSD would fit both the DSM-5 criteria and the theory of structural dissociation in all cases.

I don't see the logical, philosophical or theoretical necessity of setting a threshold. Nor do I see the clinical utility. Why can't some dissociated compartments hold full EPs or ANPs, some partial or near-threshold EPs, and others just a memory without there being a full EP?

The question of how rudimentary an EP can be and still qualify as an EP is difficult if not impossible to answer empirically. But why does it matter? Why can't dissociation without an

EP still be structural dissociation? Speaking metaphorically, some structurally dissociated boxes hold an EP and some don't – why can't that be true? Why does the theory of structural dissociation have to require a full EP? Couldn't it be modified or expanded like any other scientific or clinical theory?

Alternatively, we could continue to require the existence of an EP for structural dissociation to be in place, but allow non-EP dissociation to exist, and allow it to be called non-structural dissociation. This option will be considered further below.

Nijenhuis (2014) seems to disagree with the requirement that only complex dissociative disorders and PTSD are examples of structural dissociation:

The concept of 'distinct personality states' in DSM-5 involves an exaggeration that hinders to see or accept the fact that several other mental disorders also involve conscious subsystems or parts that are insufficiently integrated. PTSD is one of these (p. 80).

“Several other mental disorders. . . PTSD is one of these”. . . Which DSM-5 disorders does Nijenhuis have in mind, besides PTSD? If there can be several, why not more than several? Adhering to the requirement for a full EP in all cases of structural dissociation, and limiting the structural dissociation-based diagnoses to PTSD and complex dissociative disorders is easy at the level of theoretical definition, but much trickier to sustain clinically.

2. Should only structural dissociation be regarded as true dissociation? If yes, should dissociative amnesia be classified as a dissociative disorder?

If only structural dissociation is true dissociation, and if structural dissociation requires at least a rudimentary EP, then it seems unlikely that cases of simple dissociative amnesia qualify as true dissociative disorders. This is a big problem historically, politically, clinically and empirically. Dropping dissociative amnesia from future editions of the DSM would require overcoming massive resistance. Such a dramatic change would require substantial empirical evidence by DSM rules. How could that evidence be gathered?

DSM rules specify that disorders cannot be added or dropped without conclusive empirical evidence. This is why lobbying to drop DID from DSM-5 was unsuccessful: there was no empirical foundation for such a change. Significant changes to DSM should not be made based solely on a theory, no matter who agrees with it, or how persuasive it is clinically.

Even if empirical research could demonstrate that there are no EPs in most cases of simple dissociative amnesia, most clinicians, I imagine, would not see this as a reason to drop dissociative amnesia or move it to another section of the DSM. Where would it be moved to, adjustment disorders? Perhaps, but then why can't some adjustment disorders be dissociative disorders? If they are, they should be in the dissociative disorders section. How could dissociative amnesia be empirically proven not to involve an EP? And, in any case, why should this requirement of structural dissociation theory be accepted by the field as a whole?

The basic problem is that the requirement to divide what is now called dissociation into true structural dissociation and something else that needs a different name, is not compelling to many

or most experts in dissociative disorders. It seems more legislative in nature than scientific. If this requirement was enacted by the field as a whole, DSM-5 would have to be drastically revised, all measures of dissociation would have to be drastically revised, and the empirical foundation of the dissociative disorders field would be dismantled. All the research would have to be redone, with only structural dissociation allowed into the measures and the DSM. This just isn't going to happen. The inevitable massive institutional resistance to such drastic change could in turn generate resistance to the theory of structural dissociation.

In any case, amnesia correlates highly with all other elements of what is currently measured as dissociation. It hangs together scientifically and statistically with depersonalization, derealization and identity alteration (switching between EPs and ANPs). Why should a theory over-ride the empirical literature?

If the EP requirement was required by the field as a whole, then the symptom of dissociative amnesia would be based on structural dissociation in cases of DID, but on some non-dissociative mechanism in simple dissociative amnesia, which would no longer be called dissociative amnesia. This would mean that symptoms were being categorized based on hypothesized structures and mechanisms that had not been demonstrated empirically.

In medicine, it is common for the same symptoms and clinical syndromes, such as congestive heart failure, to have multiple causal pathways. Why should we call a clinical picture congestive heart failure only when the etiology is a primary cardiac problem, and not when it is based on a primary pulmonary problem? The symptoms are the same. The requirement that only structural dissociation should be called dissociation seems to be inconsistent with general medicine. This is true no matter what the philosophical arguments about qualia or FPP, QSPP, SPP and TPP criteria.

Proposing that only full-EP structural dissociation should be called dissociation seems to be a semantic requirement. What if we agreed that dissociation is the superordinate category, and that it includes both structural dissociation and non-structural dissociation? Then structural dissociation would be specified and limited, at least in theory, and non-structural dissociation could await future clarification and delimitation. This would be an evolutionary rather than a revolutionary change in the field, would be more clinically palatable, and would foster easier acceptance of the theory of structural dissociation.

The problem is not that there are errors in Nijenhuis's (2014) philosophical thinking. The problem is more like a difficulty in translational research: it's not that the laboratory findings are wrong, it's a problem with translating them into the clinical arena, which contains a lot of uncontrolled variables and a lot more complexity than were accounted for in the laboratory. In this analogy, Nijenhuis' philosophical thinking takes place in the laboratory.

3. Is depersonalization-derealization disorder (DD) an example of structural dissociation?

This is a more complex question than the one concerning dissociative amnesia. As for dissociative amnesia, we have to decide whether all, some or no cases of DD are based on structural dissociation. If we decide, all or none, then there is no problem. Once we decide

that some cases are based on structural dissociation, but not all, then the problems discussed in the preceding two sections arise automatically. In DD, however, there are three possible configurations, to my way of thinking: no EP; one ANP and one EP; and no EP with two ANPs. Once there are multiple ANPs and EPs then a complex dissociative disorder is in place, structural dissociation applies, and there is no controversy. The DD then becomes part of a more complex dissociative disorder. The configuration of two EPs with no ANP could occur in theory, but no one has provided a clinical example of that, to my knowledge.

In my view, DD is based on two ANPs or one ANP and a buried EP. In the two ANP configuration, there is the prior executive self who has been disconnected and buried, and a new, disconnected, floater ANP who is depersonalized. The new ANP feels like he has lost the old self with all its emotional connections. The properties of FPP, QSPP, SPP and TPP are in place, but they don't seem real: the life has been taken out of them through a structural dissociation-based withdrawal. For this to be an example of structural dissociation, however, the no EP/two ANPs configuration must be allowed, and the requirement for an EP must be optional.

The floater ANP in DD may know intellectually that he is the same person, and may not talk about the prior ANP as a separate person, but that does not necessarily mean that there is no structural dissociation. Careful interviewing of the floater ANP, reversal of the structural dissociation, and a subsequent careful interview of the prior ANP would be required in order to decide if this was structural dissociation. One might say it was structural dissociation with lack of insight.

This is not just a theoretical matter. If many or most cases of DD involve two ANPs, then the plan of therapy should be based on structural dissociation, with a variety of strategies to create co-consciousness and inter-personality communication and cooperation between the two ANPs. The same would be true in the one EP/one ANP configuration. If there is no structural dissociation, then it is hard to see how treatment strategies derived from the DID literature could be helpful.

In treatment-resistant cases of DD, how would one decide whether a hidden EP or ANP was not present? Could one use techniques from the hypnosis or hidden observer literature? Would experimental challenge paradigms or subliminal cue paradigms be capable of settling the matter? It seems likely to me that in rigid two-ANP systems, with high treatment resistance, it may never be possible to contact the prior self. Why should we conclude that there is no second ANP? Why should we decide that there is? It's hard for me to imagine how there cannot be some kind of buried, disconnected, dissociated prior self, whether it is active or quiescent. I imagine that in a successfully treated DD, most of the time the person would feel like he has been gone and is now back.

This is reminiscent of combat veterans with PTSD. It is common for family members to say that the person who went over to Iraq or Afghanistan never came back, even though the body came back. Where is that missing person, if not buried inside? I once interviewed a case of dissociative fugue while the person was still in the fugue: the fugue personality spoke about the prior personality as if he was a separate person, and vowed to beat him up if he ever came back and tried to take over the marriage. This was clearly a second ANP. In other fugue cases, the fugue identity is much more rudimentary, however, which brings us back to the question of

how rudimentary an EP can be. The same question applies to a second ANP. In classical DD, however, the prior ANP cannot be rudimentary because he previously functioned as a full ANP. Only the second ANP could be rudimentary; in most, if not all cases of DD, the new ANP is very rudimentary in terms of its sense of personal reality, by definition.

Nijenhuis (2014) describes many sexually abused adolescents in a manner that makes them seem like they have structural dissociation in place:

Adolescents who experienced physical and/or sexual maltreatment, whether emotionally neglected or not, reported significantly more symptoms of PTSD, dissociative amnesia, depersonalization and derealization, negative mood, and anhedonia than adolescents who experienced only neglect. (p. 85).

Given this description by Nijenhuis, why would we not assume that the DD is part of the structural dissociation? Why would we assume there are two mechanisms or psychological processes at work? Again, this violates Occam's razor.

As might be expected, patients with depersonalization and derealization in addition to the standard PTSD symptoms that include positive dissociative symptoms report more dissociative symptoms than patients without serious depersonalization and derealization symptoms (p. 86).

Sometimes DD seems to be part of structural dissociation and sometimes not: for example Nijenhuis characterizes the ANP in cases of structural dissociation as being, "Emotionally numbed. Bodily numbed. Depersonalized. Focused on wills of daily life." (p. 90). These are examples of somatoform dissociation based on structural dissociation, according to the theory.

The arguments for why and when DD is and is not based on structural dissociation are not compelling or conclusive, in my opinion, and need more attention.

The same problem applies to the biological similarities between PTSD and complex dissociative disorders reviewed by Nijenhuis (2014), for example reduced hippocampal volume. Reduced hippocampal volume is not specific to PTSD or dissociative disorders and can occur in schizophrenia and depression. Does this mean that some cases of schizophrenia are based on structural dissociation, or does it mean that the brain change is not specific to structural dissociation? When hippocampal volume is reduced in schizophrenia, is this due to the endogenous biology of the schizophrenia, or to trauma the person has experienced? Can some of the schizophrenia have been caused by the trauma? Why yes, and why no?

This brings us back to the question: how widespread can structural dissociation be in the DSM or ICD? Should we re-diagnose cases of schizophrenia with structural dissociation as dissociative disorders, or say that some cases of schizophrenia can be based on structural dissociation? How does the theory of structural dissociation provide answers to these questions, other than by legislation or convention?

In my view, the theory of structural dissociation is a significant contribution to the mental health field, but it is not perfect and should not be regarded as immutable. It should be subject to modification and refinement, by its original developers and others, just like any scientific theory.

Abstract

Key words: theory of structural dissociation, PTSD, dissociative disorders, dissociation of the personality

The author discusses a series of unresolved problems in the theory of structural dissociation as enunciated by Nijenhuis (2014). These include: 1) how rudimentary can an emotional personality (EP) be and still qualify as structural dissociation? Do all cases of PTSD have an EP?; 2) should only structural dissociation be regarded as true dissociation?; If yes, should dissociative amnesia be classified as a dissociative disorder?; 3) is depersonalization-derealization disorder an example of structural dissociation?; and, 4) what other disorders could be based on structural dissociation? Although the theory is an important contribution to the mental health field, it should not be regarded as complete or immutable.

References

- American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders, fifth edition DSM-V*. American Psychiatric Publishing, Washington D.C./London.
- Nijenhuis ERS (2014). Ten reasons for conceiving and classifying posttraumatic stress disorder as a dissociative disorder. *Psichiatria e Psicoterapia* 33, 1, 74-106.
- Ross CA (2013). *Structural dissociation. A proposed modification of the theory*. Manitou Communications, Richardson, TX.
- Van der Hart O, Nijenhuis ERS, Steele K (2005). Dissociation: An insufficiently recognized major feature of complex PTSD. *Journal of Traumatic Stress* 18, 413-425.
- Van der Hart O, Nijenhuis ERS, Steele K (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization*. Norton, New York.

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