Historical, Scientific and Clinical Perspectives on Complex PTSD and other ICD-11 Trauma Related Disorders

Friday 28 January 2022
09:00-17:05

Speaker Biographies and Abstracts

Conference Chairs
Dr Gordon Barclay, *CRM supervisor and trainer, Honorary Clinical Senior Lecturer, School of Medicine, Glasgow University, UK*

Dr Gordon Barclay, MA, MBChB, DRCOG, MRCGP, MRCP, MPhil, MRCPsych, PGDiploma in CAT, CRM supervisor and trainer, honorary clinical senior lecturer at Glasgow University, retired from the NHS in 2019 from his dream job in Argyll as a consultant general adult psychiatrist to pursue his interest in training and supervision, and works in private practice in Glasgow.

He has a special interest in the treatment of trauma and dissociation, supervises five regular monthly groups in the UK and Europe focusing on the treatment of psychological trauma, holds regular trainings in CRM (www.comprehensiveresourcemodel.com), and runs a workshop entitled "Introduction to Working Relationally with Dissociation/Towards a Dialectical Self".

Gordon is also passionately interested in education in general psychiatry, believing it vital that we remain confident enough to encourage the robust debate so essential for change and progress within our discipline, and vigilant enough to guard against whatever might oppose the tolerant Popperian spirit which makes such progress possible.

Dr Nuri Gené-Cos, *Consultant Psychiatrist and Head of the Trauma and Dissociation Service*

Dr Gené-Cos is the lead Consultant Psychiatrist for the Trauma and Dissociation Service specialising in the assessment and treatment of psychological trauma-related conditions including PTSD, CPTSD and Dissociative Disorders.

Dr Gené-Cos is an EMDR therapist (Eye Movement Desensitization and Reprocessing); Sensorimotor Psychotherapist and Lifespan Integration Therapy (LI) Consultant.

She has presented at national and international conferences and workshops on a series of topics including PTSD, CPTSD, borderline personality disorder and brain electrophysiology in relation to anxiety disorders.

Dr Gené-Cos completed her Doctor of medicine and surgery, LMC (MD) degree in 1981 at Autonomous University of Barcelona, Spain. Moving to London, she trained in adult psychiatry and neuropsychiatry at Charing Cross Hospital. She is a fellow of the Royal College of Psychiatry.

She became interested in the area of post-traumatic stress disorder while doing her doctorate as a lecturer at the Royal London Hospital. She was appointed as a consultant psychiatrist at the Traumatic Stress Service in 2002.

She completed her PhD in 2009 at the University of London in Mismatch Negativity (MMN) in anxiety disorders (brain electrophysiology in, PTSD, NES, epilepsy and panic disorder).

The relevance of dissociation to the diagnosis of Schizophrenia: A secret history

Professor Andrew Moskowitz, *Professor of Psychology, Touro College, Berlin, Germany*

As is well known, Eugen Bleuler renamed, in 1908, Emil Kraepelin's diagnosis Dementia Praecox as Schizophrenia. The name has stuck, but its literal meaning as 'split mind' has been a thorn in the side of many, who have been at great pains to dispel public confusion between Schizophrenia and Multiple Personality Disorder (now known as Dissociative Identity Disorder). While no one contends that these are the same disorder, there are at least three robust connections between schizophrenia and dissociation that have been regularly minimized, if not completely ignored, over the past several decades. They are: 1) the central role of dissociation (renamed 'Splitting') and 'complexes' (trauma-driven divisions of the personality) in Bleuler's concept of Schizophrenia; 2) the dissociative nature of most of Kurt Schneider's 1st rank symptoms of Schizophrenia, central to the diagnosis of Schizophrenia for most of the

past 50 years, and 3) the overwhelming clinical and empirical evidence that many psychotic symptoms, particularly voice hearing, are traumatic in origin and dissociative in kind. All of these issues will be discussed in this talk.

Andrew Moskowitz, Professor of Psychology at Touro College Berlin, is a world-renowned expert on the relationship between psychosis, trauma and dissociation. First editor and the major contributor to the award-winning 'Psychosis, Trauma and Dissociation' (Wiley, 2008, 2019), Prof. Moskowitz has worked for the past 25 years to build mutual understandings between the fields of trauma/dissociation and psychosis/schizophrenia, publishing regularly in both trauma/dissociation and psychosis journals and presenting at both psychosis-and dissociation-related conferences. He is a past president of the European Society for Trauma and Dissociation (ESTD), and a former executive board member of the International Society for Psychological and Social approaches to the Psychoses (ISPS), as well as an associate editor of the European Journal of Trauma and Dissociation. Prof. Moskowitz was the first to propose that auditory verbal hallucinations, or voice hearing, be considered essentially dissociative in nature, and has written extensively on the historical connections between dissociation and the diagnosis of Schizophrenia. He has also focused on issues of diagnosis and differential diagnosis and was a key player in developing the ICD-11 dissociative disorder diagnoses.

Neuroimaging Trauma-related Dissociation: providing evidence for the trauma-dissociation relationship and clinical relevance

Dr Simone Reinders, *Senior Research Associate and* Trauma-related Dissociation Research Group Lead*, IoPPN, King's College London, UK*

The learning objectives of Dr Reinders' presentation:

1. Explain how objective brain imaging data can inform the debate on the aetiology of DID.
2. Describe how structural brain imaging can aid an earlier diagnosis and therefore has clinical relevance.
3. Evaluate the evidence for biomarkers for pathological dissociation

Dr A.A.T. Simone Reinders is a leading neuroscientist and international expert in the neurobiology of trauma-related dissociation and the brain imaging correlates of Dissociative Identity Disorder (DID). Simone studied Applied Physics and Artificial Intelligence and obtained her doctorate in

Medical Sciences with the highest Dutch distinction Cum Laude at the University of Groningen, Netherlands. She received the most prestigious grant for young investigators, which allowed her to successfully lead a multi-centre neuroimaging project.

Simone's pioneering research showed identity-state-dependent blood-flow patterns in the brain of individuals with DID. Follow-up research showed that these patterns cannot be simulated and that DID and PTSD share trauma-related neurobiomarkers. This significantly advanced understanding of brain function and structural brain abnormalities in DID.

Simone is currently working as a Senior Research associate at the IoPPN of King's College London, UK, where she leads the Trauma-related Dissociation Research Group. Her most recent work addresses DID-dismissive perspectives using brain imaging [1] and reveals the CA1 area of the hippocampus as biomarkers of dissociative Amnesia in DID [2].

Simone is Chair of the ENIGMA-Dissociation Working Group. This year she was awarded a Mid Career Achievement Award from the ISSTD.

Twitter: @AATSReinders
Websites: www.neuroimaging-DID.com
[1] Reinders AATS and Veltman DJ. Br J Psychiatry 2020: 1–2.
[2] LI Dimitrova, et al. and Reinders AATS. Neurosci Biobehav Rev 2021.

Learning from our patients/experts by experience
Experts: Anne, Amanda and Rachel

Anne:
I had pain in my legs and felt there was a connection between this and my head. I was not aware of being anxious and overwhelmed. I was given a diagnosis of FND.

Due to the impact of my symptoms, I saw a therapist. In my presentation I will discuss my therapy assessment and the subsequent treatment.

The early stages of therapy involved education and building a timeline, as well as grounding techniques. I recorded thoughts and sensations, which was difficult as I was unfamiliar with my feelings. I became aware of triggers, what my responses were and how to get my body back into the window of tolerance.

My timeline brought me back into my memories, leading to fitful sleep and dreams. Several of my dreams following treatment were very significant to me.

Thinking of myself as an onion, it is as if layers were carefully removed at a pace that I could work with, receiving insight with minimal pain.

Amanda:
My first realisation of mental health was at 13yr old, brought to the surface by being bullied. For 40 long hard suicidal years I struggled, going to psychiatrist, psychiatric nurses , CBT, day patient at mental health clinics , diagnosis of severe clinical depression, psychosis, bipolar, being told ECT was the answer, to the last diagnosis of you have to learn to live with it just like a diabetic lives with diabetes, so at this point we sold up and moved from Yorkshire to Kintyre to see if a quieter life would help.

This is where I met Dr B, and at my first meeting I told him my story and begged for help to manage my illness so I could try live some sort of life, his reply was what if I can make you better!!!!.

After going round in circles for 40 yr NOBODY had said this.

So my journey began

First of all to be able to understand about how trauma & dissociation affects you is vitally important as you realise why you have these problems, which starts you thinking yes that's why I feel like that today, the younger me from the past is in trauma.

Being grounded in today it is equally important to be able to think correctly that it's the past and being able to understand it's coming from the younger you, which then enables you to connect with that younger you to help "heal" their trauma. To gain the ability into this way of thinking you start to realise "I don't feel right" and connect this to a past trauma immediately, this in turn gives you strength and confidence to help the younger you.

Also throughout this process you gain a better understanding of you as a person and why life has been this way for you and how you can change it to live a life without trauma and dissociation, because you begin to rationalise the thoughts & feelings are from the past which undoubtably gives you courage & strength to help the younger you.

Rachel:
Hello, I am one of Dr Gordon's patients (or should I say Expert by Experience as he has endearingly titled us?) The experience which began my journey was what I later understood to be a sudden onset collapse of protective dissociative barriers. I had been working, living and apparently well. Then over the course of a week my well being dissolved completely, I had to leave work and would not return for six months.

My symptoms began with vivid traumatic flashbacks which consumed every waking moment, gnawed at me in the space between consciousness and unconsciousness and devoured me whole through dreams. I existed mostly in a catatonia punctuated with short bursts of hysterical emotion, at least that how those around me described it. This time is now hard for me to recall. I spent six months in this state.

Early on in the process I found myself at the local mental health resource centre attempting to describe what I was experiencing. The traumatic memories up until that point of collapse were entirely inaccessible, so I told the nurse I was remembering things that never happened. I was remembering the physical feeling of paralysing terror, I was remembering forgetting and forgetting remembering. Nothing made sense. I was suffering psychosis, I told her.

Nurse was pleasant, not so sold on my psychosis diagnosis, and she asked me to wait while she spoke with the psychiatrist to see if he could see me quickly in between patients before I left, which he did, and I was also put on the waiting list (a waiting list which ended up being 8 months long). The psychiatrist agreed to see me quickly, I went through the same process with him. He seemed most bemused by me, asked repeatedly if I had "other partners" that aren't my wife, stated psychosis was a large word and enquired as to where I had learned it, finished the conversation by asserting that I likely had brain damage from my mother's hard labour and a result of that a "sensitive" brain which would be prone to strange ideas. "You'll be fine, do refrain from too much TV" he concluded.

Now when I tell you I skipped out of that office you must believe me. I was so elated to have someone tell me the memories where not real and also not indicative of more sinister things to come. The relief. However that relief did not last long at all, and the symptoms persisted. I sat with them for months. I found small gaps amongst my new wall staring habit to frantically ask google what was wrong with me. Eventually I came across the term dissociation and something clicked into place.

With massive trepidation I approached Frank Corrigan's team for consultation. Dr Gordon was rather quick to identify the experiences I shared as ones of a dissociative nature. As we moved through treatment my intellectual understand of what was happening improved. The existential questions I faced remain: "Do I know who I am?" "Will the fabric of my own reality ever again feel within my grasp?" "Can I live with such uncertainty?" The weight of these questions were made less crushing by Dr Gordon's repeated assertions that is was an 'adaptive, protective response' and completely normal'. The first time he told me this I was appalled by his audacity, as I considered the freak show which resided at the intersection between my nervous system and psyche to be repulsive. However, by the 15th time and after much CRM, DBR and IFS I could adopt some of his compassionate view on the issue. This compassionate view proved to be vital for treatment, the nature of dissociative symptoms are so disorienting, they feel like such an acute form of self abandonment, self harm. If I had not had these specific symptoms addressed directly, spoken into the world, contextualised, affirmed I would never have found the space to hold compassion for those parts of myself that felt so not myself.

Symptoms and background neuroscience in Complex PTSD, illustrated with clinical cases

Dr Nuri Gené-Cos, *Head of Department and Lead Clinician, Consultant Psychiatrist and Trauma Therapist, Trauma and Dissociation National Specialist Service (TSS), Maudsley Hospital, London, UK*

Overview of presentation:

- Using the three stage model for treating complex clinical presentations with PTSD. The presentation will focus on stage one treatments identifying neurobiological models which can help with emotional regulation.
- The importance of understanding reactivity versus responding, and engaging the frontal lobe to advance trauma therapy.
- Modalities of treatment in complex cases.

The clinical relevance of seeing common CMHT presentations through an ICD-11 lens

Dr Gordon Barclay, *CRM supervisor and trainer, Honorary Clinical Senior Lecturer, School of Medicine, Glasgow University, UK*

ICD-11, released on the 18th June 2018 and presented at the World Health Assembly in May 2019 for adoption by member states, will have come formally into full effect by the date of our colloquium on 28th January, 2022, and speaking from the perspective of a consultant general adult psychiatrist and referencing clinical material, Gordon will address the challenge of understanding the possible implications of this significant shift in the nosological landscape for psychiatrists working in a community mental health team (CMHT) setting, and for other clinicians working in the field of mental health. He will discuss case material relating to common presentations to a CMHT and consider the relevance of ICD-11 diagnoses such as complex PTSD with reference to aetiology and phenomenology/nosology, as well as thinking about possible implications for treatment options. He will also give some time in his presentation to reflecting on the significance for our patients of adopting ICD 11 diagnoses, and consider briefly why the term “dissociation“ can sometimes be a contentious one for clinicians, while often very helpful for our patients.