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Limbic Psychotherapy® and the Frame of Functional Dissociation: Quickly Healing from Dissociative States and Chronic Trauma

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Abstract

Within the array of methods amalgamating restricted verbal and non-verbal tactics, integrative therapies steeped in the complex neurophysiological facets of the condition display the greatest prospects. At the juncture of physical and psychological dimensions, these 'bottom-up' methodologies possess a distinct capacity to activate the patient's neurophysiological reserves while safeguarding against any susceptibility to suggestion from the therapist. Targeted manual interventions, previously employed in TICE® (Mayer, 2017), enhance the initial effects, which are fundamentally derived from the patient's innate self-healing abilities. This constitutes the core essence of Limbic Psychotherapy®, an approach honed over decades of clinical experience with patients. Limbic Psychotherapy® regulates the limbic system by intervening directly at the neurophysiological level, specifically addressing the equilibrium between the ventral vagal and dorsal vagal pathways of the autonomic nervous system, as outlined in S. Porges' model. Limbic Psychotherapy® unveils its full potential in cases of Functional Dissociation® (Mayer, 2023), a clinical framework ideally suited for addressing dissociative states, chronic stress, persistent pain, digestive issues, addictions, and trauma. Through the application of dual attunement and specialized somatic interventions, the regulation of sympathetic/parasympathetic responses often initiates as early as the inaugural session, offering immediate relief to the patient.v

Keywords: Psychotherapy; PTSD; Functional Dissociation; Equilibrium; Trauma; Addictions; Digestive Issues; Psychological Automatism

Abbreviations: SDP: Structural Dissociation; ANP: Apparently Normal Part; EP: Emotional Part; ASD: Acute Stress Disorder; PTSD: Post-Traumatic Stress Disorder; DID: Dissociative Identity Disorder.

Introduction

Pierre Janet (1859-1947) first described traumatic dissociation in 1889, becoming the founder of the field of Psychotrauma. But it wasn't until the 1960s and 1970s that researchers turned their attention back to dissociative states [1,2] developed neo-dissociation, based on a continuum of altered states of consciousness from normal to pathological [1,2]. In 1980, the DSM introduced Dissociative Troubles, following in Janet and Hilgard's footsteps. In Van der Hart, et al. [3] presented "The Haunted Self", a textbook that would become the new standard for traumatic dissociation, setting out the theory of Structural dissociation of the personality in DID and complex PTSD.

We wished to draw inspiration from these great precursors (and others) to propose a new conceptual framework facilitating both the understanding and treatment of dissociative states and chronic trauma. Based on the model of functional dissociation [4], which is much more common than structural dissociation and DID, a new integrated psychotherapeutic approach, Limbic Psychotherapy® [5], enables the practitioner to rapidly target the cause of the patient's suffering, and bring relief from the very first session.

By acting directly at the neurophysiological level, Limbic Psychotherapy® regulates the limbic system, and in particular the balance between the ventral vagal and dorsal vagal pathways of the autonomic nervous system, according to S. Porges' model. This non-verbal, "bottum-p" approach prevents the clinician from accidentally producing suggestions to the patient. Sympathetic/parasympathetic regulation often kicks in from the very first session, bringing immediate relief to the patient. Specific manual interventions, already used with TICE® [6], potentiate the effects obtained, which are based from the outset on the patient's self-healing, without intermediaries.

To the origins of Psychotrauma

The European 18th century witnessed significant advancements in hypnosis, with its therapeutic potential swiftly coming to light. However, a groundbreaking shift occurred when J.M. Charcot, a neurologist at the Salpetriere Hospital in Paris, France, replicated these experiments and elucidated that the trances experienced by his hysterical patients were rooted in "ideas." Within this atmosphere of enthusiasm, the career of a young philosophy professor named Pierre Janet commenced. He volunteered to treat hysterical patients at a hospital in Le Havre, Normandy, France, and became the first to comprehend the interplay between hysterical episodes, hypnosis, and dissociation.

In his view, individuals with hysteria and high susceptibility to hypnosis grapple with a disjunction of thoughts and functions, one rooted in traumatic experiences. This pivotal revelation found its way into his psychology doctoral thesis, "Psychological Automatism" (recently translated into English). Within this body of work, as well as in several earlier research papers introduced the groundbreaking notion that intense emotions and unendurable events possess the capacity to fracture the personality into two distinct components. One part appears ostensibly normal albeit subdued, while the other remains beyond the reach of consciousness, harboring the traumatic incident along with its psycho-sensory-motor characteristics, and retaining the memory of the event. This memory, however, becomes relegated to the subconscious as it detaches itself from the ego and the individual's conventional memory, a term Janet himself coined [7].

As J Garrabe pointed out as early as 1999, Janet's pioneering work (after a period of neglect) finally re-emerged in international psychiatry in the late 1970s, particularly following studies of Vietnam veterans and abused women: indeed, it played a decisive role in the appearance of dissociative disorders, or DID, in the two international nosographies, the DSM and the ICD. However, with the exception of D-PTSD (DSM-V), the nosographic category whose explicit cause is Trauma, namely PTSD, is not linked to dissociation in either classification. It is interesting, therefore, to note some similarities and differences between Janet's conception of traumatic symptoms on the one hand, and contemporary psychiatry on the other (PTSD and TDI).

The DID (Dissociative Identity Disorder), only disorder to place dissociation at the heart of its symptomatology, is described in very similar terms by the latest versions of the two international nosographies (ICD-11 and DSM-V). It is characterized by the presence of at least two distinct personality states involving discontinuity in the sense of self, which can take partial or complete control of the subject. DID is accompanied by multiple functional impairments involving affect, memory, perception or cognition. An important symptom is amnesia of traumatic episodes as well as of everyday events. Finally, in both nosographies, dissociative disorders can lead to depersonalization or derealization.

The symptoms of PTSD and DID, in current classifications, closely parallel those observed by Janet. In particular, intrusions, flashbacks and - above all - amnesia are well documented in Janet's work as consequences of Trauma. Similarly, the presence of at least two personality states is characteristic of traumatic dissociation. There are, however, a few differences between Janet's view and our recent classifications. The most important of these is that, for Janet, the symptoms of our PTSD derive directly from a state of personality dissociation. A concession to this has been made in the DSM-V, which has created a dissociative PTSD, bringing this category significantly closer to that of DID. On the other hand, while Pierre Janet is the creator of the notions of depersonalization and derealization, he never made them dissociative symptoms, but characteristics of psychasthenia, akin to our modern depression. Following in his footsteps, authors such as O. van der Hart and I. Saillot have long been stressing this disjunction, which they see as one of the last 'stumbling blocks' to the unification of traumatic and dissociative disorders in contemporary classification.

In the formulation of the contemporary model of traumatic dissociation, Janet also outlined a treatment regimen designed to reintegrate the fragmented personality. This treatment would go on to become the gold standard for DID treatment

a century later [8], consisting of three phases: stabilization, reduction of traumatic memories, and fortification of the personality. Another significant contribution made by this eminent clinician was his explanation of hypnosis. According to him, this practice facilitated access to the traumatic memories of patients, enabling their reduction and, most importantly, their reintegration into the individual's normal personality and personal history. Consequently, once the personality was reassembled, patients ceased to be susceptible to hypnotic states. It should be noted that since Janet's time, this definition of hypnosis has fallen out of widespread use.

From Structural Dissociation to Functional Dissociation

The inclusion of dissociative disorders in the DSM-III marked a significant departure from decades of neglect for the concept of dissociation. Indeed, these publications inspired countless clinicians worldwide to dwelve into research on dissociation and related issues. This is precisely why Van der Hart, Steele, and Nijenhuis presented a seminal reference manual in 2006 titled "The Haunted Self," proposing a novel perspective on dissociation rooted in the early work of Pierre Janet: the concept of structural dissociation of the personality (SDP). Within this framework, a traumatic shock gives rise to the fragmentation of an individual's personality into two or more dissociated parts [9].

Primary structural dissociation entails the presence of a single Apparently Normal Part (ANP), which is linked to feelings of detachment, emotional numbing, and partial or complete amnesia regarding the traumatic experience. Simultaneously, it involves a solitary Emotional Part (EP), which typically has a narrow focus and is associated with heightened memory recall and reliving of the traumatic incident. This primary structural dissociation is likely characteristic of uncomplicated forms of trauma-related disorders, including basic Acute Stress Disorder (ASD), straightforward Post-Traumatic Stress Disorder (PTSD), uncomplicated Dissociative Amnesia, and simple forms of Somatoform Dissociative Disorders, such as DSM-IV Conversion Disorders or ICD-10 Dissociative Disorders of Movement and Sensation.

Secondary structural dissociation of the personality is extending beyond the presence of a sole Apparently Normal Part (ANP) and Emotional Part (EP), primarily governed by daily life action systems and defensive action systems, respectively, can encompass further fragmentation involving two or more defensive subsystems. These additional divisions may include hypervigilance, flight, freeze, fight, total submission, as well as the "attachment cry" and recuperation. Each of the EPs is marked by an even more pronounced narrowing of the scope of consciousness, significantly constraining their experiential realm and range of behaviors to particular defensive interest subsystems. The level of consciousness varies; it remains elevated in cases of hypervigilance and freeze but diminishes in instances of total submission.

Tertiary structural dissociation refers to the division of the Apparently Normal Part (ANP) in addition to the dissociation among Emotional Parts (EPs). This phenomenon is primarily observed in individuals with Dissociative Identity Disorder (DID), a condition often comorbid with complex Post-Traumatic Stress Disorder (PTSD) or personality disorders. Early and prolonged exposure to trauma can hinder the development of a relatively unified pre-traumatic personality. Consequently, childhood trauma can disrupt the typical developmental trajectory toward the integration of action systems designed for daily life functions, leading to the emergence of multiple ANPs. Additionally, recurrent childhood trauma can intensify the secondary elaboration of Eps.

According to these authors, the concept of dissociative disorder, as defined in this manner, encompasses not only Dissociative Identity Disorder (DID) but also Post-Traumatic Stress Disorder (PTSD) and various other disorders originating from trauma [10]. Structural Dissociation (SDP) is, therefore, a profoundly severe condition, often accompanied by multiple coexisting disorders. Most individuals with Dissociative Identity Disorder (DID) receive ongoing care in either hospital settings or day programs.

However, it's not uncommon for individuals with symptoms closely resembling structural dissociation to seek help at psychotherapy private offices. Among the symptoms frequently reported in these settings, patients describe a sense of internal division, feeling torn between various aspects of their personality, and sometimes hearing an inner voice. This inner voice can either be desired, such as an advisor, or more commonly unwanted, manifesting as negative or threatening intrusions. Presently, these individuals receive inadequate diagnoses and often endure multiple years of diverse treatments, both psychological and pharmacological, without experiencing significant improvement. This is why we find it compelling to associate these numerous clinical cases with a new diagnostic category: Functional Dissociation®.

Functional Dissociation and it's Treatment

Aside from being recognized as the pioneer of modern dissociation, Pierre Janet also laid the groundwork for the concept of psychasthenia. Originally introduced by Mayer B, et al. [4], the concept of Functional Dissociation® establishes a connection between O. van der Hart and his

colleagues' Structural Dissociation (SDP) and Pierre Janet's Psychasthenia [11]. Functional dissociation emerges as a more prevalent disorder among the general population when compared to DID. This notion was somewhat anticipated by Bateson and his exploration of the double bind [12].

The existence of divisions within the core of one's personality was also recognized by a prominent thinker in the field of human sciences: Gregory Bateson. In the late 1950s, the renowned anthropologist and leader of the Palo Alto School embarked on the task of modeling Bleuler's schizophrenia using concepts from the emerging field of communication. Collaborating with pioneering computer scientists and several psychiatrists, he developed the concept of the "double-bind" [12]. According to him, dissociation - or schizophrenia, as a result - can be elucidated by the child receiving conflicting messages from their parents. For instance, a parent consistently demands affection but physically rejects the child when he or she approaches. The idea of the double-bind bears many resemblances to functional dissociation, as f-ANP and f-EP closely embody the paradoxical instructions highlighted by Bateson and his colleagues. However, it differs in one significant aspect [13].

The primary distinction between Bateson's double-bind and functional dissociation lies in the fact that a substantial number of patients exhibit more than two dissociated components. While some clinical cases involve only one f-ANP and one f-EP, more frequently patients have several f-EPs. All these dissociated components emit conflicting and irreconcilable signals. Often personified as imaginary characters or individuals from the patient's childhood, these functionally dissociated components render daily life unbearable for the individuals by demanding behaviors that cannot be harmonized. Bateson's double-bind did not receive the recognition it deserved in the field of psychiatry; perhaps one reason is its restriction to two paradoxical instructions. Why not three, four, or more? In reality, our extensive clinical experience informs us that contradictory messages are often more numerous than two. This is why, within the functional dissociation model, we propose to integrate the concept of not only the double-bind (Bateson) but also the triple-bind, quadruple-bind, and finally, the n-uple-bind. These multiple constraints aptly illustrate the functional dissociation of patients into as many f-EPs as there are insurmountable paradoxical instructions.

The physiological processes that drive our body's functioning are influenced by what we experience: we are the result of interactions between our body and the outside world. The outside world presents an infinite variety of sensory, motor, social, verbal, memory and other stimuli to the body and brain at any given moment. The latter react to all these components autonomously, often long before any cognitive processing of the information can take place. Cognitive processing comes second. Often, it simply doesn't happen, as when we smile spontaneously at a friend, or when we mechanically hold a book while chatting. Thanks to its capacity for innate and acquired reflexes, the brain has the ability to discover traumas in the body on its own, even though consciousness cannot access them. To achieve this, the therapist invites the patient to think about his or her problem, as he or she needs to enter a state of activation, from moderate to intense, without exceeding his or her tolerance threshold. The degree of activation can (but need not) be objectified by a score between 0 and 10, as on the SUD (Subjective Units of Distress) scale (Figure 1).

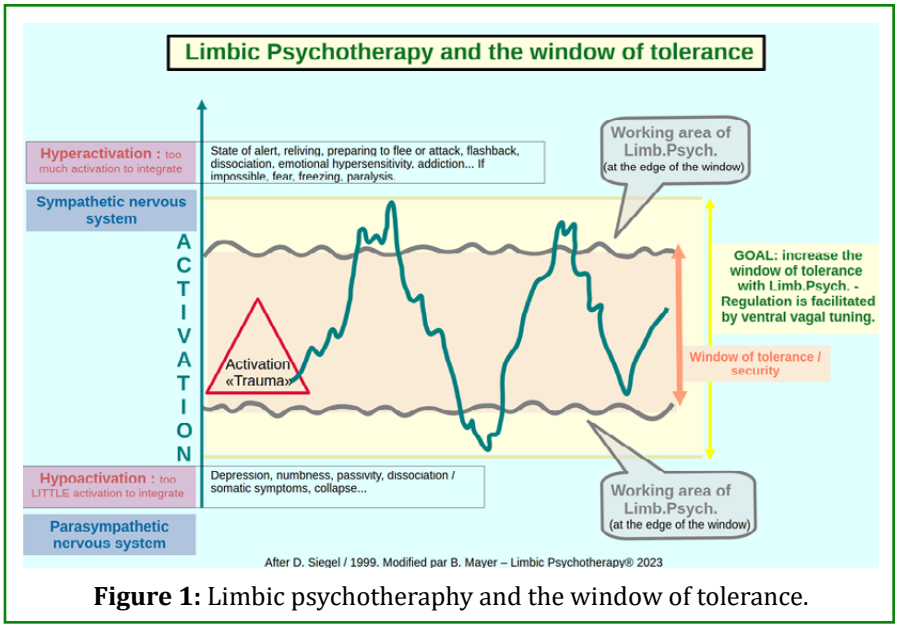

Figure 1: Limbic psychotheraphy and the window of tolerance.

Once the patient has been activated to the limit of his or her tolerance window Figure 1, the session can begin somatic work. The aim is now to gradually immerse the patient in the depths of his or her body-mind processes. For this work, the use of words, analysis and argumentation is generally not useful, as the trauma is in the body, and therefore in the brain, and it is the patient's brain that will provide the key to his or her disorder. So, by concentrating on the body, the patient taps into his brain processes like a scanner picks up shades of grey on a page. Activation then appears in different parts of the body, depending on the patient. It is often located in the head, abdomen or chest. These sensations, anchored in the present, i.e. in the "here and now", initiate a healing process that is also firmly rooted in the moment.

Limbic Psychotherapy® makes it possible to "dose" the degree of activation for each patient, according to the severity of their disorders, but also according to their own window of tolerance, which is different for everyone. By modulating activation while reconnecting brain and body, the patient remains in control of the process of change: healing himself from within, in a movement of self-control. This doesn't mean that the therapist is useless, but he or she plays the role of a facilitator, opening the way. Thus, on discovering Limbic Psychotherapy®, many patients testify to an apparent paradox: although the therapist seems to do little, and his interventions are moderate, all admit that they couldn't have done it alone. And this is understandable, given that many of our patients suffer from attachment disorders. Having been abused or assaulted by others, sometimes since childhood, they have lost the ability to trust others... including a clinician. The clinician's role is to help them regain this trust, which - in many cases - will also boost their self-confidence and self-esteem. The clinician is always attentive to the biography of his patients, and will always adapt his interventions to the nature of their traumatic past.

Limbic Psychotherapy®: A New Approach for Dissociative States and Trauma

Our prior research [6] has enabled us to introduce TICE© (Integrative Mind-Body Therapy) as a constituent of integrative psychotherapies that leverage deep physiology and neurology to intervene directly at the origins of the patients' issues [6]. Numerous studies have demonstrated that analogous methodologies provide significant relief to patients. This approach is often referred to as "bottom-up" due to its foundation in the patient's neurophysiology. In the following sections, we will delve into the primary theoretical underpinnings of Limbic Psychotherapy® and its clinical applications.

In truth, as P. Janet previously posited, addressing trauma necessitates action at the bodily level rather than solely within the realm of the mind [8]. In 1924, he articulated that "everything psychological is intertwined with the conduct of the entire individual, not limited to changes within the brain." This elucidates why Limbic Psychotherapy® operates without intermediaries, directly addressing the origins of traumas entrenched within the body and the nervous system. This innovative method offers a direct route to the sources of suffering, disentangled from the traumatic personality.

Within this dissociative perspective, the stimuli and therapeutic bodily movements employed in the TICE® approach serve the purpose of promptly identifying the Emotional Part(s) (EPs) responsible for destabilizing the patient. These interventions initiate a dialogue between these dissociated facets, ultimately leading to the integration of the entire personality. It is during this phase of the intervention that the concept of the "window of tolerance" assumes its utmost significance. Indeed, regulating the activation of the sympathetic and parasympathetic pathways to restore balance between dorsal and ventral vagal states, in accordance with S. Porges' theoretical framework, becomes paramount. This comprehensive undertaking necessitates a two-fold alignment-both neurophysiological and relational-enabling the therapist to establish a connection with the patient's neurobiology.

The therapist will maintain a watchful eye on the patient's physiological condition throughout the therapeutic process, considering both heightened and diminished levels of activation within their window of tolerance. Continuously monitoring this condition is crucial for the ability to employ regulatory techniques should excessive activation occur. In this regard, the practice of Mindfulness proves to be a valuable tool for the therapist, who guides the patient through their bodily and neurophysiological experiences step by step as part of the therapeutic journey. It is within this therapeutic timeframe that novel dialogues will be initiated and consciously experienced, facilitated by specific somatic interventions. This approach enables various regions of the brain, diverse emotional systems, and, of course, the ANP and EPs, to engage in non-verbal communication and initiate the process of reintegrating the fragmented personality.

The quick results of Limbic Psychotherapy® hinge on its direct engagement with the dorsal and ventral vagal pathways, as well as the sympathetic and parasympathetic systems. Porges' polyvagal theory has elucidated that traumatic states, dissociative states, and developmental disorders arise from an excessive activation of the dorsal vagal pathway, resulting in an inadequacy of the ventral vagal pathway and disruptions in social relationships. Limbic Psychotherapy® establishes a connection with the ancient and instinctive

pathways within the nervous system that have evolved over millions of years in mammals. By unlocking the resources previously constrained by trauma, this approach triggers the activation of the ventral vagal pathway, fostering healing and self-repair. This transformation often occurs within the initial sessions or within a remarkably brief timeframe, leading to an immediate sense of relief for patients.

Considering this perspective, the practice of Mindfulness becomes a valuable asset for the therapist who guides the patient through their bodily and neurophysiological journey within the therapy process. It is during these therapeutic sessions that fresh dialogues unfold and are consciously experienced, facilitated by specific somatic interventions. This approach enables various regions of the brain, diverse emotional systems, and, of course, the Apparently Normal Part (ANP) and Emotional Parts (EPs) to engage in non-verbal communication, initiating the process of reunifying the dissociated personality.

In cases involving acute or chronic traumas, persistent attachment issues, and dissociative states, non-verbal methodologies like Limbic Psychotherapy® are particularly well-suited for treatment. This is especially true because the therapist refrains from inducing any form of suggestion, even in a metaphorical sense. Functional dissociation shares a constellation of cognitive, emotional, and behavioral symptoms with structural dissociation. This array of symptoms underscores the necessity for treatments to adopt a multidimensional approach. Purely verbal therapies rely on patients' verbal accounts, but traumatized individuals may not always be capable of providing such testimony.

Conclusion

Among the approaches that incorporate limited verbal or non-verbal techniques, integrative therapies grounded in the profound neurobiology of the disorder hold the most promise. Positioned at the crossroads of physical and psychical aspects, these non-verbal, "bottom-up" methods possess the unique ability to mobilize the patients' neurophysiological resources while safeguarding against any risk of suggestion by the therapist. This forms the core of Limbic Psychotherapy®, an approach built upon decades of clinical expertise with patients.

Focusing on the neurophysiology of mind-body links, integrative non-verbal therapy aims to mobilize the patient's own resources, with a curative goal that often resembles self-healing (as D. Grand has already pointed out). The gradual or rapid uncovering of the main problem leads to the emergence of the (often numerous) PEs, some of which are allies of the PAN, while others are its aggressors. This system, stuck in the past, is unable to evolve, leading to chronic suffering. By identifying the neurophysiological states corresponding to these functionally dissociated parts, the treatment rapidly leads to a remarkable effect: internal energies are released to liquidate actions that were once impossible, and often unfinished for years.

From this perspective, the therapeutic alliance combined with a Mindfulness-based approach allows the treatment to progress while completely preserving the patient's autonomy and agency. Whether addressing structural or, more commonly, functional dissociation, the integration of the reunifying personality unfolds without imposition. This integrative approach empowers the therapist to steer clear of (re)assuming the role of an aggressor, a significant pitfall found in many other approaches, as previously theorized in the last century. Our aspiration is that these novel therapeutic concepts will aid both individuals seeking treatment and healthcare providers in effectively harnessing these therapeutic tools to enhance well-being.

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