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Recognizing Dissociative Disorders

PATIENTS WITH A HISTORY OF TRAUMA OR NEGLECT ARE AT INCREASED RISK FOR DISSOCIATIVE DISORDERS?

Patients with a history of trauma or neglect are at increased risk for dissociative disorders. They are often hidden and remain undiagnosed even after years of treatment. How can a physician best understand these problems? You are listening to ReachMD XM 157, The Channel for Medical Professionals. Welcome to the Clinician's Roundtable.

I am Dr. Leslie Lundt, your host, and with me today is Dr. Kaimana MacDonald. He is an Assistant Clinical Professor at the University of California at San Diego in the Department of Psychiatry. Dr. MacDonald is a Medical Director of Lasting Recovery Outpatient Substance Abuse Program, Assistant Medical Director of the Psychiatry Consultation-Liaison Service and Medical Director of the Clinical Trials all at UCSD. He has boarded both in Psychiatry and in Family Practice.

DR. LESLIE LUNDT:

Welcome to ReachMD, Kai.

DR. KAIMANA MACDONALD:

Thanks, I am glad to be here.

DR. LESLIE LUNDT:

Kai, what are dissociative disorders? I am sure a lot of our listeners remember that term from psych, but can't remember the details.

DR. KAIMANA MACDONALD:

Great question, and it's unfortunately appropriate title for a group of disorders that's characterized by, I think probably the best term is by odd disturbances in the way people's brains and minds work. It includes disturbances of identity, of memory, and a feeling kind of connected with the earth and the world around you. So it's a confusing cluster of problems.

DR. LESLIE LUNDT:

It sounds almost physiologic structural. Does neuro imaging help us at all?

DR. KAIMANA MACDONALD:

Well, that's a great question, speaking from my personal opinion I think neuro imaging, which for people in the other non-brain based professions is akin to, you know, what's functional imaging of the heart does for us in understanding it. Functional imaging has really shown us a lot about dissociative disorders and how they really are best understood as brain-based problems with how the brains of people function.

DR. LESLIE LUNDT:

I am guessing that screening for dissociative disorder isn't real high on most physicians' list. When do we start thinking about this as even a possible problem we should be looking for in our patients?

DR. KAIMANA MACDONALD:

That's probably the most useful strategy Leslie and it's a good question. Patients with significant trauma histories, including our stalwart veterans who are returning from awful situations are often at risk. Also, the patients with substance use disorders, eating disorders, and then a class of the patients that really bedevils a lot of primary medical doctors, are people with unexplained somatic symptoms. All of those are at a higher risk of having a dissociative problem than, you know, the general population.

DR. LESLIE LUNDT:

Now, worst case scenario, what's the risk if we miss a dissociative disorder in one of our patients?

DR. KAIMANA MACDONALD:

These are hidden disorders. They are silent. A little bit like attention-deficit disorder or other problems that aren't so overt, they can sneak away. Probably the risk is decreased therapeutic benefit and then essentially patient suffering; a lot these patients have symptoms or problems like someone with an anxiety disorder, depressive disorder that's never been diagnosed and essentially they just suffer in silence, so I think those are the two main difficulties.

DR. LESLIE LUNDT:

What are the common look alike for dissociative disorders?

DR. KAIMANA MACDONALD:

Yeah, that's another great question and it helps kind of tie-down what a dissociative disorder would look like, so a big one is drugs.

Certain drugs like ketamine and marijuana can induce dissociative states. Those of you who lived and partied in the 60s and 70s may actually have had some of these experiences. So drugs are a big one. Certain seizures can cause dissociative phenomenon and then certain attentional problems, posttraumatic attentional problems, and certain psychotic disorders, like I just saw actually a patient on the medical floor who thought she had one of the common popular dissociative disorders called multiple personality disorder, and she was convinced based on the psychotic delusion that she was another person, a little boy and she wasn't, those are the main ones that a person would see in an outpatient type of practice.

DR. LESLIE LUNDT:

You mentioned seizures; I wonder would temporal lobe seizures be especially problematic?

DR. KAIMANA MACDONALD:

That's one of the kinds that's been associated with dissociative phenomena and again I would say that's rare, but if that is the cause, your certainly want to catch that.

DR. LESLIE LUNDT:

Now, there was recently a paper just published that concluded that dissociative disorders in children often persist into adulthood, would you agree with that?

DR. KAIMANA MACDONALD:

They tend to be a like a lot of brain-based disorders, pernicious, and lasting and then they kind of having a creation of subsequent problems, as I mentioned, eating disorders, personality disorders, anxiety disorders, substance use disorders, and whether that association is causal or associative is not clear, but again they can tend to lie under the surface. I am thinking about a patient who when he finally got his alcohol use disorder under control, it became pretty obvious that he had a dissociative disorder related to a traumatic rape and so again these can really fly under the surface of other more obvious disorders.

If you're just joining us, you are listening to The Clinician's Roundtable on ReachMD XM 157, The Channel for Medical Professionals. I am Dr. Leslie Lundt, your host, and with me today is Dr. Kaimana MacDonald. We are discussing dissociative disorders.

DR. LESLIE LUNDT:

Kai, how do we treat these patients?

DR. KAIMANA MACDONALD:

For someone who is in a primary care or nonpsychiatric setting, I think the best thing to do is to really recognize that these exists, that they are brain-based disorders and many consider them to be essentially a normal response to stress that's greater than a person's brain can bear and do a little eduction. You know, these kind of problems are not common and then if they are troubling to the patient, and etc., then I think a referral to a mental health professional where they won't be so peculiar is appropriate at that point.

DR. LESLIE LUNDT:

Mental health professional, does this need to be a psychiatrist or are other therapists capable of dealing with these people?

DR. KAIMANA MACDONALD:

The primary treatments at this point are therapeutic, although we are drilling into the biology of these problems. They aren't a lot of medication treatments that tend to be particularly useful per se, although anxiety-based treatments and another treating insomnia associated with them can help. A therapist who is used to dealing with patients with trauma will also be very effective in help to these patients.

DR. LESLIE LUNDT:

So, is this necessarily leading them to a course of long-term psychotherapy or is this just something that can be handled in managed care, 6 or 8 secessions?

DR. KAIMANA MACDONALD:

Depending on the severity of the symptoms, by and large, these are pretty pernicious problem, and I would say 6 to 8 sessions may be sufficient for psycho ed. If you actually want resolution, I think it, like a lot of more pernicious problems, would require a bit longer.

DR. LESLIE LUNDT:

Now, back to medication, you mentioned maybe some antianxiety medication or something to help with insomnia, what about other medications, I am wondering especially about anticonvulsants or antidepressants?

DR. KAIMANA MACDONALD:

The only study that even discusses the treatment of dissociation that was positive relates to an SSRI, and again, where you may see this most commonly is associated with posttraumatic stress disorder and so treating that with an SSRI at least by a single study look like it reduces the incidents of dissociation. I don't know of any trials with anticonvulsants that can conclusively reduce these phenomena and there was a negative trial actually with Lamictal, so it looks like one of the problems that medication, at least at this point, isn't that impactable.

DR. LESLIE LUNDT:

So psychotherapy is the way to go. Now Kai, you're doing some research at a dissociative anesthetic, tell us about that.

DR. KAIMANA MACDONALD:

Real interesting story, still very, very tentative, but there have been a couple of trials of using IV ketamine and again there were people in the 70s and 80s who played around with this and went into what's called the K-hole which is a very altered dissociative perceptual experience caused by ketamine, but there have been some trials using this IV drug, which is currently used for burn victims and other patients who need an anesthetic, but doesn't put you down very deep. There are trials showing that it helps at least for a week, very short term, but very quickly with a severe major depressive disorder, treatment-resistant major depressive disorder, so very interesting, very tantalizing. The ugly downside is that it affects, at least by current literature last a week only, and as you know, for a chronic disorder that's not very reassuring, but it promises that this may be a good avenue for future, perhaps more acute onset antidepressants, that is the hope.

DR. LESLIE LUNDT:

What is the mechanism there? I am not following the neurotransmitter change.

DR. KAIMANA MACDONALD:

Great question, ketamine works on NNDA systems, which are fairly complicated. It is essentially one of what would be called glutamatergic agent, but like ECT, we still don't exactly know how ECT works, that's been the hypothesis is that may be it's glutamatergic, so that's where the thinking is at this point.

DR. LESLIE LUNDT:

And ketamine has to be given IV?

DR. KAIMANA MACDONALD:

That's how it's been studied and there are some thoughts that it may be the IV delivery that's really critical that is acute onset, so that's the way the studies for depression have been done.

DR. LESLIE LUNDT:

So thinking about that for a minute, if a dissociative kind of precipitant like ketamine might work even temporarily for depression, is there any evidence that patients that have dissociative disorders are at less risk for having a major depressive episode?

DR. KAIMANA MACDONALD:

There is no data about that at all and a temporary inducement of a dissociative phenomenon and the traumatic inducement, I think, would probably be fairly different. The same way, for example, dissociative disorders are really interesting if you have any listeners who believe in _____

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