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Dissociative Subtype of PTSD?

TO THE EDITOR: In an important article in this *Journal*, Lanius et al. state that they presented support for a dissociative and nondissociative subtype of PTSD (1). They describe convincing evidence of two different psychobiological reaction patterns to reminders of traumatic experiences in patients with PTSD: hyperaroused, subjective experiences of reliving traumatic experience vs. detachment (i.e., depersonalization, derealization) without hyperarousal. The first subtype would be nondissociative and the second dissociative. However, this categorization is confusing. As Lanius et al. note, dissociation involves compartmentalization of memory, and discontinuity of experience and self. Thus, in dissociation, (re)actions and mental contents belonging to one (psychobiological) compartment are not (or are less) present in another compartment. This division of memory, experience, and self manifests in negative and positive dissociative symptoms. For example, a survivor mediated by one compartmentalized set of (re)actions and mental contents, may be detached from what he or she feels, knows, and remembers when mediated by another set: negative dissociative symptoms. Positive dissociative symptoms entail well-documented intrusions from one compartmentalized set of (re)actions and mental contents into another. These include re-experiencing of traumatic memory, described in the DSM-IV as "dissociative flashback episodes," other bodily and emotional feelings, and trauma-related hallucinatory voices (2). The logical conclusion is that both psychobiological reaction patterns in PTSD described by Lanius et al. are dissociative. Our definition of dissociation as an undue division of an individual's personality, i.e., the dynamic, biopsychosocial system as a whole that determines characteristic mental and behavioral actions, into dissociative subsystems (2,3), may be clarifying. In one such dissociative subsystem, the patient is fixated in traumatic memories, and when triggered, re-lives aspects of traumatizing events, involving hyperarousal or detached hypoarousal (as in playing dead). In another subsystem the patient mentally avoids these memories, with detachment (numbing, depersonalization, derealization, sometimes with dissociative amnesia). These subsystems can intrude on one another. Traumatized patients differ in the degree to which either subsystem dominates. Alternating dominance of these different subsystems and their psychobiological features within survivors has been documented (4). We suggest a serious re-examination of the oft forgotten argument that PTSD is best categorized as a dissociative disorder, rather than an anxiety disorder.

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