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Limbic Psychotherapy®: A Novel Approach to Treat Dissociative States, Traumas, Attachment Disorders, and Their Somatic Dimensions

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ABSTRACT

Pierre Janet (1859-1947) introduced traumatic dissociation in 1889, laying the groundwork for the study of psychotrauma. In the 1960s and 1970s, researchers like Spiegel (1963) and Hilgard (1977) revisited dissociative states, proposing neo-dissociation, a continuum of modified states of consciousness from normal to pathological. The DSM integrated Dissociative Troubles in 1980, following Janet and Hilgard's work. In 2006, Van der Hart, Steele, and Nijenhuis introduced "The Haunted Self," establishing the theory of Structural dissociation in DID and complex PTSD.

Inspired by these pioneers, we present a novel conceptual framework, rooted in the model of Functional dissociation® introduced in 2022, more common than structural dissociation or DID : Limbic Psychotherapy®, an integrated approach rapidly addressing patient suffering. Limbic Psychotherapy® operates directly on the neurophysiological level, regulating the limbic system and balancing the ventral vagal and dorsal vagal pathways of the autonomic nervous system, following S. Porges' model. This non-verbal, "bottom-up" method avoids inadvertent suggestions by the clinician, often providing immediate relief by sympathetic/parasympathetic regulation. Manual interventions, previously used in TICE® (Mayer, 2017), enhance patient self-healing, eliminating intermediaries. This innovative approach facilitates the understanding and treatment of dissociative states and chronic trauma, offering a promising path to alleviate patient distress.

Keywords
Limbic Psychotherapy®, Functional dissociation®, Trauma, Pierre Janet, Neurophysiology.

Introduction

In Europe, until the 16th century, many individuals suffering from dissociative disorders expressed their symptoms through a religious prism [1]. At the end of the 19th century, Jean-Martin Charcot (1825-1893) developed a classification of somnambulistic seizures [2] observed in "hysterical" (dissociative) patients, and Pierre Janet (1859 - 1947) continued this work. He showed that these subjects possessed several personalities, at least one of which was inaccessible to language: the subconscious personality. Janet used a special hypnosis for traumatized subjects [3] and published his findings in "Psychological automatism" [4]. The psychological mechanisms highlighted by Janet directly inspired the introduction of dissociative disorders in the DSM-III in 1980 [5].

One of Janet's main contributions was to link seemingly organic disorders with trauma [6] in relation with strong emotions [7]. This is why he was interested in paralysis, contractures and pain, thus confirming the link between body and mind. This work made Pierre Janet a precursor of Limbic Psychotherapy®, an approach focused on regulating the limbic system to reunite the dissociated personality.

A precursor of research into subcortical circuits in relation to the body is the physiologist Charles Sherrington (1857-1952), who in 1919 established the law of reciprocal inhibition, also known as "Sherrington's Law", according to which excitation of an agonist

muscle leads to inhibition of the antagonist muscle. Sherrington's law helps us to better understand the processes by which trauma is inscribed in the body, as the neurophysiological pathways of stress and well-being are indeed antagonistic.

Neuroscientist Stephen Porges is the author of the polyvagal theory of emotion [8], according to which our autonomic nervous system is composed of two regulatory pathways: the dorsal vagal pathway maintains the stress and hypervigilance of post-traumatic states, while the ventral vagal pathway contributes to safety and social relationships. These two pathways thus echo Sherrington's antagonistic pathways. By acting on these neurovegetative pathways, Limbic Psychotherapy® relies on non-verbal modalities, offering access to traumatic experiences impossible to express through speech [9].

Pierre Janet's work has been thoroughly updated with the theory of Structural Dissociation of the Personality (SDP), developed by O. van der Hart and his team. The authors of "The Haunted Self" [10] demonstrate that, in response to trauma, the personality fragments into several parts: the "Apparently Normal" Part (ANP) and the Emotional Part (EP). The ANP handles everyday tasks, while the EP contains the trauma, frozen in the past and inaccessible to language [11]. Thus, dissociation is a dysfunction resulting from emotional dysregulation, i.e., a dysfunction of the limbic system.

Functional Dissociation©: From Deregulation to Regulation

Our daily lives depend on close collaboration between our brain, our immune system and our endocrine system. These interactions are essential if we are to adapt to dangerous situations and react to changes in our environment. Hormones are released into our bodies by the pituitary gland and hypothalamus, and regulated by the limbic system, which interprets emotions induced by the outside world. Brain function is closely linked to the activity of the limbic system, which plays a modulating role on the immune and endocrine systems.

In general, the brain releases adrenalin, noradrenalin and cortisol for only a few minutes. However, in traumatized individuals, this stress-related secretion can be considerably prolonged, leading to disruption of the autonomic nervous system. Limbic Psychotherapy® directly addresses the cause of the problem, targeting the heart of the patient's problem and restoring unity to the dissociated personality, without the need for suggestions or pre-established protocols.

The concept of Functional Dissociation© recently introduced [12], provides a better understanding of these phenomena by linking SDP and Janet's Psychasthenia. Functional Dissociation© differs from structural dissociation in that the dissociated parts of the personality maintain mutual awareness, and are in conflict. What's more, unlike psychasthenia, which Janet himself considered practically incurable, Functional Dissociation© can be treated rapidly, thanks to tools that the great psychologist didn't have at his disposal. Indeed, the diagnosis of dynamic dissociation is accompanied by a treatment, Limbic Psychotherapy®, which focuses directly on the autonomic nervous system.

With this in mind, therapeutic body stimulation (TICE®) helps to identify the emotional parts (EP) that are disturbing the patient, and to initiate a dialogue between them, promoting personality integration. This process is not difficult to achieve in our patients, although many years of experience are still essential. Plunged into double and multiple constraints, the patient must be kept fully aware, in the present moment: to achieve this, light bodily interventions potentiate the effects; these may involve percussion, vibration or a combination (percussion-vibration), or intervention on trigger points or metaphorical points. In this way, bodily stimulation reinforces the permission(s)-authorization(s) given to the patient to experience these contradictory states (his or her EPs) simultaneously in a subcortical, or neurophysiological mode, where rational reasoning having lost its hold, all the opposites can at last be perceived together.

It is at this stage that the window of tolerance is important for the regulation of sympathetic and parasympathetic pathways, in order to rebalance the dorsal vagal and ventral vagal pathways. This work requires tuning on two levels, enabling the therapist to connect with the patient on both neurophysiological and relational levels. Limbic Psychotherapy® opens up direct access to the dorsal and ventral vagal pathways: by releasing the resources hindered by the trauma, it activates the ventral vagal pathway, thus promoting healing. This is why the practice of mindfulness is an asset for the therapist, who accompanies the patient through his or her body and neurophysiology, step by step. During this therapeutic period, specific somatic interventions are mobilized.

Clinical Case: Cynthia Leaves Behind a Suffering of Nearly 10 Years

A recently treated clinical case fits this aspect particularly well. Cynthia is a 45-year-old woman who was present at the Bataclan (Paris) during the 2015 terrorist attacks. She came to see me because of incessant psychological suffering and chronic pain. During the first interview, I discovered that this patient was a case of re-traumatization, as her childhood had been chaotic and she had a history of attachment disorders prior to the attacks.

For this Limbic Psychotherapy® treatment, we need to take into account the patient's posture and the slightest of her spontaneous movements from the outset, so as to work right at the limit of her window of tolerance, with the aim of rapidly widening it. Cynthia’s fears and suffering literally put her into survival mode, and totally disorganize her. These feelings and her behavior are neurophysiologically dysfunctional, and psychoeducation will help her better understand what's going on inside herself.

Our work consists in moving from deregulation to regulation, and to do this, we target the autonomic nervous system, within the framework of S. Porges' polyvagal theory: in this way, we follow physiology and nothing but physiology. Coupled with specific bodily interventions, the approach consists in letting the

patient's images, memories, sensations, beliefs and so on come and go, alternately bottom-up and top-down. This co-regulation is imprinted somatically, leading to a very important state: mindfulness. Mindfulness is a major step in therapy, already identified by P. Janet as "presentification" or "realization".

In this session, I help Cynthia to recognize and accept now what happened in the past, to make explicit what was implicit. Our exchange is as follows (extract):
-- (C.) I know it happened a few years ago, but I still have the feeling that I'm in danger and that I'm going to die;
-- (B.M.) Yes, that's why I'm going to ask you to say, out loud, one or two sentences, even if you don't mean them, while I do some manual stimulation on certain points of the body, which may be painful, as I explained to you initially; say out loud "even with this part of me that's afraid of dying, I have the right to exist now", "I love and accept myself fully, even with this part of me that's afraid of changing"; I then ask: "What thoughts, images or bodily sensations are you noticing now?"
-- (C.) It's strange, my mind is calm now. I'm not used to it, because I've always been on edge and insecure, because my mother wanted to kill me by drowning me in a basin when I was eight;
-- (B.M.) Yes indeed, but now you're alive...

This work transforms neuroception into perception, without adding a single suggestion likely to influence the patient. The results are not long in coming: "I feel as if a joy is seeking its way through me... my muscles are also relaxed, my pains have faded away". A few sessions were enough to bring lasting relief to Cynthia, enabling her to perform what P. Janet had already called "the act of triumph", i.e. the overcoming of all the blockages accumulated over the years, and the fully successful completion of all her actions hampered by suffering and fear.

Limbic Psychotherapy®: Therapeutic Framework and Intervention Principles

In the 1950s, an important article was published: Towards a Theory of Schizophrenia [13]. The concept of double bind emerged. According to the authors, dissociation is due to exposure to contradictory messages, imposing a paradoxical situation with no possible solution. Thus, with G. Bateson, dissociation becomes the consequence of a double bind. However, these authors only identified one double bind, whereas clinical practice shows that triple, quadruple and even multiple binds are often woven: the EPs are often numerous. This is why Functional Dissociation© is more general than double-bind: it includes triple-bind, quadruple-bind and, finally, n-uple-bind [14].

Limbic Psychotherapy® uses this clinical approach: it aims to intervene on all dissociated parts by directly accessing the source of suffering, i.e. the autonomic nervous system. Unlike verbal therapies, Limbic Psychotherapy® does not rely on patients' testimonies, which they cannot always provide in the case of trauma. What's more, no suggestions of any kind, even metaphorical ones, will be induced by the therapist.

At the interface between body and psyche, Limbic Psychotherapy® adopts a bottom-up approach based on the mobilization of neurophysiological resources, avoiding the risk of suggestion on the part of the therapist. In this way, the therapeutic alliance combined with mindfulness enables the treatment to preserve the patient's freedom. Personality integration is achieved without constraint in this non-verbal context. This integrative approach prevents the therapist from (re)playing the role of aggressor towards the patient.

Focusing on the neurophysiology of mind-body interaction, Limbic Psychotherapy® mobilizes the patient's internal resources. By revealing the central problem, it brings to light the various emotional parts immobilized in the past, some acting as allies, others as aggressors. By identifying the contradictory neurophysiological states associated with these parts, treatment progresses rapidly. In other words, Limbic Psychotherapy® untangles what Janet had already described as "anchoring / ancrage". It exploits this potential within the framework of neurophysiology and S. Porges' polyvagal theory: the intervention rapidly reduces the activity of the dorsal vagal pathway, while increasing that of the ventral vagal pathway.

The case of the patient Églantine, treated some time ago in my practice, illustrates this approach particularly well. After a brilliant school cursus, Églantine had to stop her higher education "due to an exhaustion of [my] organism". She reoriented herself and had to interrupt her studies once again to undergo treatment for anorexia. Several hospitalizations followed, but this time it was her medical condition that deteriorated. Today, the 45-year-old patient consults us for her irrepressible bulimic impulses, as well as for persistent pain that makes her life impossible, and nips in the bud any form of new project.

Clinical Case: Emmy Gets Rid of Irrepressible Impulses

Emmy, this patient with a long medical history will demonstrate the value of a body-centred, non-verbal approach. The trauma will be treated where it belongs: in the body. Focusing on her traumatic vortex, Emmy is guided step by step towards a state of full awareness in the present moment, which has the effect of blurring her dissociated parts (EP), which remain stuck in the past. This stage is carried out with the patient in a state of high activation, which produces faster results: the sympathic nervous system is activated to the limit of its tolerance window, from fear to terror, for example. To put it with an acupunctural metaphor: "It's not ying, it's brand yang". In addition, the patient will be asked to quantify on a scale of 1 to 10 this positive impulse that enables her to soothe and regulate herself: the stronger the impulse, the greater the result. Part of our exchange is then as follows:
-- (E.) I feel my irrepressible urge like a ball in my plexus, my head is full, I can't think, all my muscles are tense;
-- (B.M.) I'm going to determine where in your visual area this ventral vagal disturbance is located, and then I'll ask you to focus on that point for just one or two minutes, and observe what comes to you in the way of thoughts, beliefs, memories and bodily sensations;

-- (E.) I was at 9, maybe 10 on the scale, and now I'm at 5;
-- (B.M.) What do you realize?
-- (E.) The tension in my shoulders has eased, and I'm breathing better!
-- (B.M.) Keep focusing on what's left of the compulsive sensations and cravings in your body;

I then apply a few painful digital stimulations to her hand and percussive vibrations to the 7th cervical spine and the top of her skull, while asking her to say: "Thank you, sweetness and sugar, you helped me in the past, but now I don't need you anymore". I also tell her to say out loud, while continuing the stimulations: "I love and accept myself fully, even with this part of me that's afraid not to be afraid anymore". Emmy feels calm and secure for the first time in months.

One advantage of Limbic Psychotherapy® is that it eliminates the need for different treatment phases. Phase treatment, which has proved its worth in many cases, is not necessary here. Indeed, our bottom-up approach dispenses the practitioner from having to resort to pre-fixed phases and standardized protocols that always include cognitive material: dissociations must not be dissociated! From this point of view, Limbic Psychotherapy® is an approach that avoids any suggestion on the part of the therapist, imposes nothing on the patient and does not direct his or her progress. The intervention is tailor-made: both its target and its effects are internal, i.e. neurophysiological. This specific framework prevents the practitioner from unwittingly replaying the role of the patient's aggressor, since the aggressor had acted from the outside, not the inside.

Prescribing a dissociative letter "to my dear pulse" will also help Emmy move from the traumatic vortex to the resource vortex: little by little, the information passes to the frontal cortex, facilitating personality integration. As she gradually calms down, Églantine can no longer even feel her suffering... And as often happens, it will take some time for her to fully realize that her suffering has disappeared, and above all, to accept that she is no longer afraid. Indeed, many patients have learned to live with fear to the point of worrying when it's gone.

Conclusion

Within the theoretical framework we have defined, Limbic Psychotherapy® is most effective with patients suffering from structural dissociation, functional dissociation (more numerous) or, of course, attachment disorders, and acute or chronic trauma. All these disorders manifest themselves first and foremost through organic symptoms, as already noted by P. Janet, the founder of the field.

In this regard, it's important to note that, as the ANP is phobic of EPs, one major goal is to create and maintain an atmosphere conducive to this new regulation, so as to welcome EPs: a therapeutic dyad is thus formed, ensuring the best practitioner-patient match. And the results are there in just two sessions for this case: "I feel liberated from an imprisonment," testifies Églantine, "my feeling of oppression vanishes, I'm no longer shackled by these chains...".

As a Brainspotting-France trainer and supervisor, I think it's worth pointing out that there's no connection between Brainspotting and Limbic Psychotherapy®, apart from the focus of attention shared by many other therapeutic approaches. In fact, Limbic Psychotherapy® involves - among other things - stimulation of specific points on the body, with the patient always connected to the issue that drives his or her life. This is why the treatment of these complex cases takes place in the body and not, as in other therapies such as EMDR and Brainspotting... for example, outside the body: as I often say to the healthcare professionals I train : "Please you mustn't dissociate the dissociation." As a result, Limbic Psychotherapy® is an integrated form of neurotherapy and psychotherapy whose aim is to gradually "re-ignite" the frontal lobes that have been turned off by trauma, whether acute or developmental. Only a few sessions are needed to achieve results, as the autonomic nervous system is regulated independently of the patient's will. This non-verbal mind-body approach enables dissociation and its pathological effects to be treated directly at the bodily level.

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