

Dissociative Disorders

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- *everyone occasionally* experiences failure in normal automatic integration of MEMORIES, PERCEPTIONS, IDENTITY, and CONSCIOUSNESS; such dissociation **does not disrupt everyday activities**.
e.g. person may drive somewhere and then realize that he does not remember many aspects of drive because of preoccupation with personal concerns, program on radio, or conversation with passenger.
- in dissociative disorders, dissociation **disrupts continuity of self and recollection of life events**.
 - a) when **memory** is poorly integrated (**dissociative amnesia**), patients may totally forget series of normal behaviors occupying minutes or hours and may sense missing period of time in their experience.
 - b) when experience and perception of **self-identity** are disrupted, **depersonalization disorder** is present.
 - c) when **self-identity** is fragmented along with **memory**, **dissociative fugue** or **dissociative identity disorder** is present.
- dissociative disorders are usually attributed to **psychological factors due to overwhelming stress** (generated by traumatic events or by intolerable inner conflict).
- diagnosis is not made if symptoms are caused by drug ingestion (e.g. alcoholic blackouts) or general medical condition (e.g. temporal lobe epilepsy).
N.B. necessary tests include – toxic screens, EEG.

DISSOCIATIVE AMNESIA

- **inability to recall important personal information** that is **too extensive** to be explained by normal forgetfulness.

- gaps in memory may represent **only few hours** or can encompass **entire lifetime**.
 - forgotten period of time is clearly demarcated.
 - information lost is autobiographic (e.g. who one is; what one did; where one went; to whom one spoke; what was said, thought, experienced, and felt).
 - forgotten information sometimes continues to influence behavior.
- most commonly diagnosed in young adults.
- **cause** is usually **trauma** or **severe stress** (e.g. physical or sexual abuse, rape, combat, abandonment during natural disasters, death of loved one, financial troubles) or **tremendous internal conflict** (e.g. turmoil over guilt-ridden impulses, apparently unresolvable interpersonal difficulties, criminal behaviors).
- patients may become confused, depressed, distressed, whereas others are indifferent.

Treatment – psychotherapy

- most patients recover their missing memories (but some are never able to reconstruct missing past).
- if loss of memory is of **very short time period**, only **supportive intervention** is warranted (esp. if necessity or benefit of recovering memory of some painful event is not apparent).
- when need to recover memories is **urgent** – use **hypnosis** or **drug-facilitated interviews**;
 - perform gently - circumstances that stimulated memory loss are likely to be recalled and to be very upsetting!
 - questioner must be careful to phrase questions (as not to suggest existence of event and risk creating false memory).
 - accuracy of memories recovered with such strategies can only be determined by external corroboration.

DEPERSONALIZATION DISORDER

- persistent / recurrent **feelings of being detached from one's body or mental processes** (usually feeling of being outside observer of one's life).

- person may feel unreal, as if he is automaton or is dreaming; but reality testing remains intact!
- symptoms may be accompanied by anxiety, panic, or phobic symptoms (patients fear or believe they are going crazy).
N.B. patients always retain knowledge that their “unreal” experiences are not real but, rather, are just way that they feel.
- often triggered by severe stress, but not as symptom of mental or seizure disorders!
- PREVALENCE ≈ 2% of general population.
- depersonalization is often transient and resolves spontaneously without intervention.
- even when it persists or is recurrent, some patients are minimally impaired if they can suppress feeling of depersonalization by keeping their mind busy and focusing on other thoughts.
- other patients become disabled.

Treatment – **psychotherapy** to address **all stresses** associated with onset of disorder as well as earlier stresses (such as childhood emotional abuse or neglect).

- various psychotherapies (psychodynamic, cognitive behavioral, hypnosis) are successful.
- **anxiolytics / antidepressants** help if coexisting anxiety / depression accentuates depersonalization.

DISSOCIATIVE FUGUE

- episodes (fugues) with **inability to recall one's past** combined with **loss of one's identity or formation of new identity**.

- **result** from **trauma** or **stress** (e.g. incidence increases in connection with wars, accidents, and natural disasters).
- **fugue manifests** as sudden, unexpected, purposeful travel away from home.
- fugues are **often mistaken for malingering**, because fugues remove person from accountability for his actions, absolve him of certain responsibilities, or reduce his exposure to hazardous situations; some fugues may protect person from suicidal or homicidal impulses!
N.B. fugues are spontaneous, not planned, and not faked!
- **length of fugue** may range from hours to > months (most are brief and self-limited).
- **fugue in progress is rarely recognized** - during fugue, person may appear and act normal or is only mildly confused; person may assume new name and identity and engage in complex social interactions.
- **end of fugue**: at some point, confusion about new identity or return of original identity makes person aware of amnesia and causes distress (shame, discomfort, grief, depression, intense conflict, suicidal or aggressive impulses) - person finds himself in unfamiliar circumstances and must deal with what he left behind!

Treatment after fugue ends – **psychotherapy** ± hypnosis or drug-facilitated interviews.

- efforts to restore memory of fugue period are often unsuccessful.
- psychiatrist must help person explore his handling of types of situations, conflicts, and moods that precipitated fugue to help prevent recurrences.

DISSOCIATIVE IDENTITY DISORDER (s. MULTIPLE PERSONALITY DISORDER)

≥ 2 identities (personalities) that alternate + inability to recall important personal information relating to some of identities.

- what is not known by one identity may be known by another; some identities may appear to know and interact with others in elaborate inner world (patients typically report hearing inner conversations* between other personalities, which comment on or address patient).
*patient may be misdiagnosed with psychosis.
- patients may refer to themselves in first person plural (we) or in third person (he, she, they).
- switching of identities and amnesic barriers between them frequently result in chaotic lives.
- cause - overwhelming **childhood trauma** (physical, sexual, or emotional) + **dissociative capacity** (ability to uncouple one's memories, perceptions, or identity from conscious awareness).
 - children are not born with sense of unified identity - it develops from many sources and experiences.
 - in overwhelmed children, many parts of what should have blended together remain separate with ability to escape mistreatment by “going away” or “retreating” into their own mind.
- characteristic symptoms:
 - 1) fluctuating symptom pictures
 - 2) fluctuating levels of function (highly effective ÷ disabled)
 - 3) severe headaches or other bodily pain
 - 4) time distortions, time lapses, and amnesia; depersonalization and derealization.
 - 5) suicidal ideation / attempts are common.
 - 6) many abuse substances.
- symptoms wax and wane, but disorder **does not resolve spontaneously!**

Treatment – **psychotherapy** to achieve **integration of identity states**.

- patient may be asked to keep journal between visits.
- some patients benefit from hospitalization (continuous support and monitoring are provided as painful memories are addressed).
- **hypnosis** is often used:
 - a) to explore traumatic memories and diffuse their effect.
 - b) to access identities, facilitate communication between them, and stabilize them.

BIBLIOGRAPHY for ch. “Psychiatry” → follow this [LINK >>](#)