The interesting phenomena of dissociative disorders

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Summary

Though an unfamiliar diagnosis to many primary care doctors, 'dissociative disorders' are not too rare in the community. Previously labelled as 'hysteria', these disorders are often fascinatingly described in novels and movies. There is still some confusion between the two main classifications of the ICD-10 and the DSM-IV. Nevertheless, knowledge of the different presentations can assist the doctors in understanding the range of presentation of psychiatric disorders.

摘要

"分離性疾病"在社區中並不罕見，但許多基層醫生對此診斷並不熟悉。這類疾病以前被稱為"歇斯底里"，小說和電影中常有描繪。ICD-10 和 DSM-IV 兩類之間仍有一些容易混淆的地方。然而，了解此類疾病的各種表現，有利於醫生理解精神疾病臨床表現的差異。

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Introduction

Though an unfamiliar term to many primary care doctors, the presentation of 'dissociative disorders' has caught the interest not only of psychiatrists but also the lay public. This is because of the fascinating nature of such disorders magnified not by scientific discussion but by movies made of this issue. Of particular interest is that of 'multiple personality', like that possessed by "Dr Jekyll and Mr Hyde". In America, curiosity first began in 1906 with Morton Prince's case study of Christine Beauchamp.[1] The production of the film 'The Three Faces of Eve'[2] and later 'Sybil'[3] served as a template for expressions of personal distress and confusion.

Another fascinating term is that of 'hysteria' which is now rarely used clinically. This is because of its becoming colloquially used to describe extravagant displays of emotion. Furthermore, this has sometimes been rather inaccurately used to describe histrionic personalities and other psychiatric syndromes. Actually, 'dissociation' relates to the idea that the symptoms result from a lack of coordination of different psychological functions.

I. Overview

The term 'dissociation' lacks a clearcut coherent conceptualisation for everybody, as different people use it to mean different things, even within the same field of clinical psychology[4] Nemiah[5] defined dissociation as: "the exclusion from consciousness and the inaccesibility of voluntary recall of mental events, singly or in clusters, of varying degrees of complexity, such as memories, sensations, feelings, fantasies, and attitudes". Spiegel and Cardena[6] defined it as "a structured separation of mental processes (e.g. thoughts, emotions, conation, memory and identity) that are ordinarily integrated. The DSM-IV defined it as "a disruption of the usually integrated functions of consciousness, memory, identity or perception of the environment".

One important characteristic is the apparent absence of relevant physical findings, multitudinous symptoms, evidence of psychogenesis (or temperal association between the onset of the disorder and the stressful events, problems or needs) for the diagnosis. Actually during the dissociative state, there is enhanced ability to modulate perceptual input that may facilitate control over output governing somatic functions.[7] Other points of interests are the primary and secondary gains, with the former a relief from the stressful situation and the latter some attention or compensation from others.

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Classifications

In previous psychiatric classifications, Dissociative Disorder (together with Conversion Disorder) was previously part of Hysterical Neurosis.[8] At present, confusion still arises in the DSM-IV classification when Conversion Disorder is taken out from Dissociative Disorders and considered instead as a form of Somatisation Disorder. The modern classification follows either that of the ICD-10 or the DSM-IV.

1. ICD-10 dissociative disorders

This newest edition equates Dissociative Disorders with Conversion Disorders that consist of the following subtypes:

a. Dissociative amnesia
b. Dissociative fugue
c. Dissociative stupor
d. Trance and possession disorders
e. Dissociative motor disorders
f. Dissociative convulsions
g. Dissociative anaesthesia and sensory loss
h. Mixed dissociative (conversion) disorders
i. Other dissociative (conversion) disorders that include Ganser's syndrome and multiple personality disorder
j. Dissociative (conversion) disorder, unspecified.

It should be noted that 'depersonalisation-derealisation syndrome' does not belong here, but under the section of 'Other Neurotic Disorder'.

2. DSM-IV's dissociative disorders

There are five core or primary symptoms reflecting a disturbance in the integrative functions of memory, consciousness and/or identity. These five categories are discrete but interdependent, and each can be related to a host of other psychiatric symptoms such as hallucinations, phobias, etc.

a. Dissociative amnesia (psychogenic amnesia)
b. Dissociative fugue (psychogenic fugue)
c. Dissociative identity disorder (multiple personality disorder)
d. Depersonalisation disorder
e. Dissociative disorder not otherwise specified (including 'dissociative stupor' and 'trance and possession disorders')

It can be seen that the neurological (motor and sensory) elements are not considered in this category as in the ICD-10, but are regarded as Conversion Disorders under the category of Somatoform Disorders. By definition, neither of these disorders occurs exclusively during the course of another psychiatric disorder (such as Acute and Post-Traumatic Stress Disorder), and they cause clinically significant distress or impairment in functioning.

Etiology

The phenomenon of dissociation has been with human civilisation for a very long period. The concept of dual consciousness and demonic possession has been reported in various religions over centuries. The Hindu and Buddhist thinking are full of the notion of illusion ('maya') especially involving the self. Plato in 'The Republic' pointed out "the beast" inside us. St. Augustine was perplexed by his 'pagan self' emerging in his dreams, and he wondered about the dreamer's moral responsibility. Contemporary reviews relate dissociation to various neuro-psychophysiologic functioning, as described below.

1. Perrre Janet's theory:[9] a "dissociation" of ego occurs in certain pathological individuals, and part of the personality splits off to become an autonomous subconscious subpersonality. He also described a phenomenon called 'belle indifference' in which physiological and psychological functions disappear from consciousness, and the patient appears indifferent to the distress thus caused.

2. Sigmund Freud's theory:[10] an active defence phenomenon in which the integrity of the ego is forcibly repressed or dissociated. There is fixation at the genital stage, together with sexual fantasies of children, symbolising unconscious problems in the field of infantile sexuality;

3. Carl Gustav Jung's theory:[11] a neurosis is a dissociation of personality due to the existence of complexes.

4. Ferenczi[12] presented his findings concerning the effects of childhood sexual trauma and argued that ongoing assault created fragmentation and splitting of the child.

5. Hilgard's neodissociation theory:[13] a 'hidden observer' phenomenon that causes a split of consciousness in some hypnotisable subjects. He thus postulated a hierarchical ordering of subordinate cognitive control structures, under the central control structure of 'executive ego' which plans, monitors and manages functions involving the whole person so that he or she thinks and acts appropriately. When the monitoring and executive roles are not interacting in harmony, as in the hypnotic state, there would be automaticity of behaviour (with altered level of control) and 'partial' dissociation from conscious awareness.

6. Psycho-biological model: the frontal lobe appears important in monitoring and execution, and the temporo-limbic structures in the regulation of attention, memory, emotion and autonomic activity. There could be changes in the respiration, circulation, gastrointestinal movement, etc. and they are often mediated by changes in the autonomic nervous system activity.[7]

Epidemiology

The exact prevalence of this disorder is unknown as the symptoms go undetected for years, or their elusive nature are being misdiagnosed as other disorders like depressive disorder or even schizophrenia. Recent research indicates that the symptoms are post-traumatic, with a history of abuse in 72-98% of all reported cases.[14] On the other hand, there may be over-diagnosis in organic conditions especially epilepsy.

It appears that the phenomena occur more frequently in dull and unsophisticated persons. Patients with some past physical illness usually develop features related to (or suggested by) the diseases. The incidence of multiple personality disorder is much lower, and seems to be limited to North American countries. For example, Ross reported that 4.4% of a Canadian psychiatric inpatient population were diagnosable of dissociative disorder,[15] and its generalisability was challenged. A study in the U.K. found that 4% of the new neurology outpatients could be suffering from conversion disorders.[16] Finally, the trance states and possession disorder (under unspecified dissociative disorders) are rather culture-bound and occur mainly in certain cultures or religious subcultures; and common examples are that of 'amok' that originates in Indonesia and 'latah' in Malaysia.

Management

Management of dissociative disorders is not easy, especially when the diagnosis is made after excluding organic pathology and identifying a really related psychosocial stressor.

1. Assessment

a. Organic causes such as choreas, tics, etc. have to be ruled out in the first place, including the use of functional imaging techniques such as positron emission tomography.

b. There should be a thorough understanding of the patient's personality and the circumstances in order to find out any relevant psychosocial stressor. It may sometimes be important to rule out factitious disorders and malingering, especially when there is some legal consequences.[17] Information from close relatives or friends can thus be very useful.

c. The most popular diagnostic instrument is the 28-item self-report Dissociative Experiences Scale[18,19] which also has child and adolescent versions. The most valid one is the SCID-D (Structured Clinical Interview for DSM-IV dissociative disorders)[20] by Marlene Steinberg.

2. Treatment

So far, there has been no controlled studies of treatment with such disorders, and uncontrolled case reports are difficult to evaluate as there can be spontaneous improvement and also the possibility of some placebo effects.[21]

a. General supportive psychotherapy – to the primary care doctors, one important approach is the general reassurance and removal of sick role. The International Society for the Study of Dissociation Guideline favours that therapy focusing on maintaining and enhancing the daily functioning.[22]

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b. Insight therapy – to the psychiatrists, psychoanalysis had been traditionally used for patients with hysteria. Cognitive-behavioural therapy may also be used for conversion symptoms, but whether it works for dissociative symptoms remains to be seen.

c. Hypnosis – symptom removal through suggestion, either through hypnosis (including chemical abreaction by thiopentone) can be tried especially when there is a history of some traumatic event. Recovering memories with counselling on coping are then used. However, beware of the 'false memory syndrome' whereby therapists foster false recollections in their patients,[23] thereby leading to false allegations.

d. Medications – it has been suggested that the selective serotonin reuptake inhibitors useful for PTSD may perhaps be tried for dissociative symptoms.

Prognosis or course

The course of this multi-dimensional condition is difficult to predict and the disorder usually runs a variable course. Quite often the patients do suffer from psychosocial disabilities. The symptoms can change over time as more clear-cut psychiatric or neurological syndromes come out.

II. Specific types of dissociative disorders (according to the DSM-IV*)

A. Dissociative (psychogenic) amnesia

One or more episodes of inability to recall important personal information, too extensive to be explained by ordinary forgetfulness. The information is usually of a traumatic or stressful nature. It is a usually seen in hospital emergency departments[2] and is common during wartime and in victims of 'single' severe trauma such as traffic accidents or natural disasters such as earthquakes. The main differential diagnosis is genuine organic amnesia. For the latter, one's name is commonly the last item to which orientation is lost, and the full return of memory occurs gradually if at all.

B. Dissociative (psychogenic) fugue

The sudden, unexpected travel away from home or one's customary place of work, with inability to recall one's past. There can be confusion about personal identity or assumption of a new identity (partial or complete). The sophisticated social adaptation distinguishes it from organic fugue states. Unlike the dissociative identity disorder, there is usually one single episode without recurrence and recovery is usually spontaneous and rapid. The first fugueur was described by Philippe Tissie in 1886 about a young man in Bordeaux, France called Jean-Albert Dadas who travelled often without identity to Algeria, Moscow and Constantinople,[24] and the story was revealed under hypnotism. The diagnosis at that time was 'ambulatory automatism' and the cause was either hysteria or epilepsy, with the latter being treated chemically e.g. by bromides. Mass travellers did occur too, and Sir James Fraser reported the Jakun women in the Malay peninsula who suddenly ran off singling into the jungle and returned home almost naked.[25] The most famous American fugureur was the Rev. Ansel Bourne of Massachusetts who disappeared and woke up two months later in Pennsylvania under the name of John Brown, without memory of how he got there.[26] Such conditions occur more commonly during military actions with the deserting soldiers, especially when there is compulsory conscription.

C. Dissociative identity (multiple personality) disorder

The presence of two or more distinct identities or personality states, each with its own relatively enduring pattern of perception, relating to, and thinking about the environment and self. At least two of these identities or personality states recurrently take control of the person's behaviour. The internal struggle leads to confusion over issues of personal identity, and there can be dissociative amnesia for periods when an altered identity emerges. In some patients, the different identities can interact internally or hold conversations with one another. This is the most chronic and severe category[27] and is believed to occur after severe and persistent child abuse (physical, psychological or sexual). Patients may experience hallucinations and be misdiagnosed

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Key messages

1. Dissociative disorders, though not common in primary care settings, are quite interesting psychiatric phenomena and sometimes magnified in movies and novels.
2. Modern classifications suggest discrete and interdependent categories, and the disorder is sometimes misdiagnosed including neurological diseases.
3. The exact pathology is not known, and both psychological and organic factors are possible.
4. Management is not easy and both organic and psychological disorders have to be ruled out, including factitious disorder and malingering.
5. The main current focus is on maintaining and enhancing the daily functioning of the patients and to minimise the disabilities.
6. Skilled practitioners may use hypnosis to recover past traumatic memories followed by counselling on coping.

as schizophrenia and have affective symptoms being labelled as affective disorders. The chaotic lifestyle may be mistaken as a borderline personality disorder. It may take years before the proper diagnosis is made. However, some question whether this disorder ever exists, blaming it to the invention of over-zealous therapists, an iatrogenic artefact on a suggestible and compliant patient.[28] Still others claim it as a defence for survival in response to extreme childhood trauma, especially physical or sexual abuse.[29]

D. Depersonalisation disorder

The persistent or recurrent experiences of feeling detached from, as if one is an outside observer of, one's mental processes or body. Reality testing remains intact during the experience. The symptom is the feeling that one's body or self is unreal, as if they are living in a dream or move, or feel numb, invisible or dead. Chronic depersonalisation is usually accompanied by derealisation – the feeling that features of the environment are unreal. The patient will remain intact during reality testing. Depersonalisation as an isolated symptom can occur following alcohol use, sensory deprivation, emotional stress, sleep deprivation, temporal lobe epilepsy, and the effects of some medications.

E. Dissociative disorder not otherwise specified

The predominant feature is a dissociative symptom not meeting the criteria of the above, e.g. the Ganser's syndrome (the giving of approximate answers), derealisation without depersonalisation, dissociate trance disorder (including possession trance and other culture-bound syndromes like amok, latah, etc.), loss of consciousness, and stupor or coma not attributable to a general medical condition. Amok and latah have first been described in Malaya.[30] Amok begins with a period of brooding followed by violence and dangerous use of weapons. Latah patients showed imitative and automatic behaviour such as echolalia and echopraxia after a sudden frightening experience. For 'dissociative stupor' (a specific item in the ICD-10), there is profound diminution or absence of voluntary movements and speech and of normal responsiveness to light, noise and touch. However, the normal muscle tone, static posture and breathing (and often limited coordinated eye movements) are maintained.

Also according to the ICD-10, 'trance and possession disorders' form one unique item of the dissociative disorders. 'Trance' is defined as "temporary alteration of the state of consciousness with loss of the usual sense of personal identity; narrowing of awareness of immediate surroundings, or usually narrow and selective focusing on environmental stimuli; and limitation of movements, postures, and speech to repetition of a small repertoire". For 'possession disorder', the patient is "convinced that he or she has been taken over by a spirit, power, deity or other person". These disorders must be unwanted and troublesome, occurring outside, or being a prolongation of, similar states in religious or other culturally accepted situations.

Conclusion

Dissociation has come to represent different types of phenomena and constructs, from altered experiences of detachment from the self or the surroundings, to a presumed defence to ward off ongoing anxiety or pain. Further clarification is needed in this area. ■

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