

# Dissociative Disorders

- MUST cause clinically significant distress or impairment in social, occupational, or other areas of functioning
- Disruptions tend to occur across domains of  
Cognition –in processes of consciousness, memory, identity,  
and/or perception  
Emotion –tends to be separated into non-integrated experiences  
or numbness  
Behavior –may be markedly different and/or inconsistent

# Dissociative Identity Disorder

- A. Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self- and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.
  
- B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.

# Dissociative Identity Disorder

- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The disturbance is not a normal part of a broadly accepted cultural or religious practice.  

Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play.
- E. The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

# Dissociative Amnesia

- A. An inability to recall important autobiographical information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting.

Note: Dissociative amnesia most often consists of localized or selective amnesia for a specific event or events; or generalized amnesia for identity and life history.

- B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The symptoms are not attributable to the physiological effects of a substance or a neurological or other medical condition (e.g., complex partial seizures, closed head injury, etc.).

# Dissociative Amnesia

- D. The disturbance is not better explained by Dissociative Identity Disorder, Dissociative Fugue, Posttraumatic Stress Disorder, Acute Stress Disorder, Somatic Symptom Disorder, or Major or Mild Neurocognitive Disorder.

Can specify if:

With Dissociative Fugue

# Depersonalization/Derealization D/o

- A. The presence of persistent or recurrent experiences of depersonalization, derealization, or both:
  1. Depersonalization: Experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions (e.g., perceptual alterations, distorted sense of time, unreal or absent self, emotional and or physical numbing)
  2. Derealization: Experiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted).
  
- B. During the depersonalization or derealization experience, reality testing remains intact.

# Depersonalization/Derealization D/o

- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The disturbance is not attributable to the physiological effects of a substance or another medical condition (e.g., seizures).
- E. The disturbance is not better explained by another mental disorder, such as Schizophrenia, Panic Disorder, Major Depressive Disorder, Acute Stress Disorder, Posttraumatic Stress Disorder, or another Dissociative Disorder.

# Dissoc. Dsrdrs – Prevalence

Dissociative Amnesia, - as high as 7%, particularly when diagnosed following exposure to traumatic event, but stated as 1.8% in DSM5.

Other Dissociative Disorders – Typically rare with low base rates but diagnosis of DID has increased recently, with rates being reported as 1.5% in DSM5.

Janet, regarded as the father of dissociation, saw 4 cases of DID in his lifetime

Thigpen & Cleckley, who saw the famous case of Eve in 1954, saw only one other case of DID in the subsequent 30 years (to 1984) despite hundreds of referrals

Three supervisors, ranging from 15-35 years of clinical experience, saw a total of 3 cases, 1 each for 3 supervisors – 15, 25, and 30 years. Two supervisors, with 15 and 35 years of experience, had never seen a case.

Gender differences unknown, although famous cases tend to be of women (more well-known male Dissociative Fugue cases) (Hilgard, 1977)

# Dissoc. Dsrdrs – Prevalence

DID: 3-9:1 F:M

One U.S. study found that DID was found in 6-10% of psychiatric patients.

The presence of a history of substantial abuse among people with DID is extremely prevalent.

Studies of DID patients:

| <u>Study</u>        | <u>N(female/male)</u> | <u>% P&amp;S Abuse</u> | <u>% P</u> | <u>% S</u> |
|---------------------|-----------------------|------------------------|------------|------------|
| Putnam et al. 1986  | 100(92/2)             | 97                     | 75         | 83         |
| Ross et al. 1989c   | 236                   | 89                     | 75         | 79         |
| Coons et al. 1988   | 50(46/4)              | 96                     | 60         | 68         |
| Schultz et al. 1989 | 355(319/36)           | 98                     | 82         | 86         |

# Dissoc. Dsrdrs – Course

Tend to be misdiagnosed for years before accurate diagnosis is reached.

Tends to be suspected in cases with significant childhood abuse, particularly sexual. If sexual abuse is corroborated by others and the patient has no recall of such instances, DD diagnosis much more likely (vs. self-report, which tends to more often reflect BPD, or PTSD, both of which often have childhood abuse history).

Symptoms also wax and wane, they're not consistent on a day-to-day, or even year-to-year basis in some cases.

# Dissociation - Etiology

Désaggregation (Janet, 1889)

coined to describe the process underlying the manifestation of the following symptoms:

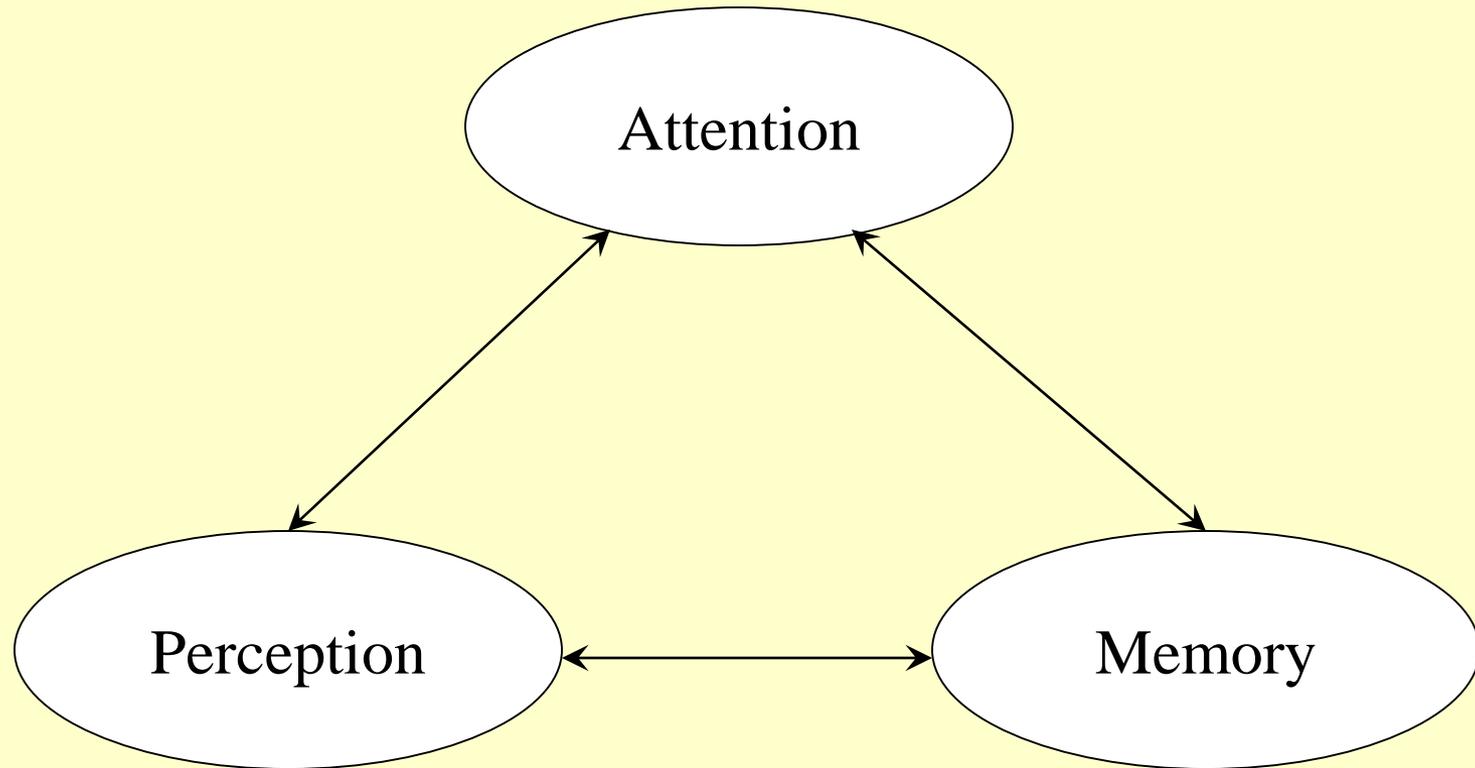
1. limb paralysis in normal consciousness but under hypnosis, free movement in all extremities
2. repetitive behaviors triggered by a distressful memory with no recollection of the behavior afterwards
3. presentation of different, incongruous personality characteristics (e.g., shyness and flirtatiousness) after certain triggering events (e.g., certain visitors)

# Dissociation - Etiology

Janet observed that the behaviors/symptoms had disconnected quality and attributed them to:

1. an amnesic process whereby his patients
  - “forgot” their sensory ability (in the case of the paralytic)
  - “forgot” their personality characteristics (the shy patient becoming flirtatious)
  - “forgot” their recent repetitive behaviors
  
2. a narrowing of the field of one’s consciousness
  - “hysteria” (narrowing of sensory/motor sensation)
  - different personalities (narrowing of self-integration processes)
  - persistent re-enactments of troubling events (narrowing of recall and memory coding processes)

# Dissociation – Etiology



# Dissociation - Treatment

Treatment is supportive and can undergo different stages

Therapeutic relationship is important as trust is necessary (particularly given abuse histories – maintenance of professional boundaries is critical)

The goal is to integrate the dissociated processes

- for amnesia, hypnosis to facilitate retrieval of memory (controversial) and rehearsal of memory
- support of patient verification of recalled memory
- grounding techniques/redirection of cognitive processes (mindfulness)
- fragmentation - experiential techniques
- facilitate the introduction of fragmented alters to each other and work towards integration

# Dissociation - Treatment

As other treatment issues arise, address through traditional therapies

i.e., problem-solving therapy

marital therapy and improved communication skills

vocational counseling

cognitive restructuring of distressing thoughts

relaxation exercises to moderate anxiety and fear responses

learning and practicing emotion regulation skills

exposure to avoided and feared stimuli

psychodynamic therapy to process and understand childhood  
history

pharmacological treatment for mood, anxiety symptoms