

# Dissociative disorders essay sample



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## Introduction

Dissociative disorder is one of the most contentious mental disorders and is subject to intense cynicism. The literature ranges from passionate discourses recognizing it as a real psychiatric disorder to equally obsessive claims that it does not exist. The purpose of my paper is to discuss dissociation and its clinical manifestations.

Dissociation is an experience, or a perceptible process, in which awareness is disrupted so that what might typically seem to be consistent, continuous, linked, and integrated is compartmentalized into self-directed groups of feelings, memories, and perceptions that can be remembered in a unreal, illusory, or vague state or that are repressed and out of conscious wakefulness.

This way of managing defensively with unbearable anxiety linked to traumatic events may be a normal, adaptive technique. Dissociation is a psychobiological means that allows the mind to “flee” what the body is experiencing (Waites 1993); it is not attributable to a physical disorder or accident or to substance abuse; it is self-preservation against trauma. Exiled memories may recur as intrusive images, physical symptoms, nightmares, or experiencing the trauma.

The dissociative phenomena are more expected present in extremely hypnotizable patients (as also are the dissociative disorders), though, the presence of dissociative phenomena may simply be isolated clinical findings. Additionally, patients who have high hypnotic potential require not have any dissociative symptoms. Indeed, training in hypnotherapy will be beneficial to

anyone intending to work in the area of dissociation. Books dealing with clinical aspects of hypnosis will also usually contain sections on dissociative issues (Spiegel 1993a, 1993b) (I not reached to hypnosis I m just telling reader that there are many books with clinical aspects of hypnosis) .

The American Psychiatric Association's (1987) Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev.) states that the vital feature of these disorders is a disturbance or amendment in the normally integrative functions of identity, memory, or realization.

The disturbance or alteration may be sudden or steady, and transient or chronic. If it occurs mostly in identity, the person's customary identity is provisionally forgotten and a new identity may be assumed (as in Multiple Personality Disorder), or the customary feeling of one's own reality is lost and is reinstated by a feeling of unreality (as in Depersonalization Disorder). If the disturbance occurs mainly in memory, important personal events cannot be recalled (as in Psychogenic Amnesia and Psychogenic Fugue) (p. 231).

Dissociative Disorders Not Otherwise Specified Disorders in which the predominant feature is a dissociative symptom (i. e., a disturbance or alteration in the normally integrative functions of identity, memory, or consciousness) that does not meet the criteria for a specific Dissociative Disorder. Examples:

1. Ganser's syndrome: the giving of " approximate answers" to questions commonly associated with other symptoms, such as amnesia,

- disorientation, perceptual disturbances, fugue, and conversion symptoms. (American Psychiatric Association, 1987, p. 276-277)
2. cases in which there is more than one personality state capable of assuming executive control of the individual, but not more than one personality state is sufficiently distinct to meet the full criteria for Multiple Personality Disorder, or cases in which a second personality never assumes complete executive control. (American Psychiatric Association, 1987, p. 276-277)
  3. Trance states, i. e., altered states of consciousness with markedly diminished or selectively focused responsiveness to environmental stimuli. In children this may occur following physical abuse or trauma. (American Psychiatric Association, 1987, p. 276-277)
  4. Derealization unaccompanied by depersonalization (American Psychiatric Association, 1987, p. 276-277)
  5. Dissociated states that may occur in people who have been subjected to periods of prolonged and intense coercive persuasion (e. g., brainwashing, thought reform, or indoctrination while the captive of terrorists or cultists) (American Psychiatric Association, 1987, p. 276-277)
  6. Cases in which sudden, unexpected travel and organized, purposeful behavior with inability to recall one's past are not accompanied by the assumption of a new identity, partial or complete. (American Psychiatric Association, 1987, p. 276-277)

Patients with dissociative disorders, particularly those with dissociative identity disorder (DID; American Psychiatric Association [APA] 1994) or

dissociative disorder not otherwise specified (APA 1994), show cyclical, far-reaching and sudden alterations of behavior, affect, sensation, awareness and knowledge. According to Putnam, these patients have developed a range of “ highly distinct states of consciousness organized around an established affect, sense of self (including body image), with a limited repertoire of behaviors and a set of state-dependent memories” (1988, 103).

Some of these dissociative states can relate to various defensive and recuperative reaction patterns similar to the automatic defensive reactions well depicted in animals under attack. Predatory attack involves various stages, each of which demands its own defensive reactions, and the defensive systems of prey take in many different subsystems adapted to meet this inconsistent threat.

#### States of Dissociative disorder

Uncontrollable and repetitive interruption of traumatic memories and linked traumatic states — including dissociative (identity) states, fragments and other ego states — and the expenditure of incessant effort to avoid internal and external reminders of trauma, with resultant detachment from the body, emotions, self and social world, lead to exhaustion and, eventually, to chronic states of misery ( Janet 1889, 1909 ). On the other hand, successful processing of traumatic memories entails integration of these states.

The observation that dissociation and the dissociative disorders resultant from it affect a wide range of mental and physical functions was vital to nineteenth-century views on hysteria. In that era hysteria take in symptom complexes that today would be diagnosed as dissociative disorders,

somatoform disorders, sexual disorders, eating disorders and personality disorders ( Janet 1889, 1909 ).

Pierre Janet, the French pioneer in the field of trauma and dissociation, defined hysteria as “ a form of mental depression typified by the retraction of the field of personal consciousness and an inclination to the dissociation and emancipation of the systems of ideas and functions that constitute personality” (Janet 1907/ 1965, 332).

Such “ systems of ideas and functions” could belong to either psyche or soma. In the introduction to his medical thesis, *L'État mental des hystériques*, Janet quoted Briquet (1859), who stated: “ Hysteria is a disease which modifies the whole organism” (Janet 1893/ 1901, xiii). And Janet immediately added: “ If it disturbs nutrition and all the physiological functions, it disturbs also the psychological phenomena, which are one of the functions of the organism.”

Modern North American (e. g. Spiegel, D. 1993a, 1993b) views on dissociation tend to be more restraining and completely or partially disregard the modifications in somatoform functions and reactions that so frequently accompany pathological dissociation. For example, the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)* defined the essential feature of the dissociative disorders as “ a disturbance or alteration in the normally integrative functions of identity, memory, or consciousness” (American Psychiatric Association [APA] 1987, 269).

In the fourth edition, *DSM-IV* (APA 1994), it was hesitantly added that this disturbance could also influence perception of the environment. As a result,

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in this diagnostic system, somatoform symptoms, which nineteenth-century French psychiatrists would have measured dissociative, are diagnosed instead as somatization disorder, pain disorder, conversion disorder, sexual disorder or body dysmorphic disorder, disorders not understood or classified as dissociative in nature.

In contrast, the latest edition of the International Classification of Diseases, the ICD-10 (World Health Organization [WHO] 1992), recognizes that dissociation may affect somatoform functions and reactions: “ The common theme shared by dissociative disorders is a partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements” (Shahul Ameen, World Health Organization. p. 151).

However, even this current international definition is more restrictive than what Janet had in mind. As defined in ICD-10, dissociative disorders of movement and sensation involve only loss of sensations and loss of or interference with movements. Disorders involving additional sensations such as pain are to be included in the somatoform disorders, and somatization disorder is not classified as a dissociative disorder.

### Clinical Practice and Diagnosis

While dissociative identity disorder is very infrequently encountered in clinical practice, as more attention is paid to the occurrence of sexual abuse of children the core trauma believed to be the etiology of dissociative identity disorder clinicians require to consider this as a possible diagnosis. A word of caution though is indicated. Childhood sexual abuse is often hard to

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document, as it typically is reported while the person is an adult, memories may be indistinct or inaccurate, and there is often little prospect to get information from others in the family of origin, so accurate assessment should be handled by skilled, experienced, balanced clinicians.

Another concern can be the bias of the clinician, who may be overzealous in looking for proof of sexual abuse and may unintentionally lead the client, especially one who may be highly susceptible or eager to please, to “remember” incidents that did not occur (Staff, 1999). Clinicians should be knowledgeable concerning the processes of memory and repression and must also distinguish their prospective power to direct client thinking.

Since “recovered” memories might not always be accurate, it is significant to obtain some sustaining evidence from outside sources; while sexual abuse certainly occurs, so do false indictments that can lead to serious family disturbance and even litigation. We all have diverse capacities for remembering and forgetting, and memories can include truth, partial truth, and distortion. Clinicians and clients ought to recognize this and not draw conclusions concerning abuse just from a set of symptoms (Staff, 1999).

The debate about recovered memory persists, with political overtones. Defenders say that opponents support a backlash against the rights of abused women and feminism generally, choosing to view women as susceptible, passive, and able to be manipulated by their therapists, and by refuting the validity of recovered memories promote the regressive “blaming the victim.” Opponents accuse proponents of providing false explanations for indistinct and ambiguous symptoms and permitting the



client to assume a victim posture, blaming shortcomings and problems on others.

They are concerned that as a consequence of what they refer to as “ false memory syndrome,” families have been destroyed and actual experiences of child abuse are discredited (Staff, 1999). The controversy extends also to whether the center of the intervention must be on investigating childhood with the accompanying modernization of the past or on the client’s present and future. The limitations that managed care places on number of sessions, of course, encourage involvement that is more present-oriented.

Myths, legends, religion, and literature all refer to alteration of identity in order to have power, be invincible, and to have the tools to cope better. Children, exposed to comics, television, and movies, as well as through their own thoughts, often believe in their “ ability” to change individuality for brief periods of time. Images of shamans, changed into animals or exemplifying spirits, may be found in Paleolithic cave paintings and modern Eskimo art (Putnam 1989).

The shaman, trained to be a master of self-hypnosis, displays numerous of the features of dissociative identity disorder, yet is not measured to have a mental disorder. Demon possession was a maladaptive figure of identity transformation common among Christians from the middle Ages into the mid-nineteenth century. A typically polite, devout person would abruptly be “ possessed” by a demon personality who would be offensive and blasphemous.

The “cure” for possession was exorcism, linking theological debate, threats, and commands between the exorcists and the demon. At the end of the process, there was a culturally authorized, religious integration ritual. By the middle of the nineteenth century cases were renowned in which the person was possessed not by a fiend but by a dead relative or neighbor and assist was sought from physicians rather than clergy (Ross 1989).

As dissociative disorders usually come to the consideration of mental health professionals when the person is an adult, the progression begins when the trauma occurred, often in childhood. Numerous people suffering from this disorder are not appropriately diagnosed until they are in their middle to late twenties. Dissociative identity disorder has been found nine times as often in women as in men, but that ratio is declining as appraisal skills improve.

There may as well be a sampling bias, since women, in addition to being more likely to seek clinical intervention, experience more continuing physical and sexual abuse and are more expected to self-mutilate or attempt suicide; thus they are more expected to come to the consideration of the mental health system. Men who suffer from dissociative identity disorder often turn their aggression outward and come to the consideration of the criminal justice system.

The difficulty in assessing dissociative identity disorder can be convoluted by the fact that people who might suspect the presence of this disorder are very afraid of being regarded as “crazy” (Kluft, R. P. 1993). Those who suffer from this disorder frequently experience a range of physiological, neurological, and medical symptoms and can have received several

psychiatric diagnoses for which involvement, often with medication, has proved ineffectual. Thus a history, upon evaluation, of inability to ease symptoms following intervention must lead the mental health professional to consider a diagnosis of dissociative identity disorder.

People with this disorder often seek intrusion with presenting problems of psychosomatic symptoms, depression, mood swings, or awareness of comparatively frequent changes in the way they behave, which might have been brought to their attention by others. Even though they may be competent of holding high-level jobs, they may often have a history of frequent, sudden job changes. Suicide gestures, or attempts, are not sporadic, nor is a history of insomnia or nightmares. A history of victimization as an adult must lead to exploration of probable childhood abuse.

A proper diagnosis can be made simply when the clinician establishes that the person experiences amend personalities who can be recognized and elicited. The clinician must “ meet” at least one alter who is moderately enduring, recognized as unique in behavior, and assumes control from time to time. This process more often than not takes time, and the revelation might come not in the actual session with the clinician but in a telephone call by “ a friend” or in a letter.

As of the nature of the disorder, it may be very hard to obtain a history. The clinician must proceed with patience and be prepared for discrepancies; amnesia, perhaps for events over numerous years, especially in childhood; and inconsistency in chronology, if the history is divided among alters. History is typically provided initially by the host personality, who may shower

the account of the history with “ I have a terrible memory” or “ I can’t tell exactly when that happened.” The host may present as depressed, anxious, guilty, compulsively good, and suffering from psycho physiological symptoms as well as from loss or distortion of time (Kluft 1993).

## Conclusion

People suffering from dissociative identity disorder often illustrate a fragile sense of identity and can be asked if they have ever felt like more than one person, if they say or do things that they feel are out of character, or if they ever feel as if they are not alone or are watching themselves in action.

However, if careful assessment results in a diagnosis of a dissociative disorder, the clinician implication must remember that these disorders, particularly dissociative identity disorder, are not diseases. They are maladaptive attempts to handle with overwhelming trauma. People seeking intervention for dissociative identity disorder goes through great pain, and some are incapable to progress beyond the point at which alters is able to communicate and cooperate with each other.

If the alters attain this level of communication, the clinician’s next step is to stab fusion, which involves removing the dissociative barriers that have alienated the alterations. Successful completion of this step is followed by assimilation of the personality. Finally, the person, having given up dissociation, should establish more varied, flexible, and adaptive coping mechanisms. Both the person and the clinician should be strongly committed to the often painful process of rebuilding. The commitment may be

rewarding, though, since the disorder has a good prognosis if the patient can accept identification and investigation of the core traumas.

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All the Pierre Janet reference is taken from these websites <http://www.oldandsold.com/articles25/religion-medicine-9.shtml> <http://www.establishment.org/history.html>