History of the concept of dissociation – hysteria, multiple personality disorder, co-consciousness, dissociation

Dissociation – definition & functions
  - Dissociation as a continuum

Dissociative disorders
1880-1920
Ascent of interest in hysteria

At the end of the 19th century & beginning of the 20th century, clinicians had an interest in patients with hysteria

- In Europe (at the Salpêtrière, in Paris) – Jean Martin Charcot, Pierre Janet, Alfred Binet, Sigmund Freud
- In America – William James, Morton Prince, Boris Sidis
History of the concept of dissociation

Clinicians described a ‘second consciousness’ – terms used include:

- **Subego** (Durand the Gros)
- **Internal spiritual man** (Deleuze)
- **Unconscious** (Freud)
- **Somnambulistic/abnormal consciousness** (Janet)
- **Subconscious person** (Binet)
Multiple Personality Disorder

Early cases of MPD:

- Shamanic transformations & possession states
- 1646 - Paracelsus described a case
- 1791 - Eberhard Gemlin treated a 20 y.o. woman with ‘exchange personalities’
- 1840 – Despine - monography setting forth treatment principles for therapy for MPD
Pierre Janet’s theory of dissociation

1889 - *Pierre Janet* investigated the nature of mental ‘désagrégation’ in hysterical patients & developed the ‘trauma theory of dissociation’

- According to Janet, normal psychological functioning is characterized by the *unity* and the *harmonious interaction* of two mental functions (preservation and reproduction of past memories & integration of mental phenomena), resulting in an *integrated, cohesive whole*
Pierre Janet’s theory of dissociation

- The integration of mental functioning requires a certain amount of psychic energy
  - When the amount of available energy is below the threshold required for normal functioning, the human psyche becomes ‘disintegrated’

- Low levels of psychic energy may result from:
  - **Genetic** – inherited - vulnerability
  - **Acquired** – through major prolonged illness, major losses, exposure to traumatic events
Pierre Janet’s theory of dissociation

Janet conducted hypnosis experiments with hysterical patients and demonstrated the existence of two levels of consciousness:

- **Principal consciousness**, believed to be the ordinary personality
- **Somnambulistic consciousness** – abnormal, ignored by the principal one; susceptible to further subdivisions
Pierre Janet’s theory of dissociation

The relationship between the normal, ordinary personality & a somnambulistic consciousness can be:

- **Relative independence** (the two personalities develop in separate directions)
- **Incomplete separation** (the second personality is not completely separate from the first one)
- **Reversed dependency** (the two personalities are interdependent, the second being the dominant one)
Pierre Janet’s theory of dissociation

The *dissociated mental content* could range from a single sensation or thought to complexes of perceptions, thoughts, or experiences. It could manifest as:

- Fixed ideas
- Amnesias
- Anesthesia
- Somnambulistic attacks
- Stigmata
Pierre Janet’s theory of dissociation

- The process of *dissociation is unconscious*; however, the resulting abnormal phenomena are consciously experienced as alien to the self.

- Janet believed that hypnosis could be used successfully in the treatment of patients with hysterical symptoms - MPD.
Multiplicty as ‘the law’

- Boris Sidis believed that the multiplicity of consciousness is not the exception, but the law. “For mind is a synthesis of many systems, of many moments of consciousness”.
  
  *Sidis, 1904*

- Sidis subscribed to Janet’s *trauma theory of dissociation*; he believed that functional dissociations occurred as a result of severe physical or psychological trauma.
The ‘hidden self’

Morton Prince viewed the ‘hidden self’ as a consciousness who perceives and observes even when the controlling main consciousness does not see or feel, a consciousness that acts like a guardian angel and can be helpful in the therapeutic process.

*Prince, 1975*
1920-1970
Decline of interest in MPD

- Climate of disbelief & skepticism – conviction that MPD was an artifact of hypnosis
- Bleuler introduced the term ‘schizophrenia’ in 1908
- A review of ‘Index Medicus’ revealed that the # of cases of MPD between 1914 and 1926 was larger than the # of cases of schizophrenia; since 1927, dramatic increase in # of patients diagnosed with schizophrenia
1970-1990
Re-emergence of interest in MPD

- 1970 - Ellenberger published his book on the origin and development of dynamic psychiatry, on the history of the unconscious
- 1977 - Hilgard (published “Divided consciousness” – neo-dissociation theory
- MPD was included in the DSM-III (1980) - reestablished the legitimacy of the diagnosis
Co-consciousness

Behars (1983) postulated co-consciousness as a universal feature of healthy living; what is pathological is not multiplicity per se, but rather the impairment of the organizing executive function, the failure to integrate experience, roles, ego states in an organized whole, a ‘cohesive selfhood’.
Dissociation - definition

Dissociation “represents the fundamental psychobiological mechanism underlying a wide variety of altered forms of consciousness, including conversion hysteria, hypnotic trance, mediumistic trance, multiple personality, fugue states, spirit possession and highway hypnosis.”

Ludwig, 1983
Functions of dissociation

- Automatization of certain behaviors
- Efficiency & economy of effort
- Enhancement of the ‘herd sense’ (e.g., submersion of the individual ego into group identity; increased suggestibility)
- Cathartic discharge of emotions
- Resolution of irreconcilable conflicts
- Escape from the constraints of reality
- Isolation of catastrophic experiences

*Ludwig, 1983*
The continuum of dissociation

Dissociation can be viewed on a continuum, from normal to pathological:

- *Minor, nonpathological dissociation* of everyday life (e.g., ‘small dissociations’ – highway trance)
- *Major pathological manifestations* (i.e., dissociative disorders)
Pathological dissociation

Characteristics of pathological dissociation:

- *Alteration in one’s sense of identity* (e.g., amnesia for self-referential information)
- *Disturbance of memory* for events which occurred during a period of dissociation
  
  Nemiah, 1981

- It is *traumatically induced*

  Putnam, 1989
Clinical features of MPD/DID

- **Commonalities:**
  - Rapid transition among personalities in response to environmental triggers
  - Amnesic barrier
  - Principle types of alter personalities: depressed/depleted host or presenting personality & child alters

*Putnam, 1989*
Clinical features of MPD/DID

- Clinical features that have changed over time:
  - Trend toward higher # of identified alters (on average, N=13)
  - Association with traumatic childhood experiences
  - Revictimization in adulthood
Symptom profile suggesting MPD/DID

- **Multiple neurological and medical symptoms** (e.g., headaches, loss of consciousness, seizures, paresthesias – numbness, tingling; visual disturbances, paresis, pain in the reproductive system, etc.)
- **Numerous diagnoses** (depression, amnesia, anxiety, substance abuse, hallucinations - berating voices, lengthy & coherent logical discussions; disembodied faces, blood, self-mutilation, etc.)
- **Refractory to standard treatment**
Dissociative Symptoms

Included in the criteria sets for:

- Acute Stress Disorder
- PTSD
- Somatization Disorder

In some classification systems conversion reaction is considered to be a dissociative phenomenon. In the DSM-IV, Conversion Disorder is placed in the “Somatoform Disorders” section.
Dissociative Disorders

- 300.12 Dissociative Amnesia (formerly Psychogenic Amnesia)
- 300.13 Dissociative Fugue (formerly Psychogenic Fugue)
- 300.14 Dissociative Identity Disorder (formerly MPD)
- 300.6 Depersonalization Disorder
- 300.15 Dissociative Disorder Not Otherwise Specified
Clinical presentations similar to DID that fail to meet full criteria (e.g., no amnesia for important events)

- **Ganser syndrome** = approximate answers
- **Derealization** (no depersonalization)
- **Dissociative trance disorder** (e.g., possession states; culture-bound syndromes – *amok, latah, pibloktoq*, etc.)
Dissociative Trance Disorder

Involuntary state of trance that is not accepted by the person’s culture as a normal part of a collective cultural or religious practice and that causes clinically significant distress or functional impairment (should not be considered when individuals enter trance or possession states voluntarily and without distress in the context of religious and cultural practices that are broadly accepted by the person’s cultural group).
Culture-Bound Syndromes

- **Amok** - Malaysia, Laos, Philippines, Polynesia, Papua New Guinea, Puerto Rico, Navajo – period of brooding followed by a violent outburst and destructive behavior directed at objects or people; tends to be precipitated by a perceived insult

- **Falling out/Blacking out** – Southern United States, Caribbean – sudden collapse, dizziness, inability to see or to move
Culture-Bound Syndromes

**Latah** – Malaysia/Indonesia
Hypersensitivity to sudden fright (more frequent in middle aged women) - often accompanied by echopraxia, echolalia, and trancelike behaviors

- Other terms for this condition: *amurakh, irkunii, olan, myriachit, menkeiti* (Siberia); *bah tschi, bah- tsi, baah-ji* (Thailand); *imu* (Ainu, Sakhalin, Japan); *mali-mali & silok* (Philippines)
Culture-Bound Syndromes

- **Pibloktoq** – arctic & subarctic Eskimo communities – an abrupt dissociative episode accompanied by extreme excitement (e.g., may tear off clothing, break furniture, shout obscenities, eat feces, etc.) lasting up to 30 minutes, frequently followed by convulsive seizures and coma lasting up to 12 hours; the individual may be withdrawn & irritable for days or hours prior to the episode – amnesia for the episode/attack
Culture-Bound Syndromes

- **Shin-byung** – Korea – *during initial phases anxiety and somatic complaints, followed by dissociation and possession by ancestral spirits*

- **Spell** – among African Americans and European Americans from the southern United States – *trance state in which individuals ‘communicate’ with deceased relatives or with spirits*
Culture-Bound Syndromes

- **Zar** – Ethiopia, Somalia, Egypt, Sudan, Iran and other North African and Middle Eastern societies – *experience of spirit possession* (not considered pathological locally)
Other dissociative disorders

- **Hypnoid states** (‘trance-like’)
- **Somnambulism** (included among sleep disorders)
- **Possession states** (can be perceived on a continuum from desirable & benevolent to undesirable & malevolent)
- **Out-of-body & near-death experiences**

*Putnam, 1989*
Famous cases of MPD

- Christine Beauchamp (Clara Norton Fowler) was reported in great detail by Morton Prince) & reportedly cured; she subsequently married one of Prince’s associates, Boston neurologist Dr. George Waterman.

- Mary Reynolds (Eve) (Thigpen & Cleckley, 1957)

- Sybil (Schreiber, 1974)
300.12 Dissociative Amnesia

- Criterion A: One or more episodes of inability to recall important personal information, usually of a traumatic or stressful nature – too extensive to be explained by ordinary forgetfulness.
- Criterion B: Not due to another Axis I condition, to the effects of a substance or a medical condition.
- Criterion C: Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
300.13 Dissociative Fugue

- **Criterion A**: Characterized by sudden, unexpected travel away from home or one’s customary place or work, accompanied by an inability to recall one’s past and confusion about personal identity or the assumption of a new identity.

- **Criterion B**: Not due to another Axis I condition, to the effects of a substance or a medical condition.
300.13 Dissociative Fugue

- Criterion C: Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

Dissociative fugue (4:22 min)
http://www.youtube.com/watch?v=QajubDsCcrw
Characteristics of Dissociative Fugue

1. **Amnesia** - absence from memory of a specific segment of time (functional retrograde amnesia)
2. **Depersonalization** - sense of detachment from the self, observing self from the outside
3. **Derealization** - sense that one’s surroundings are unreal (absence of familiar affect)
4. **Identity confusion** - subjective feeling of uncertainty or conflict regarding one’s identity
5. **Identity alteration** - objective behavior, identification of different identities
Stressors in Dissociative Fugue

- War
- Marital problems
- Financial problems
300.6 Depersonalization Disorder

- Criterion A: Characterized by a persistent or recurrent feeling of being detached from one’s mental processes or body that is accompanied by intact reality testing
- Criterion B: Not due to another Axis I condition, to the effects of a substance or a medical condition
- Criterion C: Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
300.14 Dissociative Identity Disorder

- Criterion A: Characterized by the presence of two or more distinct identities or personality states that recurrently take control of the individual’s behavior, accompanied by the inability to recall important personal information – too extensive to be explained by ordinary forgetfulness

- Criterion B: At least two of these identities or personality states recurrently take control of the person’s behavior
300.14 Dissociative Identity Disorder

- Criterion C: Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness

- Criterion D: Not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during Alcohol intoxication) or a general medical condition
  - In children: not attributable to imaginary playmates
Etiological theories for DID

- **Supernatural explanation**: spirit possession or reincarnation

- **Childhood trauma**: Coons & Milstein (1984) reported hx of sexual abuse in 75%, hx of physical abuse in 50%, and overall 85% incidence of child abuse in their sample of 20 patients. The abuse is described as sadistic—bondage, insertion of instruments into vagina, mouth, and anus; torture, forced into prostitution; some reported Satanic rituals.
Etiological theories for DID

- **Childhood trauma**: confinement abuse is common (e.g., tying, locking up in closets, cellars, or trunks; stuffing the child in boxes or bags; being buried alive), along with continuous threats of violent punishments; nonabusive trauma – witnessing violent death of a relative or close friend, massacre of several family members, sustained pain or debilitating injury (in rare instances)
A developmental model of DID

“Everyone has the potential to develop MPD; at birth, behavior is organized into discrete states of consciousness; over time, the transitions between states are smoothed out and an integrated sense of self is developed and consolidated.”

Putnam, 1989
A developmental model of DID

- MPD/DID appears to be a psychobiological response to a relatively specific set of experiences occurring within a circumscribed developmental window: early childhood.

- Children have a high capacity for fantasy, high hypnotizability & a propensity to enter a dissociative state of consciousness.

*Putnam, 1989*
Kluft’s 4 factor etiological model

1. The capacity to dissociate defensively in the face of trauma
2. Traumatic life experiences exceed the child’s adaptational capacities
3. Soothing & restorative experiences by caretaker are unavailable
4. The development of alters is shaped by external influences & internal capacities
Epidemiology of DID

- Methodological limitations preclude large scale generalizations about the overall incidence or prevalence of DID
- More common in women – a ratio of 5:1
- Occurs across all major racial groups and socioeconomic settings – cultural determinants
- Mean age of diagnosis = 28.5

Putnam, 1989
Assessment of DID

Diagnostic procedures:
- Extended interviews (several hours)
- Physical examination – look for evidence of self-mutilation
- MSE
Assessment of DID

Diagnostic procedures:


- Sequential daily task – daily diary entries for 30’

- Meet the alters – e.g., drug-facilitated interviews, hypnosis
Assessment

- Clinical Interview
- Mental Status Exam
- MMPI
- TAT
- Rorschach
- DES

Assessment of DID

Useful inquiries:

- Questions about amnesia or ‘time loss’ - ask for a number of examples
- Ask the P to close eyes and describe her/his clothes
- Questions about interpersonal relationships - being called by different names by people they don’t know; not remembering doing things
- Questions about depersonalization experiences
Assessment of DID

Useful inquiries:

- Questions about erratic school performance
- Evidence of large amnestic gaps for childhood
- Experience of being called a liar
- Flashbacks
- Sleep disturbance – nightmares, multiple awakenings
- Automatic writing
- Voices arguing, screaming ‘inside’, carrying on a discussion
Assessment of DID

- The interviewer should observe:
  - Intrainterview amnesia
  - Physical signs of switching
  - Pattern of admitting to symptoms, behaviors or experiences and subsequently denying such acknowledgments
  - The use of ‘we’ in a collective manner or of ‘he’ and ‘she’ to reference own behavior
  - Exaggerated startle reflex
‘Alters’

- ‘Alter personalities’, ‘personality fragments’, or ‘special purpose fragments’
- Putnam conceptualizes alters as ‘highly discrete states of consciousness organized around a prevailing affect, sense of self (including body image), with a limited repertoire of behaviors and a set of state-dependent memories’
‘Alters’

- An alter personality has a number of observable *internal and external functions*, attributes and behaviors.
- Over time, alters may acquire a significant degree of autonomy and investment in their separateness, may acquire new functions and relinquish old ones.
- Those who experience early severe trauma may have large systems of alters & profound personality disorganization.
‘Alters’

- Young children have externalized imaginary companion systems: cartoon characters, superheroes, animals, angels, dwarfs, machines, etc.
- The # of alters is correlated with the number & types of trauma, with the age when trauma was experienced
- The average # of alters = 13
- Organization of alters: in layers, families, tree structure
**Principles of organization of the personality system structure**

- **Original personality** = ‘the identity which developed just after birth and split off the first new personality in order to help the body survive a severe stress’, from whom all others are derived; it is not active & it is often described as having been ‘put to sleep’ or otherwise incapacitated because he or she was unable to cope with trauma (Kluft, 1987)
Principles of organization of the personality system structure

- **Host** = It consists of at least one alter, and may be a social façade created by a more or less cooperative effort of several alters agreeing to pass as one; the host is typically depressed, anxious, rigid, compulsive, suffering from a variety of somatic symptoms. Usually presents to treatment and does not know of the existence of alters. Most often, it is not the original personality.
Principles of organization of the personality system structure

- **Child alters** = They often exceed in number the adult alters; tend to be locked into a given age—express themselves in age appropriate manner, some may be nonverbal. They can ‘grow up’ in the course of therapy.

- **Cross-gender alters** = In males, the female personalities often are older, ‘good mother’ figures, who provide counsel and attempt to soften some of the angry and destructive behavior.
Principles of organization of the personality system structure

- **Persecutor alters** = See themselves in diametric conflict with the host personality. May be responsible for episodes of self-mutilation or suicide attempts. Seek to undermine treatment.

- **Suicidal alters** = Are driven to kill themselves; may represent a significant danger to the patients.
Principles of organization of the personality system structure

- **Substance abuse alters**

- **Autistic alters** = May rock, self-stimulate in the manner of autistic children – likely to emerge in a situation where the multiple is being confined, controlled, or under intense scrutiny.

- **Handicapped alters**: Blindness, deafness, muteness, loss of limb function, etc.
Principles of organization of the personality system structure

- **Promiscuous alters** = Express forbidden sexual impulses, have turbulent sexual lives – picking up strangers, set up an intimate and often masochistic situations, leaving the frightened and usually sexually frigid host to contend with the stranger’s advances

- **Prostitute alters**
Principles of organization of the personality system structure

- **Memory trace alters** = Memory for specific events or storing a more or less complete narrative of the individual’s life history.
- **Anesthetic or analgesic alters** = Deny feelings of pain and are activated when the body is injured by self or others.
- **Demon and spirit alters** = Spirits provide guidance; demons are usually malevolent & may identify with Satan or his disciples.
Principles of organization of the personality system structure

- **Administrators & OC alters** = Frequently emerge in the workplace & aid earning a living. Often are described as cold, distant, authoritarian.

- **Special talents/skills alters** = May be related to work, sports, arts, etc.

- **Internal self-helper (ISH) alter** = Physically passive and relatively emotionless; invaluable guides, they can provide timely suggestions about problems and issues in therapy.
Principles of organization of the personality system structure

- **Protector and helper alters** = They come in different forms, depending on what the patient needs protection from. Male guardians in female patients may protect the body from any perceived external danger. May offer protection internally, to counteract some of the self-destructive alters, seek help, call the rescue squad. Counterbalance to the persecutors and suicidal personalities.
Names of alters

Most personalities have a name – may be a ‘double entendre’ (Stacy = ‘stay and see’)

- Often derivatives of the legal name
- Names based on internal or external function (e.g., ‘driver’, ‘maid’, ‘cook’, ‘gatekeeper’)
- Names based on the affect they represent (e.g., ‘sad’, ‘rage’, ‘memory’)
- Unnamed alters (e.g., ‘no one’, ‘nobody’)
Switching

- **Switching** is the process of changing from one alter to another, core phenomenon in DID
  - May occur in a controlled or uncontrolled fashion
  - May be triggered by internal dynamics of the system, or it may be elicited by external events
  - Co-occurrence of alters is possible
Switching

Common switch elements:
- There is an *adaptive logic* to switching – the appropriate alter comes out.
- The patients *gains control* over the switching process in the course of therapy.
Switching

Manifestations of switching:

- **Physical changes**: dress and grooming between sessions; facial expression, postural & motor behavioral changes (e.g., blink, rapid fluttering of eyelids, transient facial twitching or grimacing, bodily twitches, shuddering, abrupt changes in posture), voice and speech changes in session.
Switching

Manifestations of switching:

- **Psychological changes**: shift in affect, behavioral age, thought processes & ability to think abstractly

- **Psychophysiological sensitivity**: differential responsiveness to drugs/medication or alcohol; differential allergic responses; somatic symptoms
Treatment considerations

- Kluft (1991): the treatment of choice is individual dynamically oriented expressive-supportive psychotherapy, augmented with hypnosis when necessary.

- Loewenstein & Ross (1992): the treatment should be conceptualized at two levels:
  - Work directly and concretely with alters
  - Regard the ‘whole system’ as the ‘real person’
Treatments considerations

- The psychotherapy is long and arduous
- Start by establishing firm boundaries & a solid therapeutic alliance
- Establish cooperation among alters
- Uncover past traumas & abreact/reprocess – titrate and process the traumatic material, so that the patient can tolerate it
- Kluft’s ‘rule of thirds’
References

References