

A Case Study Illustrating the Interplay Between Psychological and Somatic Dissociation

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Abstract

The concept of Dissociation was originally conceived as having a psychological and a somatic component. Nevertheless, recent versions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) have isolated both elements. In the DSM the psychological manifestation of dissociation is diagnosed as a Dissociative Disorder and the somatic domain is diagnosed as a Somatoform Disorder. However, recent empirical and clinical evidence have been highlighting and corroborating a high degree of comorbidity between such disorders and a constant interplay between somatic and psychological dissociation. In the following case study, the clinical constellation of the patient nicely illustrates that her dissociative defenses began as a Conversion Disorder and how, after a mishandling of the case by a clinician, her dissociation symptoms were instantly transformed in a typical Dissociative Amnesia Disorder. Cases like this convincingly illustrate how the dissociative defenses not only subsume the mental but also extend to the bodily domain.

Keywords: Psychopathology; conversion disorder; dissociative disorder; psychogenic amnesia.

Estudio de Caso Ilustrativo de la Interrelación entre la Disociación Psicológica y la Somática

Compendio

El concepto de Disociación originalmente incluía componentes psicológicos y somáticos. Sin embargo, versiones recientes del Manual de Diagnóstico y Estadísticas de los Trastornos Mentales (DSM-IV) han deslindado ambos elementos. En el DSM las manifestaciones psicológicas de la disociación se identifican como manifestaciones de un Trastorno Disociativo; mientras que el aspecto somático se identifica como parte de los Trastornos Somatoformes. Sin embargo, en estudios clínicos recientes se ha resaltado el hecho de que hay una comorbilidad extrema entre ambos trastornos y que se puede corroborar el hecho de que hay una interdependencia entre las manifestaciones psicológicas y somáticas de la disociación. En el siguiente estudio de caso, la constelación clínica de la paciente ilustra de una manera lúcida cómo sus defensas disociativas comenzaron con la manifestación de un Trastorno Conversivo y, tras un mal manejo clínico, sus síntomas disociativos de inmediato se transformaron en un Trastorno de Amnesia Disociativa. Casos como estos muestran convincentemente cómo las defensas disociativas no sólo incluyen el aspecto psicológico, sino que también se extienden al dominio corporal.

Palabras clave: Psicopatología; trastorno conversivo; trastorno disociativo; amnesia psicógena.

When in the 19th century Pierre Janet (1859-1947) formulated his ideas about the specific components of dissociation, he clearly included the presence of both psychological and somatoform dissociative phenomena (van der Hart & Friedman, 1989). Such symptoms as anesthesia, analgesia, and loss of control over motor responses were eloquent examples of what today some researchers call "somatoform dissociation" (Nijenhuis, 2000; Nijenhuis, Spinhoven, van Dyck, van der Hart & Vanderlinden, 1996, 1998; Sar, Kundakci, Kiziltan, Bakin, & Bozkurt, 2000). Nevertheless, the members of the Task Force of the DSM-III (American Psychiatric Association, 1980) decided to separate the motor/somatic component of dissociation and to categorize it

with the Somatoform Disorders. Subsequent editions of the DSM-III-R (American Psychiatric Association, 1987) and the DSM-IV (American Psychiatric Association, 1994) have retained that division. This decision has been amply rejected or questioned (Cardena & Spiegel, 1996; Kihlstrom, 1994; Nemiah, 1991; Nijenhuis et al., 1998; Ross, 1999) on various grounds.

First, there is extensive documentation that dissociative patients report a wide array of somatic and conversion reactions (Boon & Draijer, 1991; Martínez-Taboas, 1991; Ross, Fast, Anderson, Auty & Todd, 1990; Saxe, et al., 1994). For example, Saxe et al. (1994) compared somatization in dissociative and nondissociative patients. They found that 64% of the first group met the criteria for a Somatization Disorder, whereas none of the comparison patients met criteria for a Somatoform Disorder. For his part, Pribor, Yutzy, Dean and Wetzel (1993) found that women with high dissociation scores also reported many

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somatic symptoms, specially if there was a history of abuse. In this context, the research by Nijenhuis, et al. (1996, 1998) is highly relevant. Using the Somatoform Dissociation Questionnaire, which evaluates the severity of somatoform dissociative phenomena, the authors have documented that dissociative disorder patients can be clinically differentiated from patients without a dissociative disorder. The sensitivity of the scale is 94% and the specificity is 98%. Such results corroborate the clinical observation that dissociative disorder patients tend to suffer from a wide range of somatoform symptoms.

Secondly, many patients with DSM-IV Conversion Disorder present the clinical configuration of a dissociative disorder. As an example, Kuyk, van Dyck and Spinhoven (1996) and Bowman and Markand (1996) have documented that more than 60% of pseudoseizure patients present a dissociative disorder. The fact that hypnosis is a very useful clinical tool in the differential diagnosis of such seizures is another line of evidence in favor of the construct of somatoform dissociation (Kuyk, et al, 1995; Kuyk, Spinhoven & van Dyck, 1999; Martínez-Taboas, 2002).

The decision to separate the somatic component of dissociation has been described by Cardeña and Spiegel as «more a classification fashion than an absolute distinction between the disorders» (1996, p. 239). In fact, outside North America, researchers and clinicians using the International Classification of Disease-10 (WHO, ICD-10, 1993) may diagnose conversion reactions as a branch of dissociative disorders.

In the following case study, I present a clear-cut clinical situation where a female adolescent demonstrated an interplay of different dissociative phenomena. Her configuration began with some classic somatoform symptoms and, then, in a sudden and unexpected way, changed her symptomatic profile to a psychological dissociation. What is unique in this case is the exact timing of the alternation from the somatic to the mental dissociative symptoms.

The Case of Isabel

Participant

Isabel (a pseudonym) was a 15 year-old adolescent female when she came to my office in 1993 for a psychological evaluation. She could be described as tall, slim and fairly attractive. The case was referred by Dr. C-L, who was her psychiatrist. She remained cooperative throughout the entire evaluation.

Isabel is the oldest daughter of three children procreated by a married couple. The mother is a teacher at an elementary school and the father is a prominent architect.

The parents have never separated. According to the parents, from childhood until last year (1992) she was considered a leader in her school, and she had always demonstrated excellent academic progress (all her grades were A's). Isabel and her parents denied any history of sexual or physical abuse.

At the beginning of 1993 she had a car accident without any obvious health repercussions. On July 11 of 1993, when she was participating at a Catholic mass, she suddenly began to feel dizzy and fainted. Six days later she began to experience recurrent and extreme headaches, dizziness and a strange weakness in her lower extremities. When she was taken to the emergency room of an hospital, she had bradycardia (a slow heartbeat rate) and was given atropine. She also had slight arrhythmia. A week later, she could not experience any sensations in her legs and could not move them. As a result, she was taken to three different hospitals in Puerto Rico and was examined by endocrinologists, cardiologists and various neurologists. She was submitted to many medical tests, including EKG, EEG, MRI, lumbar puncture, blood tests, among others. The results were all negative; the doctors could not find a specific cause for the paralysis. As a result of this, some doctors in Puerto Rico convinced her father and mother to translate the child to a well-known hospital in the United States to continue the search for the etiology of her paralysis.

There she underwent a second round of specialized medical tests, some of them very painful. After a two week medical evaluation, the medical staff decided that Isabel's paralysis was not of organic origin. They called her parents together and explained to them that the cause of her daughter's symptoms was emotional, or a conversion symptom. One neurologist proposed to hypnotize Isabel to explore the meaning of her paralysis. Both parents agreed. The neurologist and one of his assistants took Isabel to an office and were successful in creating an hypnotic trance. But, after about fifteen minutes, Isabel began to cry and to yell in a desperate way. After various minutes of silence, the neurologist invited her parents to enter the office. To the surprise of all present, *Isabel did not recognize her parents nor anyone else*. She began to say to her mother: «Please, lady, help me. This man (referring to the doctor) is very bad». When her father and mother tried to make her recognize them, she insisted that they were complete strangers to her. Also, she could not remember her name nor her identity. On the positive side, all of those present noted that Isabel could, at last, slightly move her legs. In fact, four days later she regained complete movement of her legs. The neurologist told her parents that at the hypnotic session he had strongly commanded her to stand up and walk. He said that after a few hours

she should regain her memory. But, after 48 hours, Isabel still could not remember anything about herself and her history. On August 20 and 22, and while still in the USA, she was taken to a clinical psychologist for a psychological evaluation. The results of this evaluation revealed that her memory presented signs of “amnesic episode, disorientation, her affect was somewhat flat... Her thinking processes were well organized and appeared free from any delusional or bizarre material”. The psychologist noted that the only thing she vaguely remembered was her name and her father and mother identity. He diagnosed Isabel with Conversion Disorder, single episode and Psychogenic Amnesia. She was transferred to Puerto Rico with a strong indication of continuing psychiatric treatment.

From September through December 1993 she had been in psychiatric treatment with two psychiatrists. With the first one she had three weekly sessions of psychotherapy for two months. Isabel and her parents decided to search for a second psychiatric opinion because, allegedly, the psychiatrist hardly spoke during the sessions and they did not notice any significant advances in Isabel. On November 1993 she began with her second psychiatrists (Dr. C-I). He also diagnosed a Psychogenic Amnesia.

Psychological Testing

When I performed her psychological evaluation, and after slightly more than three months after the hypnotic session, Isabel had recuperated some of her autobiographical identity and memory. For example, she told me that many of her memories had returned very slowly and mainly in the form of flashbacks. She had already recognized her parents and her two brothers. She remarked that she had not lost her academic skills or knowledge; only those aspects of her identity. In other words, her procedural (her skills and habits) and her semantic (conceptual and factual knowledge) memory were unimpaired, but her episodic or autobiographical memory was totally impaired. Such a finding is consistent with recent research on dissociative amnesia (Schacter, 1996). She noted that when some of her former teachers or school friends visited her, she still had to pretend to know them, because she had trouble recognizing some of them.

Isabel and her parents told me that in August, September and October she had various episodes where she woke up at two or three in the morning in a dissociative crisis. She began to yell, cry and was violent toward her parents. During such crises she repeatedly said that she wanted to leave. Such crises lasted about one hour and were frequent. Afterwards she had no

memory of such episodes. At other times, still during her crises, she called herself Anita and said she was a little girl. As such crises were disturbing to her parents, her first psychiatrist decided to put Isabel on an antipsychotic (Haldol) and an anticholinergic (Cogentin).

When I decided to interview Isabel alone, she said that “*I know that I am not me, but I do not know who I am*”. She also said that “*I do not care about my past or who I was*”. She repeatedly said that she could not feel any loving feelings toward her parents, specially because both of them were overprotective and restricting her activities. She told me that she perceived her home as a cell and herself as a prisoner. However, she did not know how to tell her parents that she was so deeply dissatisfied because she did not trust them. She told me that one of her cousins had told her that before her Conversion Disorder, she was depressed because her parents did not want her to be out at night with her friends and that she was very resentful toward them. When I inquired about the name of Anita, she told me that Anita is a 15 year-old girl who had always been her best friend. Contrary to herself, Anita was described by Isabel as always happy, with liberal parents and as someone who was enjoying her life. At the time of the interview, she could move her lower extremities normally.

The psychological evaluation consisted of the Dissociative Experiences Scale (DES), the Thematic Apperception Test (TAT), the Draw a Family Test, the Incomplete Sentence Test, the Minnesota Multiphasic Personality Inventory (MMPI), the Draw a Person Test, and the Bender-Gestalt.

Results of Psychological Tests

The DES is a self-report instrument that quantitatively measures dissociative symptoms and experiences (Bernstein & Putnam, 1986). A total score of 30 suggest the presence of significant pathological dissociation. She obtained a score of 38 on the DES, which suggest the presence of marked dissociative symptoms. Specifically, she had elevated scores (+80) on the following seven items:

- 1) Some people find that they have no memory for some important events in their lives.
- 2) Some people have the experience of looking in a mirror and not recognizing themselves.
- 3) Some people sometimes have the experience of feeling that other people, objects, and the world around them are not real.
- 4) Some people sometimes have the experience of feeling that their body does not seem to belong to them.

5) Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time.

6) Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them.

7) Some people sometimes find that they cannot remember whether they had done something or have just thought about doing that thing.

The TAT is a projective test in which the individual reveal their attitudes, feelings, conflicts and personality characteristics by making up stories about a series of relatively ambiguous pictures (Groth-Marnat, 1990). On the TAT a peculiar thing occurred. After reacting to cards # 1, 14, 12M, 3BM, I showed card #13MF. Picture 13MF presents a young man standing in the foreground with his head in his arms. In the background is a woman lying in bed. The most frequent plots that patients generate center on guilt induced by illicit sexual activity. It also usually provides information on the subject's attitudes and feelings toward aggressive and sexual feelings. She began saying: "I see a man..." At that specific point, she had a mental blackout or a discrete dissociative episode that lasted more than a minute. As a result Isabel insisted that she did not want to continue with the TAT. Isabel's reaction is consistent with the idea of central and overwhelming conflicts with her sexual feelings and/or experiences. I should stress that, at least in my interview with her and her parents, they all stated that there was no history of sexual abuse. Of course, the possibility is open to the reality of such experiences, although they were not explicitly revealed during the psychological evaluation.

The Draw a Family Test is a projective test where the individual depicts groups of significant people in his or her environment (Groth-Marnat, 1990). On the Draw a Family Test she drew her parents and her two brothers, but she did not draw herself. It is interesting to note that in her previous evaluation with the psychologist in the USA, she also did not draw herself in the Family Kinetic Drawing. This usually is encountered in persons who are deeply dissatisfied with their family. Also, in the previous psychological evaluation all of her family members had their hands hidden behind their backs, which can be interpreted as her perception that her family did not provide her with support nor with a nurturing environment.

The Incomplete Sentences Test, is a projective test in which the individual is required to complete a variety of sentences. The responses may be analyzed for the projection of unconscious themes (Groth-Marnat, 1990). On this test, Isabel once again demonstrated a deep displeasure with her family environment. She said that

she did not have any loving feelings toward her parents; that she detested their overprotection; that she was ashamed of their behavior; and that she was only happy when she was outside her home. About her past, she wrote: "*I could not answer this because I have forgotten part of my life*". About herself she said that "*I hate to be what I am right now*"; that she was sad nearly all the time and that she only trusted her friend Anita. Also, Isabel evidenced a strong preoccupation with her physical appearance. She wrote that she wanted to be a famous model, that her most important wish was to have a perfect body, that she did not want to be fat, that she was ashamed of her weight and that her principal weakness was her extreme preoccupation with her figure.

The MMPI is a widely used self-report test used to determine the individual's personality profile as well as any tendency to lie or to fake the results (Greene, 1991). On the MMPI, Isabel was characterized as a deeply dissatisfied person, with frequent lability in her moods and with recurrent somatic symptoms. She demonstrated a 3-1 codetype, showing the classic conversion "T", which means that Isabel had rigid defenses and that many of her efforts were ineffectively directed toward trying to ward off anxiety. Many clients with such a profile use somatic symptoms to avoid thinking or dealing with psychological problems. "When physical symptoms do appear, they are relatively restricted and specific both in location and nature, frequently involving pain in the extremities or head" (Greene, 1991, p. 271). In addition there was evidence of great conflict with her parents. "These clients are fighting against something which is usually some form of conflict with authority figures" (Greene, 1991, p. 155).

On the Draw A Person Test, Isabel drew a very little woman with her arms at the back. She mainly projected a deep sense of interpersonal insecurity, sexual inadequacy, and there are signs of depression.

Lastly, the Bender-Gestalt is a test where the individual copies nine geometrical figures which form the basis to hypothesize on the presence of functional and organic disorders. Although in Isabel's drawings there are no clear organic indicators, I found significant details that suggests the presence of anxiety, depression, insecurity and self-doubt (Groth-Marnat, 1990).

Overall, Isabel demonstrated primitive and rigid defenses, a tendency toward using somatic symptoms to express her dissatisfaction, problems with authority figures, a tendency toward experiencing many dissociative symptoms, and a confusion about her identity and self.

I should mention that after the psychological evaluation I lost contact with Isabel. The exception was a phone call from her mother, five months after the evaluation, informing me that Isabel had recently been diagnosed with bulimia.

Discussion

The case of Isabel presents some striking findings. First, we can clearly note the interplay between her conversion and dissociative symptoms. After manifesting a classic pseudo-neurological conversion reaction, where she could not move nor feel her lower extremities, she transformed her conflicts in a more psychological way, blocking her identity and her sense of self completely. As is usually the case in patients with Conversion Disorder, Isabel inscribed her conflicts and impotence in her body in what she perceived as an intolerable and coercive family environment. Helene Cixous (quoted in Showalter, 1985, p. 161), says: "Silence, silence is the mark of hysteria. The great hysterics have lost speech...their tongues are cut off and what talks isn't heard because it is the body that talks". I agree with Kihlstrom (1994), Nemiah (1991), and Nijenhuis (2000) when they criticize the DSM-IV for separating the somatic aspects of dissociation, creating the misleading impression that dissociation can affect only memory and identity. As Kihlstrom (1994) puts it: "The symptoms of the conversion disorders are not physical, but mental in nature. And they do not suggest physical disorder, but rather a disorder in consciousness" (p. 387). According to the research of Nijenhuis, et al. (1996), the frequent somatic and conversion symptoms of dissociative patients are a reflection of what they call "somatoform dissociative phenomena". This posture is consonant with the ideas of Pierre Janet, when he stated that dissociation pertains to both psychological and somatoform components of experience.

Although some authors have documented that dissociative disorder patients present a comorbidity with the somatoform disorders (Nijenhuis, 2000; Rodin, de Groot & Spivak, 1998; Sar, et al., 2000; Saxe, et al., 1994), the case of Isabel is striking in the sense that her dissociative defenses *began* as a somatoform manifestation, but subsequently were substituted and transformed to dissociative defenses of memory and identity. Noteworthy is the fact that as soon as the somatoform dissociation terminated, the other immediately surfaced. This clearly indicates that her dissociative defenses were metamorphosed from the somatic to the psychological domain.

In the second place, the case of Isabel resurrects the issue of symptom substitution. By this I mean that, in some cases, the patient's symptoms are metaphorical defenses. If the symptom is treated in a forceful way, without clarifying its function for the individual, then it can be substituted for another. I think that this case exemplifies such a possibility. When the neurologist closed the door of his office, and in an hypnotic state suggested that Isabel

walk, without examining the context or meaning of her symptoms, he was creating the opportunity for the substitution of one symptom for another. I should note that even some eminent behavior therapists, who traditionally have disputed the idea of symptom substitution, had documented some remarkable cases of symptom substitution in patients with Conversion Disorder (Blanchard & Hersen, 1976).

This case also highlights the fact that the etiology of some dissociative disorders can not be accounted for by a trauma model. In the case of Isabel there is no convincing evidence that she had been traumatized. Rather, her dissociative reactions and defenses appear to be a way that she used to psychologically escape from an intolerable family situation, where she was overwhelmed by her parents exigencies and overprotection. An interesting clinical detail is that when she had her dissociative crisis at night, she alleged to be Anita (Isabel's best friend), who reportedly had liberal parents that allowed her to express her energies and interests without interference. So, through her dissociative regressions, she could fantasize that she was the person that she wanted to be.

The fact that in the follow-up period she recuperated her identity, but began to manifest an eating disorder, is also consonant with some literature that suggests a link between some types of eating disorders and dissociation (Chandarana & Malla, 1989; Demitrack, Putnam, Brewerton, Brandt & Gold, 1990; Rodin, et al. 1998; Vanderlinden & Vandereycken, 1997). In the case of Isabel I am tempted to speculate that as her dissociative defenses eroded, they were substituted by an obsession with her body. By this means she could divert her deep dissatisfaction with her parents and her life circumstances, and transform them into another type of aversion: her sexuality and her body.

Isabel's previous psychotherapeutic approach have been ineffective, mainly because the psychiatrist adopted a passive stance, which did not enhance her capacities to identify and modify her primitive intrapsychic defenses and dysfunctional family dynamics. In my opinion, an effective therapeutic approach in this case should be directed toward the development of more problem-solving coping behaviors, a reduction of her avoidance and dissociative coping style, more efficient communication skills and systemic family therapy. These interventions could allow her to be more expressive of her needs, of her preferences and to negotiate with her parents a new democratic decision-making approach that would permit a more flexible family system. Unfortunately, as far as I know, the treatment approaches of her psychiatrists have been pharmacological together with a type of non-specific support psychotherapy.

References

- American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders* (3rd. ed.). Washington, DC, USA: Author.
- American Psychiatric Association (1987). *Diagnostic and statistical manual of mental disorders* (3rd. ed. rev.). Washington, DC, USA: Author.
- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC, USA: Author.
- Bernstein, E. M. & Putnam, F. W. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease*, 174, 727-735.
- Blanchard, E. B. & Hersen, M. (1976). Behavioral treatment of hysterical neurosis: Symptom substitution and symptom return reconsidered. *Psychiatry*, 39, 118-129.
- Boon, S. & Draijer, N. (1991). Diagnosing dissociative disorders in the Netherlands. *American Journal of Psychiatry*, 148, 458-462.
- Bowman, E. S. & Markand, O. N. (1996). Psychodynamics and psychiatric diagnoses of pseudoseizure subjects. *American Journal of Psychiatry*, 153, 57-63.
- Cardeña, E. & Spiegel, D. (1996). Diagnostic issues, criteria, and comorbidity of dissociative disorders. In L. K. Michelson & W. J. Ray (Eds.), *Handbook of dissociation* (pp. 227-250). New York, NY, USA: Plenum.
- Chandarana, P. & Malla, A. (1989). Bulimia and dissociative states: A case report. *Canadian Journal of Psychiatry*, 34, 137-139.
- Demitrack, M. A., Putnam, F. W., Brewerton, T. D., Brandt, H. A. & Gold, P. W. (1990). Relation of clinical variables to dissociative phenomena in eating disorders. *American Journal of Psychiatry*, 147, 1184-1188.
- Greene, R. L. (1991). *The MMPI-2/MMPI: An interpretive manual*. Boston, MA, USA: Allyn and Bacon.
- Groth-Marnat, G. (1990). *Handbook of psychological assessment*. New York, NY, USA: Wiley.
- Kihlstrom, J. F. (1994). One hundred years of hysteria. In S. J. Lynn & J. W. Rhue (Eds.), *Dissociation: Clinical and theoretical perspectives* (pp. 365-394). New York, NY, USA: Guilford.
- Kuyk, J., Jacobs, L., Aldenkamp, A. P., Meinardi, H., Spinhoven, P. & van Dyck, R. (1995). Pseudo-epileptic seizures: Hypnosis as a diagnostic tool. *Seizure*, 4, 123-128.
- Kuyk, J., Spinhoven, P. & van Dyck, R. (1999). Hypnotic recall: A positive criterion in the differential diagnosis between epileptic and pseudoepileptic seizures. *Epilepsia*, 40, 485-491.
- Kuyk, J., van Dyck, R. & Spinhoven, P. (1996). The case for a dissociative interpretation of pseudoepileptic seizures. *Journal of Nervous and Mental Disease*, 184, 468-474.
- Martínez-Taboas, A. (1991). Multiple personality in Puerto Rico: Analysis of fifteen cases. *Dissociation*, 4, 189-192.
- Martínez-Taboas, A. (2002). The role of hypnosis in the detection of psychogenic seizures. *American Journal of Clinical Hypnosis*, 45, 11-20.
- Nemiah, J. C. (1991). Dissociation, conversion, and somatization. *Annual Review of Psychiatry*, 10, 248-260.
- Nijenhuis, E. R. S. (2000). Somatoform dissociation: Major symptoms of dissociative disorders. *Journal of Trauma & Dissociation*, 1, 7-32.
- Nijenhuis, E. R. S., Spinhoven, P., van Dyck, R., van der Hart, O. & Vanderlinden, J. (1996). The development and psychometric characteristics of the Somatoform Dissociation Questionnaire (SDQ-20). *Journal of Nervous and Mental Disease*, 184, 688-694.
- Nijenhuis, E. R. S., Spinhoven, P., van Dyck, R., van der Hart, O. & Vanderlinden, J. (1998). Psychometric characteristics of the Somatoform Dissociation Questionnaire: A replication study. *Psychotherapy and Psychosomatics*, 67, 17-23.
- Pribor, E. F., Yutzy, S. H., Dean, J. T., & Wetzel, R. D. (1993). Briquet's syndrome, dissociation, and abuse. *American Journal of Psychiatry*, 150, 1507-1511.
- Rodin, G., de Groot, J., & Spivak, H. (1998). Trauma, dissociation, and somatization. In J. D. Bremner & A. R. Marmar (Eds.), *Trauma, memory, and dissociation* (pp. 161-178). Washington, DC, USA: American Psychiatric Press.
- Ross, C. A. (1999). Dissociative disorders. In T. Millon, P. H. Blaney & R. D. Davis (Eds.), *Oxford textbook of psychopathology* (pp. 466-481). New York, NY, USA: Oxford University Press.
- Ross, C. A., Fast, E., Anderson, G., Auty, A. & Todd, J. (1990). Somatic symptoms in multiple sclerosis and MPD. *Dissociation*, 3, 102-106.
- Sar, V., Kundakci, T., Kiziltan, E., Bakin, B., & Bozkurt, O. (2000). Differentiating dissociative disorders from other diagnostic groups through somatoform dissociation in Turkey. *Journal of Trauma & Dissociation*, 1, 67-80.
- Saxe, G. N., Chinman, G., Berkowitz, R., Hall, K., Lieberg, G., Schwartz, J., & van der Kolk, B. A. (1994). Somatization in patients with dissociative disorders. *American Journal of Psychiatry*, 151, 1329-1334.
- Schacter, D. L. (1996). *Searching for memory*. New York, NY, USA: Basic Books.
- Showalter, E. (1985). *The female malady*. New York, NY: Pantheon.
- van der Hart, O. & Friedman, B. (1989). A reader's guide to Pierre Janet on dissociation: A neglected intellectual heritage. *Dissociation*, 2, 3-16.
- Vanderlinden, J. & Vandereycken, W. (1997). *Trauma, dissociation, and impulse dyscontrol in eating disorders*. New York, NY, USA: Brunner/Mazel.

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