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Dissociation: historic elements and controversial issues

Диссоциация: историч еские аспекты и спорные вопросы.

Summary. This article intends to make a review on dissociation focusing on the evolution of the concept, methods of assessment, epidemiology and polemic issues. It will make a short introduction to the trauma model. Some controversial aspects(nosological vs. transnosological phenomena, continuum vs. categorical) are discussed taking into account recent researches. Some answers of the Author:
The multidimensional construct of dissociation employed as a psychological mechanism, a symptom part of other psychiatric diagnosis and a syndrome -did it extended too far its original concept forgetting some of its aspects?
What is the meaning of the presence of dissociative symptoms in the clinical picture of some psychiatric entities? Beyond nosologic specificity can we go further on syndromatic specificity?
Which model is the most appropriate to dissociation, the continuum model or the categorial one? This is another question yet to be answered. With many contributions from neuropsychological ground, psychological trauma, personality variables, culture, there is a need to integrate all the emergent data in an unified construct.

Резюме. Данная статья предна значена для обзора, сфокусированного на диссоциации, эволюции концепци и, методах проверки, эпидемиологии и полемических аспектах. Она создаст короткое представление о модели травмы. Здесь обсуждаются также некото рые противоречивые данные с учётом современных исследований (нозологи ческие версии, транснозологические феномены, континуумные и категориа льные версии). Некоторые ответы автора:
Многозначный конструкт диссоциации употребил как психологический механизм, симптомную часть другого психиатрическо го диагноза и синдрома простёр ли он слишком далеко свою оригинальную концепцию забывания некоторых собственных аспектов?
Каково значение имеющихся в клинической карти не некоторых психических сущностей диссоциативных симптомов? Вне нозо логической специфики можем ли мы идти дальше на синдромологической спе цифике?
Какая модель является наиболее подходящей для диссоциации, континуальная или категориальная? Ещё один вопрос ждёт отв ета. Учитывая вклады исследований, имеющих нейрофизиологическую основ у, психологическую травму, личностные, культуральные вариации, назрела н еобходимость интеграции всех крайних данных в объединённый конструкт.

Dissociation is in the realm of several controversies and a challenging debate organic versus functional nature of symptoms, nosologic versus transnosological phenomena, etiopathogenic factors, consciousness and memory functions.

Since Janet, a large evolution in the knowledge of this matter has been achieved.

Janet developed the concept of "desegregation" later translated to English as dissociation to elicit the underlying mechanism that was responsible for the removal of mental contents from conscio usness resulting in the failure to integrate mental functions. Therefore some mental functions and aspects of thought, emotion, behavior, or other experiences could be disintegrated escaping from conscious control.

He affirmed that some individuals on account of

constitutional factors or traumatic history hadn't enough energy to integrate all experiences.

Considering that dissociation, conversion, actually individualized syndromes, shared the same pathological mechanism dissociation Janet included these syndromes under the same designation of hysteria.

Freud, on the other hand, explained the removal of mental contents from the consciousness by an active mechanism named repression. Repression would remove undesirable thoughts and emotions from the consciousness with the objective of protecting against psychic pain motivated either by external or internal conflicts. If this model shares some similitude with Janet's model, it is important to point out the differences. To Janet in a more psycho physiological perspective dissociation is a passive mechanism characteristic of deficit individuals and occurring in a limited time. To Freud dissociation is a defense mechanism shared by all individuals, active in the lifetime.

Evoking a more contemporary definition in the perspective of Spiegel and Cardeñ a (1991) [30], dissociation refers to the separation of mental functions, which are normally integrated and accessible to consciousness. The disintegration can affect several functions: memory, identity, perception, emotions; assuming different clinical manifestations.

Classificatory Systems

Regarding classificatory systems dissociative disorders have been the subject of several realignments.

In the DSM I dissociative reaction is separated from conversive reaction, whereas in DSM II they are gathered under the same designation of hysteria. In DSM III and DSM III-R the distinction between conversion disorders and dissociative disorders is recovered and these disorders are classified as two different diagnostic categories.

Finally in DSM-IV, dissociative disorders are classified in five different clinical entities:

Dissociative Amnesia- one or more episodes of inability to recall important information of a traumatic or stressful nature too extensive to be explained by ordinary forgetfulness. It does not occur exclusively as a symptom of another dissociative disorder, post-traumatic stress disorder, acute stress disorder or somatization disorder. It must be functional, not due to the direct physiological effects of a substance, or a neurological or other medical condition. Severity of symptomatology causes disruption or impairment in normal individual functioning in different relevant areas.

Dissociative Fugue- sudden, unexpected travel away from home or one's customary place of work with inability to recall one's past with cognition about personal identity or assumption of a new entity. It does not happen exclusively in the course of dissociative identity disorder and it is not due to effect of a substance or general medical condition. It causes clinically significant distress or impairment in important areas of functioning.

Dissociative Identity Disorder- presence of two or more distinct identities or personality states. Two of these identities/personality states recurrently take control of the person's behavior. There is also an inability to recall important personal information, which is too extensive to be explained by ordinary forgetfulness. The disorder cannot be attributed to physiological effects of a substance or to general medical condition.

Depersonalization- persistent or recurrent experiences of feeling detached from, and as if one is an outside observer of one's mental processes or body with reality testing intact. It does not occur exclusively in the course of another mental disorder and it is not due to the effects of a substance or general medical condition. It causes significant distress or impairment in important areas of functioning.

Dissociative Disorders Not Otherwise Specified It includes disorders in which the main feature is a dissociative symptom but that don't meet the criteria for any specific dissociative disorder.

From DSM IV classification controversies raise. Some authors argue that dissociation of motor function and sensation ought to be categorized in the same diagnostic group in DSM IV. For this reason in a historic standpoint, conversion was included under the label of hysteria. On the other hand if we look into ICD-10 we can consider conversion as a part of the dissociative category.

Besides dissociative phenomena in DSM IV are divided across several disorders, for example: post-traumatic stress disorder, acute stress disorder, and borderline personality disorder.

Some clinicians also question the validity of some dissociative disorders such as the dissociative identity disorder.

In what classification issues concern, again, a consensus isn't achieved.

Screening Instruments and Diagnostic Interviews

Trying to diagnose and measure these phenomena, scales and interviews were elaborated.

The Dissociation Experiences Scale (DES; Bernstein and Putman, 1986) is the most used and widely quoted instrument more than two hundred publications. It is a self-report scale of 28 items with a good validity, sensitivity and specificity. There is also the Dissociation Questionaire (DIS-Q;Vanderlinden) developed from the DES. Other self-report measures were elaborated but aren't sufficiently validated [1-livro Ross].

There are two main diagnostic interviews the Structured Clinical Interview for DSM-IV Dissociative Disorders Revised (SCID-D-R; Steinberg, 1994) an exhaustive interview to evaluate dissociative disorders according to DSM IV criteria and Dissociative Disorders Interview Schedule (DDIS; Ross et al, 1989).

Specific scales oriented to childhood and adolescence Child Dissociative Checklist (CDC; Putnam et al, 1993) and Adolescent Experiences Scale (ADES; Amstrong et al, 1997) were also developed.

Epidemiology

The spite a growing sensitization and a more accurate diagnostic of dissociative disorders it is yet to be established with accuracy the incidence of dissociative disorders in general population.

A large study conducted in the general population (n=1055) [24] showed that dissociative experiences had no correlation with gender, socio-economic factors such as social status, level of education, house dimensions, place of birth and relevance of religion in everyday life. Authors estimated the prevalence of dissociative experiences in general population to be in the interval between 5 and 10%.

Recent data point to a prevalence between 3 and 11% [25] in America and Europe. It is reported a higher prevalence of dissociative symptoms in younger ages [36].

Considering the Dissociative Identity Disorder (DID) lifetime prevalence in general population is reported to be 1%. It also appears to be more prevalent in females although studies in general population didn't show significant difference. Follow up studies regarding DID reveal a change in female-male ratio form 1:1 in childhood to 8:1 in adolescence.

Theoretical Models The Trauma Model

The association more frequently referred in the literature is with psychological trauma.

The evidence of this linkage has been supported by several lines of investigation: traumatized samples show higher levels of dissociation than control samples; in addition dissociative disorder patients report higher levels of trauma; dissociation proximal to trauma has been pointed as a predictor of future PTSD and some reports also establish the connection between severity of trauma and dissociation levels.

There is a lot of data with different traumatized samples (combat veterans, victims of abuse) showing significantly higher levels of dissociation than non-traumatized groups.

As for the higher prevalence of trauma in dissociative disorder patients investigations found a history of childhood abuse in 72% to 98% of all registered cases of dissociative disorders (Kluft, 1988; Putnam et al, 1986) [32]. Obviously a relevant question is the validity of memory and false memory syndrome but a fuller discussion is beyond the extent of this chapter.

Marmar and Weiss studies with Vietnam veterans and previous investigations by Arieh Shalev are examples that support the evidence that peritraumatic dissociation can be a predictor of future PTSD.

Several studies reveal the association between severity of trauma and dissociation. Spiegel and Cardeña (cit Butler et al, 1996) [5] made a wide revision of investigation linking trauma and dissociative experiences. The authors concluded that retrospective studies showed a strong correlation between sexual or physical abuse in early age and future dissociative symptomatology and that severe and repeated childhood abuse was more strongly correlated with adult dissociation than isolated episodes. In addition a number of studies document the importance of other factors mediating trauma that could account for the variance found in these studies.

Some studies report the influence of family factors in the development of future dissociative tendencies. Irwin (1996) [17] found that perception of emotional support in childhood was predictive of dissociation pointing the lack of emotional support as an important mediator of future dissociative symptomatology.

Other studies show that dissociation could play a role in the transgeracional transmission of maltreatment [8].

Looking at these investigations in the perspective of the "Discrete Behavioral States" model [23] we could say that family-child interactions have a marked influence in the behavioral states-related tasks.

According to this model trauma is supposed to induce behavioral states different from normal and to influence affect and physiological variables. Trauma would also difficult the acquisition of control over behavioral states. Maltreatment and family interactions work in a complex way modulating child's metacognitive and integrative functions. Trauma impairs consolidation of self and behavior predisposing to dissociative symptomatology.

In a biological ground there is also some evidence of a correlation between biological markers associated with trauma, stress responses and dissociation.

It is suggested that trauma provokes biological changes for example in the sympathetic nervous system, in the hypothalamic-pituitary-adrenal axis, in the immune system - thus traumatized individuals would show a disturbance in the feedback mechanism of these systems, being more vulnerable to additional stress.

A number of studies also refer decreases in left hippocampal volume in women victims of childhood sexual abuse.

As Janet pointed out dissociation might have

defensive psychological functions towards trauma. These defensive functions have been broadly discussed [23]. Dissociation functions as an adaptative process resulting in the isolation of affect and information, automatic behavior, identity alteration and separation from self.For example, dissociative automatic behavior in catastrophic circumstances can be protective and even life saving allowing the individuals to perform heroic acts. Dissociation can also provide a way of psychological complying with painful events without being completely aware of what is happening.

Nevertheless the difficulties of evaluating individuals in the post-trauma, there are several reports of dissociative automatic behavior and depersonalization after major disasters: airplane crashes, earthquakes.

Another way dissociation plays a defensive role is through compartmentalization the isolation of domains of awareness and memory. Hence compartmentalization allows the separation of painful memories, avoiding psychological conflicts.

However, frequently, some of these painful memories intrude into normal awareness in a form of flashbacks.

An additional defensive function that dissociation performs is through the alteration of identity and estrangement from self, giving the individual a protection from a overwhelming experience by dissociating aspects of identity that connect him with the experience.

In the trauma model dissociation functions as an adaptative process resulting in the isolation of affect and information, automatic behavior, identity alteration and separation from self regarding different aspects of dissociation.

In our investigation [28] the relationship between dissociation and trauma appears to be confirmed. We've evaluated eating disorder patients (n=50) (DSM IV criteria): restrictive anorexics, anorexics mixed type and bulimics. Among eating disorder patients we found high levels of dissociative symptoms, moreover that the levels of dissociation were correlated with history of childhood trauma and severity of trauma. We also found that there was a trend for anorexics mixed type and bulimics to report higher levels of dissociation, particularly symptoms of depersonalization / derealization when compared with restrictive anorexics. These two subpopulations displayed also a preponderance of early sexual and physical abuse when compared with restrictive anorexics.

In another study with unipolar depressive patients (n=30) (DSM IV criteria) [29], the dissociative symptomatology correlated significantly again with history of childhood traumatic experiences.

It is yet to be enlightened the nature of this linkage.

Network Models

In a more neuropsychological perspective the network models gave also a contribution to the comprehension of dissociative phenomena.

I would like to mention the model of Bower[2] and the model of Yates and Nasby[37].

With the purpose of explaining the role of affect in learning processes, Bower developed a model; according to this model networks would be composed by memory nodes and emotional nodes. Memory would be stored in the event nodes and to be retrieved it would be necessary that the correspondent node would be activated above the threshold of excitation. The greater the number of connections, the higher the probability of being reactivated. There would be a intersection between emotional excitation and contextual excitation; therefore the excitation from emotional nodes would be summed to contextual excitation being easier to achieve the threshold of excitation. This author pointed that affective nodes with opposite affective sign would mutually inhibit. Hence memories that were associated with certain affects would be more easily found under the same emotional states and more inaccessible under opposite emotional states.

The adaptation of this model to dissociative phenomena suggests that DID (dissociative identity disorder) or dissociative fugue would organize under extreme emotional state consequently hardly accessible under the emotional state more prevalent in the individual.

The model by Yates and Nasby created to explain post-traumatic dissociation, shares some concepts with Bower's model. Based upon the same neural net, the main change is the assumption of direct inhibition between emotional nodes and event nodes. If under traumatic circumstances an emotional node is intensively excited, this excitatory or inhibitory connection between emotional nodes and memory nodes could settle in an unique direction in a semi-permanent form. Therefore by mutually inhibited connections, groups of emotional nodes with a constellation of memory nodes excitatory associated could constitute the core of several self-representations/personalities. Nevertheless these models don't give us a complete explanation for other features of dissociative states.

Other Models

The association between dissociation and hypnotizability has been intensively discussed and investigation has provided numerous data to the debate but this and other conceptualizations are not going to be discussed here - they are beyond the scope of this chapter.

Dissociation and Personality Variables

At this stage we have little information on personality variables and dissociation, needing further investigation. Nevertheless there are studies reporting higher levels of dissociative symptomatology in several personality disorders. In a study [20] with emergency workers, the authors investigated which personality variables would predispose to higher levels of dissociation in the presence of trauma, hence a higher risk of PTSD (post-traumatic stress disorder). They concluded that workers uncertain of identity, reluctant to leader roles, shy, inhibited, with global cognitive styles, believing that fate is determined by factors they cannot control and reacting to trauma by emotional suppression, face a higher risk of dissociative reactions to trauma and future PTSD.

Ellason and Ross [9] studying individualized cases of DID (dissociative identity disorder) found a significant correlation with borderline, self-defeating and passive-aggressive personality disorders.

In a more psychodynamic perspective, the notion of "dissociative character" is being explored mainly by North American authors. This character would have its clinical expression in DID. Therefore, DID would belong to a spectrum or would be comorbid with narcissistic and borderline personality disorders. Bower [3] proposes an explanatory model - dissociative character would be a primitive form of dissociation in which identity division is enhanced by auto-hypnotic states of consciousness. As a result altered states of consciousness would be created as a reaction to hyper-stimulations by external trauma and reactivated by actual intra-psychic conflicts.

Nosological vs Transnosological Phenomena

Another important subject is the conceptualization of dissociation as a transnosological phenomena associated with other major psychiatric entities versus the conceptualization of dissociation as an individualized nosological category.

This debate has arisen from reports showing that dissociative symptoms are not uncommon in many psychiatric categories leading some authors to point the apparent lack of specificity of dissociative symptoms.

Besides, it is important to underscore the point that there are several difficulties in evaluating dissociative symptoms. These difficulties can be attributed to the use of self-report measures, to the fact of fundamenting some evaluations upon memories of patients and to the use of tests not initially designed for dissociative symptomatology.

In a research conducted by Kluft [19] to evaluate the prevalence of dissociative experiences in other psychiatric diagnosis (DSM III criteria) , the author found the following rates 15 to 90% in affective disorders, 35 to 100% in anxiety disorders and 60 to 90% in somatoform disorders.

Even though existing data shows a great variability across investigations regarding methods of assessment, according to a revision by Gastó [26], prevalence of dissociative experiences in the in-patient psychiatric population lies between 2,4 and 11,3%.

There are also reports that document the existence of dissociative symptoms in psychotic disorders. A study with schizophrenic patients [10] showed that they had higher levels of dissociation than the control group and those patients with mainly positive symptoms also presented higher levels of dissociation than patients with more negative symptoms. In this investigation dissociation correlated significantly only with hallucinations and hallucinatory behavior.

Several studies have also reported high prevalence of dissociative experiences in eating disorder patients [35].

Looking at dissociative symptomatology and Axis II pathology several positive correlations were found with almost every personality disorder.

In an investigation [27] conducted in a psychiatric hospital a positive correlation was found between dissociation levels and all personality disorders being the more significant correlations with borderline, anti-social, schizotipic and dependent.

Focusing now on our studies [28] [29] - it was reinforced the existence of a transnosological pattern in dissociative phenomena. We've evaluated comparatively the prevalence and types of dissociative experiences (amnesia, depersonalization/derealization, absorption) using the DES (dissociative experiences scale) in samples of eating disorder patients (n=50), depressive patients (n=30) and alcoholic patients (n=30) (DSM IV criteria). Phenomenological aspects: generalized anxiety symptoms; panic, phobic and obsessive symptomatology were assessed by the HAMA and a clinical interview. History of childhood traumatic experiences and severity of trauma were also evaluated. We have studied the correlation between phenomenological aspects, childhood trauma and dissociation levels.

We found high rates of dissociative symptomatology in eating disorder patients (n=50), depressive patients (n=30) and alcoholic patients (n=30).

Eating disorder patients reported significant higher rates in the DES total score and particularly in the subscale of depersonalization/derealization than normal.

Equally the alcoholic patients had also a significant difference on the total DES score and all the three subscales: amnesia, depersonalization/derealization, absortion when compared with the control group.

In the depressive sample we have also found higher levels of dissociative experiences than in normal samples. Nevertheless it is not conclusive if the correlation is predominantly due to eating, alcoholic, depressive symptomatology or to other psychopathological features personality or symptomatic related not evaluated in these investigations.

In our conceptualization the results of these investigations may reinforce the conceptualization of dissociation as a transnosological phenomena not invalidating the existence of dissociative disorders as a nosological entity.

Analyzing the results, namely phenomenological aspects of the samples another relevant question raises beyond nosological specificity could we go further on syndromatic specificity?

Actually higher levels of dissociative experiences in the clinical samples correlated with a predominance of anxiety symptomatology (HAMA scores), higher prevalence of panic and phobic symptoms and a lower prevalence of obsessive symptoms.

Examining these results we could hypotesized about a syndromatic connection between anxiety and dissociative symptoms as it is classically mentioned.

Continuum versus Categorial Model

The previous debate leads us to another topic: the continuum versus the categorial model of dissociation.

Some authors support the idea of dissociation as a continuum from the minor dissociative experiences from everyday life to more disturbed pathological forms classified as dissociative disorders by the DSM IV.

The continuum model has been defended by authors like William James (1902) and Morton Prince (1908, 1927). In the conceptualization of Prince clinical dissociation was a form of hypnosis ranging in a spectrum from «light» to «deep» hypnotic states.

More recently other authors such as Spiegel (1963) and Hilgard (1977) also second the continuum model.

Setting against this perspective is the categorial model early supported by Janet (1930). Janet stated that the mechanism of dissociation was a pathological one and that individuals like his patient Lucie, presenting pathological dissociation, were different from normal and had a constitutional energy deficit.

It is also the categorial model that seconds the DSM IV classification.

Recent research provided new arguments to the debate. Data from a PTSD sample (Putnam et al.,1996) exhibit a bimodal distribution of DES scores-one group scoring an average of 17 and another group that scored an average of 44. These results suggest the existence of two types of PTSD regarding pathological dissociation and give a new support to the categorial model. Also a review of large data collected using the DES with a reanalysis of the factor analyses l (Waller et al.,1996), showed that the categorial model rather that the continuum one would apply better, mainly for pathological samples. So we meet with two models of dissociation, the continuum and the categorial do individuals with clinical dissociation represent a «discrete» type or one extreme of a continuum? Maybe these two models are not necessarily mutually exclusive and each one could explain some aspects of dissociative phenomena.

Conclusion

Since Janet's original concept a large evolution in the knowledge of dissociation has been achieved .We face some difficulties in delimiting the construct of dissociation with a general consensus and have an accurate assessment.

The association most frequently referred is with trauma - there is a need to better explore the complexities of the trauma model.

Dissociative symptoms appear to occur in a transnosological pattern. More studies are needed to elicit the clinical implications of this finding.

Some debates are still open requiring a further investigation:

-classificatory aspects (exclusion vs inclusion of somatic components)

-continuum vs categorial model.

After this brief review of historical aspects and controversies, obviously many important questions remain and should be considered for further investigation and discussion. I would like to finish this chapter mentioning some of them.

The multidimensional construct of dissociation employed as a psychological mechanism, a symptom part of other psychiatric diagnosis and a syndrome -did it extended too far its original concept forgetting some of its aspects?

What is the meaning of the presence of dissociative symptoms in the clinical picture of some psychiatric entities? Beyond nosologic specificity can we go further on syndromatic specificity?

Which model is the most appropriate to dissociation, the continuum model or the categorial one? This is another question yet to be answered.

With many contributions from neuropsychological ground, psychological trauma, personality variables, culture, there is a need to integrate all the emergent data in an unified construct.

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