SYMPTOMS AND DISORDERS IN PATIENTS WITH EATING DISORDERS

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ABSTRACT

This study sought to describe the relationship between dissociative symptoms and syndromes in patients with eatingdisorders. We studied 38 patients clinically identified with eating disorders. They were evaluated in two sites by experienced clinicians usingstandard interviews to elicit symptoms of eating disorders, dissociative disorders and to obtain histories of traumatic abuse. A self report measure, the Dissociative Experiences Scale, was used to identify those with frequent dissociative symptoms. The temporal relationship of these symptoms to eating and sexual behaviors was explored by a uniformly administered interview. Diagnoses of dissociative disorders and other comorbid syndromes were made using DSM-III-R *criteria. We found that dissociative disorders were prevalent in our sample (29%). The prevalences of multiple personality disorder and depersonalization disorder were 10% and 18% respectively. The presence of dissociative disorder was significantly related to a history of self-harm. Dissociative symptoms which occurred frequently were temporally associated with the binge/purge cycle or severe restriction in 74 %, with sexual behavior in 39% and with self-harm in 28%. A dissociative disorder diagnosis was correlated to history of trauma or abuse but was not limited solely to sexual abuse. We conclude that dissociative symptoms are relevant to the behaviors characteristic of patients with eating disorders Trauma should be considered in those who present with discrete dissociative disorders. These comorbid syndromes may alter outcome in patients with eating disorders.*

INTRODUCTION

Dissociative experiences occur in patients with psychiatric disorders and in normal populations. When dissociative experiences include significant amnesias, divided self experience and ritualized behavior, they can interfere with interpersonal and occupational functioning. Dissociative states have been described in case reports of patients with eating disorders (Torem, 1986; Pettinati, Horne, & Staats, 1985; Sanders, 1986) . Demitrack, Putnam, Brewerton, Brandt, and Gold (1990) reported a significantly higher frequency of dissociative experiences in patients with eating disorders when compared to controls. In addition, these researchers found frequent and extensive dissociation significantly related to self-harming behaviors.

In working with patients with severe eating disorders, we found that some patients reported dissociative symptoms including depersonalization, trance-like states, out-of-body experiences, amnesias, and multiple personalities. Many of these patients also reported histories of childhood trauma. In the past decade, Kluft, Putnam and others have attempted to systematically describe the phenomenology and comorbidities of patients who report multiple personalities (Kluft, 1985; Putnam, 1989; Ross, 1989). Studies of patients with multiple personality disorder (MPD) have shown that both multiple personality disorder and dissociative phenomena in general occur in those with histories of childhood trauma (Kluft, 1986; Ross, 1986; Putnam et al, 1986; Sanders et al, 1991).

Ross, Anderson, Fleisher and Norton (1991) recently reported a 3.3% frequency of MPD diagnoses in a group of psychiatric inpatients. The prevalence of dissociative disorders in populations of patients with eating disorders is unknown. This study assessed the presence of the clinical syndromes of dissociation in patients with eating disorders. It aimed to identify patients who *meet DSMIII-R* criteria for dissociative disorders and to explore the relationship between dissociative phenomena, eating behavior, history of abuse and self harm.

METHODS

Twenty consecutive inpatients were recruited from a specialty unit for eating disorders in a private St. Louis hospital. In addition, patients were also recruited after referral to a tertiary care day treatment program for eating disorders at the Neuropsychiatric Institute at UCLA. All patients

participating gave informed consent following the procedures of the relevant Human Studies committees.

All were ascertained solely *on* the basis of having an eating disorder diagnosed by the treating clinician. After consent was obtained, each subject completed the Dissociative Experience Scale (DES) (Bernstein & Putnam, 1986), a 28-item self report scale which measures the frequency with which dissociative phenomena occur.

Next, a 2 1/2 hour interview using structured or semi-structured questionnaires was performed by psychiatrists. Investigators (Helzer & janca, 1989) used sections from the DSM-III-Rchecklist to elicit symptoms of post traumatic stress disorder, depression and dysthymia. Modules for somatization disorder and mood disorder were taken from the Diagnostic Interview Schedule (DIS) modules developed by Robins and Helzer, Cottler, & Goldring in 1989). The Dissociative Disorders Interview Schedule sections for dissociative disorders and borderline personality disorder developed by Ross, Norton, Anderson and Anderson (1989) were used to systematically elicit the presence or absence of the criteria for diagnosis of the dissociative disorders. They have reported inter-rater reliability for this method for MPD at 0.68, with excellent agreement with clinical diagnosis.

Diagnoses of dissociative disorder was made following *a DSM-III-R* algorithm (American Psychiatric Assoc, 1987). The diagnosis of MPD was made if the subject reported the following:

1. Experiences of two or more personalities existing each dominant and in control of behavior more than one time.

2. These personalities were complex and distinguishable, and some amnesia existed between these personalities.

The diagnosis of Dissociative Disorder Not Otherwise Specified (DDNOS) was assigned if the subject experienced significant dissociative phenomena but did not meet full criteria for MPD. We made the diagnosis of Psychogenic Amnesia if the patient did not meet criteria for MPD but had *a* sudden inability to recall important life events not explained by ordinary forgetfulness or intoxication. Depersonalization Disorder was identified if the subject had one or more episodes of depersonalization, not related to substance abuse, sufficient to cause problems in work or in social relationships. For all diagnoses identified by the clinician, the dates duringwhich the syndrome was diagnosed by history (past and/or present) were also recorded.

To explore the relationship between dissociation and eating disorders, each subject was asked about DES items which were reported as occurring greater than 25% of the time.First, we asked if they felt these symptoms occurred randomly or in relation to an external event. Next, every subject was asked specifically if she noted any relationship between the phenomena and intoxication, eating behavior, sexual behavior, and/or self harming behaviors.

Excerpts taken from the Wyatt Sexuality Questionnaire were used to identify sexual behavior and to ask questions about sexual abuse (Wyatt, 1988). Questions were always asked in the same format and order.

Data from both sites were coded by the same investigator (KEM) and analyzed using the SAS version 6.03 for personal computers for data entry,rnanagement and statistical analysis (SAS Institute, Inc., 1988).

RESULTS

Sample Characteristics

Twenty interviews of consecutive inpatients were cornpleted at the St. Louis site. Every patient approached on this unit agreed to participate in the study. Eighteen interviews with outpatients were completed at the Los Angeles site. Only 60% of the outpatients approached agreed to participate. The most frequent reason for refusal of participation offered by the outpatients was the estimated length of time for the interview and testing indicated in the informed consent statement. Thirty-five subjects were caucasian and three were of other racial backgrounds (one African-American, one Arab-American, and one Hispanic). Seventy-nine percent were single and fifteen percent were married. The age range was 19 to 35, with a median age of 25 years. All subjects met criteria for an eating disorder. Multiple analyses were made comparing the patients studied at the two sites on demographic, clinical and test variables. Other than participation rate, there was not difference (all $p > .05$) between sites or status of patient (site is confounded with inpatient vs. outpatient status) with respect to characteristics of the eating disorders frequency of dissociative disorders, mood disorders, borderline personality disorder, substance abuse, history of trauma or DES scores.

As Table 1 shows, our population was severely ill, manifesting symptoms of both bulimia (BN) and anorexia (AN) currently although many had never met full criteria for AN.

Dissociation and Dissociative Disorders

Dissociative disorders were frequent. Four cases (of the 38) meeting criteria for MPD were identified. Four additional cases (diagnosed with DDNOS) demonstrated a partial syndrome of divided identity experience, but without repeated, full assumption of separate identify with amnesia. Six subjects reported depersonalization experiences sufficient to interfere with daily living. Of the six, two met criteria for depersonalization disorder alone, two reported some experience of divided identity (included in the DDNOS), and two met the full criteria for MPD. One case of psychogenic amnesia without other dissociative disorder was identified. No case of fugue was identified. Table 2 presents the dissociative symptoms seen in the 11 patients given a dissociative spectrum diagnosis.

DES Scores and sub-factor scores were higher than expected for normals. The median scale score in our sample was 11.6 (mean=15.43, SC =13.7) . DES factor scores for the absorption and depersonalization/derealization factors were significantly greater in patients with dissociative disorders than in patients without co-morbid dissociative disorders.

Absorptive and imaginative involvement was common among our patients; most items loading on this factor report-

ed to occur more than 25% of the time among our patients with and without dissociative syndromes. Other commonly occurring phenomena across all patients were having a high threshold for pain and having an unclear memory as to whether one has done something or just thought about doing it, items not assigned to a specific factor. On the other hand, depersonalization and derealization experiences were reported to occur more than 25% of the time in patients with identified dissociative disorders but less than 10% of the time in those without dissociative disorders. As noted above, scores on the depersonalization/derealization factor differed significantly between patients with and without a dissociative diagnosis.

Dissociative phenomena were often temporally related to bingeing, purging and restrictive eating. Seventy-four percent (28) of our subjects reported some association of significant dissociative symptoms with their specific disordered eating behaviors. This held true for 19 of the 27 (70%) of the patients without dissociative disorders and 9 of the 11 patients (81%) with dissociative disorders. The non-dissociative disorder group reported an average of 1.5 dissociative symptoms associated with eating behavior compared to an average of 3.7 in the dissociative group (t=-2.58, p <0.05). Several questions seemed to identify symptoms more commonly associated in time with characteristic eating behaviors Staring off in space not aware of the passage of time was related in 10 cases. Listening, but not hearing was related to disordered eating behavior in eight patients Being involved in a daydream but having it feel real was related to eating behavior in five patients. Talking out loud to oneself and hearing voices were also identified as being related to disordered eating behavior in five patients each.

Some patients also reported that sexual behaviors were sometimes associated with dissociative experiences (10 of 27 non-DD patients-mean 0.7 symptoms vs. 5 of 11 DD patients-mean 2.0 symptoms p > 0.05).

Self-harming behaviors were temporally associated with some specific dissociative symptoms, as one might expect. Only five of the non-DD patients reported any connection while six of the DD group did note a connection (mean 0.3 vs. 2.4 symptoms, T=-2.42, p <0.05).

TABLE 1
History and Symptoms of Eating Disorders

Signs and Symptoms	**Percent (n-38)**
History of restrictive eating	92%
History of disrupted menses	71%
Currently does not eat regular meals	60%
History of being overweight (>15% 1BW)	18%
History of binge eating	79%
Currently binges less than 3 times per week	45%
Excessive exercise	63%
No history of purging	13%
Self induces vomiting	*79%*
History of diuretics	34%
History of laxative abuse	63%
Syndrome pattern : eating behavior	
Restrictive eating only	13%
Bingeing/purging only	8%
Mixed syndromes	79%
Current primary eating disorder diagnosis	
Bulimia	71%
Eating Disorder NOS	8%
Anorexia	21%

Trauma Histories

Many of the subject (66%) reported some history of childhood trauma (cf. Table 4) . Ten subjects (26%) reported a history of PTSD; three suffered from **PTSD** at the time of the interview. Any history of trauma, including sexual and physical abuse or reaction to trauma-PTSD, was significantly correlated with an increased DES score (p = 0.02) and significantly increased the probability of a diagnosis of dissociative disorder (p = 0.03) in our sample.

Nineteen (50%) of our patients reported lifetime histories of sexual abuse. Six (17%) reported forced sexual contact in childhood (before adolescence). Six (17%) reported rape during adolescence. Eleven(29%) reported rape as an adult. Sexual abuse was not significantly associated with DES scores, factor scores, or the presence of dissociative disorder. Eleven (29%) patients reported histories of physical abuse. Physically abused patients were significantly more likely to have depersonalization disorder than those not abused (5/11 =45% vs. 2/21 = 22%, Fisher's exact test= 0.024). There also was a tendency for these patients to have higher DES scores (p= .06) than those not physically abused. There was a tendency for patients with depersonalization disorder to be more likely to have a diagnosis of post-traumatic

TABLE 2
Criteria for Dissociative Disorders in Eleven Patients

Case Number	1	**16**	**29**	**34**	**4**	**35**	**23**	37	**18**	**33**	28
Diagnosis	**MPD**	**MPD**	**MPD**	**MPD**	**NOS**	**NOS**	**NOS**	**NOS**	**DEP**	**DEP**	**PA**
MPD	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No
2+ domonant personalities	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
Others in control		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
Identities complex behavior, social relations	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes			
Personalities in control of body **on** 3 occasions	Yes	Yes	Yes	Yes	?	No	?	?			
Amnesia			Yes	Yes	?	Yes	No	No	Yes	No	
Depersonalization	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes	No	
Episodes cause problems work/social life	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes	No
Body part changes shape or size	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes	No
Out of body experience	Yes	Yes	No	no	No	No	Yes	Yes	Yes	No	No
Unreality when not impaired by drugs or alcohol	Yes	Yes	Yes	Yes	No	No	yes	Yes	No	Yes	No
Psychogenic Amnesia	Yes	Yes	Yes	Yes	No	No	No	No	No	Yes	
Sudden inability to recall important events	Yes	Yes	Yes	Yes	No	No	No	No	No	No	Yes
No medical explanation	Yes	Yes	Yes	Yes	-	-	-		Yes	No	Yes
Psychogenic Fugue	No	No	No	No	No	No	No	No	No	No	No
Sudden unexpected travel with amnesia	No	No	No	No	No	No	No	No	Yes	No	No
Assume new identity	No	?	No	No	No	No	No	No	No	No	No
DES Score	39.6	*72.7*	27.1	25.2	10.0	9.5	18.3	4.5	12.1	39.5	9.1
Amnesia	14.4	63.8	5.6	8.8	3.1	0.0	13.1	0.6	1.3	25.0	0.0
Absorption/imagination	50.6	73.3	53.3	45.08	27.2	11.7	18.9	5.0	10.0	51.7	20.0
Depersonalization/unreality	65.0	88.3	34.2	8.38	0.0	19.2	20.0	6.7	8.3	36.7	3.3

TABLE 3
DES Scores and Dissociative Disorders in Subjects with Eating Disorders

	Mean	Standard Deviation	Median
Patients without Dissociative Disorder			
Amnestic dissociation	4.91	8.15	2.50
Absorption/Imagination	19.19*	13.40	17.56
Depersonalization/Unreality	4.17**	6.64	1.67
DES Total Score	11.80	**8.02**	**10.89**
Patients with Dissociative Disorders			
Amnestic dissociation	12.33	18.75	5.63
Absorption/Imagination	34.24*	21.53	27.22
Depersonalization/Unreality	26.36**	28.03	19.17
DES Total Score	**24.33**	**20.12**	**18.32**
All Patients			
Amnestic dissociation	7.06	12.38	3.44
Absorption/Imagination	*23.55*	17.38	19.72
Depersonalization/Unreality	10.59	17.30	11.60
DES Total Score	**15.43**	13.70	**11.60**

**p = 0.01 Absorption factor with vs. without DD*
***P = 0.03 Depersonalization factor with vs. without DD*
****p=0.07*

stress disorder than those without it. (4/7=56%vs.6/27=22%a, Fisher's exact test = 0.10).

COMORBIDTTY

Somatic symptoms were common in this population: specifically fainting, dizziness, weakness, and menstrual abnormalities. Most of these somatic complaints occurred after the onset of the eating disorder and could be explained by endocrine or metabolic abnormalities related to starvation or dehydration. Only two patients met criteria for Briquet's syndrome or somatization disorder.

The diagnosis of borderline personality disorder (BPD) was common in this group of patients with eating disorders (20/ 38=53%) . BPD was significantly associated with the diagnosis of dissociative disorder (9/11=81% vs. 11/27 = 41%, X^2 =5.29, p = 0.02). Six of seven patients with a depersonalization diagnosis also received a borderline personality disorder diagnosis (86%), Fisher's exact test = 6.06.

Seventy four percent (N=28) of the subjects had a lifetime diagnosis of depression and thirty two percent (N=12) also met the criteria for dysthymia (eleven had both major depression and dysthymia). Depressive *syn*dromes are characteristic of patients with dissociative disorders. All eleven patients with a diagnosis of dissociative disorder met criteria for major depressive episode at the time of the interview. (11/11=100% vs.19/27=70%a,X^2 =4.13,p=0.04). Naturally, all patients with depersonalization disorder had depression (7/7 vs. 19/27, Fisher's exact test = 0.12).

Forty-seven percent (N=18) reported significant self-harming behaviors including cutting, biting, head banging, etc. Eleven of the 18 reported that self harming was temporally associated with dissociative symptoms; seven reported the two experiences were unrelated to each other. Self-harm was significantly more likely to be reported by patients with a dissociative disorder diagnosis (8/11-72% vs. 10/27=37%, x2 < 0.05) . All of the patients with a diagnosis of depersonalization reported self harm (100% vs 37% of those without DD, Fisher's exact test=0.008). The DES depersonalization factor was significantly related to self harm (p=.02). The DES total score, however, was not significantly related to self harming behavior. Borderline personality disorder also predicted self harming behavior in this population, but not as well as a depersonalization disorder.

Twenty six percent of our sample had attempted suicide in the past. There was a tendency for patients with dissociative disorders to be more likely to have reported a suicide attempt (5/11=45% with vs. 5/27= 18% without DD, Fisher's exact test=0.10). Four of the seven patients with depersonalization reported suicide attempts (56% vs5/27, Fisher's exact test=0.06).

Twenty six percent of our population admitted to recent substance abuse (including alcohol). Twenty patients (52.6%) admitted to a history of alcohol abuse. No current opiate or cocaine abuse was reported.DES questions refer to dissociative symptoms not related to substance abuse.There was no increase in mean DES scores or infrequency of dissociative disorders in the patients who report alcohol or other substance abuse.

DISCUSSION

This study set out to explore dissociative symptoms and syndromes among patients with eating disorders and to expli-

TABLE 4
Trauma Histories

Trauma History	N	Mean	Standard Deviation	P. Value
Sexual abuse (SA)				
Yes	19	16.5	16.3	.62
No	19	14.4	10.9	
Physical Abuse				
Yes	11	24.8	20.3	.06
No	27	11.6	7.5	
PTSD				
Yes	10	15.3	21.1	.13
No	28	4.1	5.2	
Any Trauma				
DES Total Score				
Yes	25	18.46	15.6	.02
No	13	9.6	5.9	
Amnesia Factor				
Yes	25	9.5	14.7	.02
No	13	2.3	2.4	
Absorption Factor				
Yes	25	26.4	18.7	.11
No	13	18.0	13.2	
Depersonalization Factor				
Yes	25	13.6	22.2	.07
No	13	4.9	5.3	.07

cate the possible relationship between these phenomena and self destructive behaviors, including eating behaviors. Conclusions drawn from our findings maybe limited by some weaknesses. First, the diagnosis of dissociative disorder can be difficult since the patient may not be aware that she has it or may not choose to reveal it to an interviewer, especially without an extended period of time in which to build rapport. Even the use of a structured interview for dissociative disorders like the DDIS may miss some diagnoses and overrepresent the diagnoses in some very suggestible subjects. It is clear, however,that many of these eating disorder patients did report dissociative symptoms that interfered tremendously with their interpersonal interactions and with their recovery from illness. Further, these patients also reported patterns of symptoms consistent with well defined dissociative disorders.Measurement of inter-rater reliability was not possible_ Ross and his colleagues (1989) described good inter-rater reliability for clinician interviews. We attempted to minimize error by eliciting symptoms following the same format and instructions. Again, no differences in covariants were found between sites.

Our systematic assessment of the temporal link between dissociation experiences and various harmful behaviors, particularly disordered eating behaviors, may contribute to the understanding of these complex, interrelated phenomena. This may be the first study that identifies a temporal link between bingeing, purging, and active restrictive eating and dissociative phenomena. Rituals associated with bingeing, purging and restrictions are often temporally related to dissociative experiences. Dissociative symptoms are related to other factors associated with poor prognosis (self harming behaviors, suicide attempts) and to identifiable clinical syndromes of dissociative disorders.

The 28% rate for dissociative disorders and 10% rate for MPD was unexpectedly high. Multiple personality disorder in patients with eating disorders may be over-represented when compared to most psychiatric populations. A full 16% of our sample reported depersonalization experiences sufficient to cause interference with social and work activities. Dissociative symptoms, as measured by the DES, were quite frequent in our sample. Demitrack et al.'s finding (1990) that DES scores are high in eating disorders patients is replicated.Our median DES score of 11.6 was slightly lower than the median of 16.7 described in their group but well above their median total DES score of 6.4 in young normal controls.

Absorption factor symptoms were common in these patients, with or without dissociative disorders, and account for most of items which were endorsed as occurring greater than twenty percent of the time in over half of the subjects.

The subgroup of subjects with dissociative disorders have significantly higher scores on both the absorption and the depersonalization sub-scales than the patients with eating disorders alone.

Depersonalization Disorder was a better predictor of both self harm and suicide attempts than depression, DES score, or borderline personality disorder. This may have been a function of sample or chance variation since all of these predictor variables were correlated and predicted these two behaviors to a degree.

Our patients were very ill with multiple comorbidities similar to other samples of patients with eating disorders. The high rate of depression and borderline personality by *DSM-111-R* measures is similar to other reports (Halmi et al 1991; Gartner, Marcus, Halmi & Loranger, 1989; Hudson, Pope, Jones, & Yurgelem-Todd, 1983; Mitchell, Hatsukami, Eckert, & Pyle, 1985) of outpatient and inpatient groups with eating disorders, suggesting our sample was a typical clinical sample.

Other investigators presented preliminary data on a study of 25 eating disorder patients in the Netherlands (9 inpatients and 16 outpatients) (Havenaar, Boon & Tordoir, 1991). This study used the DES (Bernstein & Putnam, 1986) and the SCID-D (Steinberg, Rounsaville,& Cichetti, 1990) for the diagnosis of dissociative disorders. They found a mean **DES** score of 16.77 (vs. 15.43 here). However, they did not find any cases of dissociative disorder. (0 of 25 vs. 11 of 38, Fisher's exact test = 0.0-02) . These findings may reflect important differences in research subjects. Two striking differences were noted. They reported a history of abuse in only four cases (16%) while we found it in 25 of our 38 (66%) patients. They noted psychiatric comorbidity (Axis I or Axis II) in only 9 patients. All thirty eight of our patients had diagnoses in addition to eating disorder and/or dissociative disorder diagnoses (DD - mean number of comorbid diagnoses ever 6.8 vs non-DD mean number of comorbid diagnoses ever 4.8, $t=2.35$, $p < 0.03$). All but one had a current diagnosis affecting their clinical picture in addition to eating and dissociative disorders. Either or both of these differences might be crucial.

Our data suggests that dissociative disorders along with dissociative symptoms may occur frequently in some clinical populations of patients with eating disorders, particularly those with multiple comorbid psychiatric problems. Dissociative states can interfere with a person's sense of control over and acceptance of responsibility for her behavior. This may account for some treatment resistance.

Aside from the temporal relationship between these phenomena, the exact relationship between dissociation and eating disorders remains unclear. A predisposition to dissociate may make some individuals more prone to develop an eating disorder after experimenting with dieting. Eating behavior may be understood as a way to manage extreme anxiety states, and at times induce dissociation. Dissociative phenomena may be correlated with endocrine and neurologic changes that occur in these patients. Neurochemical alterations in the same area of the brain may account for both eating disorder and dissociative syndromes. It may also be that dissociation is simply a marker for markedly dysfunctional family life, significant childhood trauma, very early developmental difficulties or multiple psychiatric problems.

These data suggest that all patients with eating disorders should be interviewed regarding dissociative experiences and related aspects of their experience. Treatment should take into account the presence of dissociative disorders. If dissociative symptoms are identified, monitored, and addressed, a better outcome might be achieved in a group that is often refractory to other treatments.

APPENDIX

Case #1 -
Multiple personality disorder, depersonalization disorder

A 24-year old woman presenting with anorexia with history of bulimia reported divided identity with complex behaviors and interactions and variable amnesia between states; one identity restricts and self harms while the other binges. This patient has spent most of the past three years as an inpatient and had multiple suicide attempts and self harming behaviors (cutting). She has a history of shop-lifting. This patient was repetitively abused sexually by a 12 year old neighbor when she was 8 years old.

Co-morbidity: Depression, dysthymia, shop lifting, PTSD, borderline personality disorder. DES, 39.6; amnesia 14.4; absorption, 50.6; depersonalization, 65.0.

Case #16 -
Multiple personality disorder, depersonalization

A 39 year old woman with a history of obesity and gastroplasty surgery with bulimic syndrome and atypical psychosis by history. She has had multiple suicide attempts and self harming behavior (scratching and burning) . This patient was sexually and physically abused by her father in early childhood. She reports that she feels and behaves as if she has several personalities, including a male personality. These personalities have different relationships and amnesia does exist among the personalities. This patient also had multiple physical complaints some explained, others unexplained and possibly self induced.

Co-morbidity: Depression, substance abuse (alcohol), dysthymia, somatization disorder, PTSD, borderline personality disorder, Briquet's syndrome. DES, 72.7; amnesia, 63.8; absorption, 73.3; depersonalization, 88.3.

Case #29 -
Multiple personality disorder, depersonalization, psychogenic amnesia

A 23-year old woman with bulimia and anorexia. This patient felt that she had multiple personalities each dominant at a particular time and in control of behavior. She believes that each has complex behaviors and specific social relationships. She also reports depersonalization extensive enough to cause difficulty in work and social life. She reports a history of self harming behavior (scratching and burning) . She also reports history of rape in early childhood with initial reexperiencing phenomena and persistent avoidance of

stimuli and arousal.

Co-morbidity: depression, dysthymia, substance abuse (stimulants, marijuana, cocaine), PTSD, borderline personality disorder. DES, 17.1; amnesia, 5.6; absorption, 53.3; depersonalization, 34.2.

Case #34 -
Multiple personality disorder, psychogenic amnesia

A 32-year old woman with bulimia reports two separate personalities. Each has been dominant at different times and in control of behavior with complex behavior and social relationships occurring multiple times. She has a history of suicide attempts and self harm (scratching).

Co-morbiditiy: Depression, borderline personality disorder. DES, 25.2; amnesia, 8.8; absorption, 45.0; depersonalization, 8.3.

Case #4 -
DD-NOS

An 18-year old woman who is a restricting purger (vomiting and diuretics), 140 weight range. She reports a very different self experience between heavy and light self; each personality has separate types of behaviors and each has been in control of her body at least twice. The complexity of the personalities is not known to the patient. This patient denies sexual abuse.

Co-morbidity: depression, dysthymia, borderline personality disorder. DES, 10.0; amnesia, 3.1; absorption, 27.2; depersonalization, 0.0.

Case #35 -
DD-NOS

A 24-year old woman with anorexia reports that at least two personalities were in control at any given point in time but that personality interacting socially had occurred less than twice. Her dissociative symptoms occur mostly during or after excessive exercise. She denies any history of abuse.

Co-morbidity: depression, dysthymia. DES, 9.5; amnesia, 0.0; absorption, 11.7; depersonalization, 19.2.

Case #23 -
DDNOS, depersonalization

A 32-year old patient with bulimia reports experience of two or more different personalities in self in control of behavior, but not involved in relationships with others. They gain control of her body repetitively, possibly in association with amphetamine abuse. She also reports drug free episodes of depersonalization causing problems in her life along with out of body experiences. Her history includes self harming behavior (pinching and scratching) and shop lifting. There is no history of sexual abuse. This patient did report regular physical abuse by her boyfriend in adulthood.

Comorbidity: Bipolar disorder, dysthymia, substance abuse (alcohol,stimulants) , borderline personality disorder. DES, 18.3; amnesia, 13.1; absorption, 18.9; depersonalization, 20.0.

Case #37 -
DD NOS, depersonalization

This 41-year old woman reports two personalities that are dominant, complex and in control of behavior, but she is unsure about whether these personalities have been totally in control more than twice. She reports significant interference from depersonalization experiences with strong sensations of unreality. She has a history of suicide attempts and shop-lifting. She denies any history of sexual or physical abuse.

Comorbidity: Depression, dysthymia, alcohol abuse, borderline personality disorder. DES, 4.5; amnesia, 0.6; absorption, 5.0; depersonalization, 6.7.

Case #18-
Depersonalization

A 26-year old woman who is a restricting purger gives a history of depersonalization experiences sufficient enough to cause problems in life along with out of body experiences. She reports self harming behaviors (scratching and burning). She also reports prolonged PTSD following repetitive urologic procedures performed between ages of 3-9. She presently continues to have flashbacks of these procedures. This patient was also beaten by her mother regularly with riding crops, snorkels, and other objects until age **14.**

Case *#33 -*
Depersonalization

A 34-year old woman with diagnoses of anorexia and bulimia with multiple obsessive thoughts. She reports depersonalization disorder with multiple episodes of disruptive depersonalization and additional sensation of unreality. She has a history of suicide attempts and self harming behaviors (cutting, scratching). She has a history of shop lifting.

Co-morbidity: Depression, substance abuse (alcohol, stimulants, marijuana, cocaine, other), borderline personality disorder. DES, 39.5; amnesia, 25.0; absorption, 51.7; depersonalization, 36.7.

Case #28 -
Psychogenic Amnesia

This 26-year old bulimic patient reports amnesia for her childhood that is too extensive to be explained by ordinary forgetfulness. She denies history of abuse of any kind. She reported unexplained headaches leading to medical workup and intervention, but the symptoms were never entirely explained. She reported no other unexplained somatic complaints.

Co-morbidity: Depression, dysthymia, substance abuse (alcohol, stimulants, marijuana, cocaine), borderline personality disorder. DES, 9.1; amnesia, 0.0; absorption, 20.0; depersonalization, 3.3. ■

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