ANXIETY AND THE PSYCHONEUROSES

SECTION IV

DISSOCIATIVE REACTIONS

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DISSOCIATIVE REACTIONS

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The human being may respond to a situation of intense psychic conflict in a number of ways. For example, he may push an unbearable memory or wish out of his conscious awareness in such a manner that it remains irretrievable under ordinary circumstances. This is called repression. If the conflict concerns something in his immediate environment that he perceives but does not wish to perceive, he may unconsciously pretend that it is not there, ie, he uses the defense of denial. If he finds himself having intolerably conflicting feelings toward one particular person, he may resolve the conflict by "splitting the object" as it were, ie, he may idealize one person and invest his opposite feelings of hate or rage in a suitable scapegoat.

On the other hand, the individual may resolve an intense conflict between feelings or ideas by separating or dissociating them, ie, not by splitting the object but by splitting his own personality or ego. Thus, he may be aware of ideas representing one side of the conflict at one time and of the other side of the conflict at another time, but does not allow both into his awareness equally and simultaneously. Perhaps a commonplace example, drawn from our clinical experience, will illustrate this principle.

At a rather critical period of therapy, the patient was informed that the doctor would not be able to see him for his regular appointment the next day. The patient clearly indicated that he heard and understood this, but on the following day he left his work at a certain time, drove to the therapist's office building and, not until his arrival in the waiting room, did he suddenly remember that the appointment for that day had been cancelled. It is of interest that following recall, the patient became tense, restless, had difficulty sleeping that evening, and had a dream in which repressed reactions to the therapist were clearly revealed. It would appear that the patient had dissociated two conflicting thoughts: his wish to believe that the appointment had not been cancelled and his knowledge that it had been. The dissociation enabled him to act as though his wish were fulfilled, and this, in turn, helped him to maintain the repression of unacceptable rage toward the therapist.

It is difficult to draw a sharp distinction between repression and dissociation, since both involve the exclusion of ideas and feelings from awareness. In general, the term repression refers to the relatively enduring exclusion from awareness of certain sexual or aggressive drives, or both, and associated ideas. Dissociation may be considered a compensating process in which the individual does not allow certain conflicting ideas or feelings into awareness simultaneously, yet retains elements pertaining to each side of the conflict retrievable to consciousness under certain conditions. In the above example, the dissociated thought (his knowledge of the cancellation) readily replaced an unrealistic wish fulfillment when the patient entered the doctor's waiting room. The underlying rage, however, remained largely repressed, only being

indirectly manifested in a state of tension and in disguised dream material.

Among the clinical syndromes usually included under the concept of dissociative reactions are amnesia, somnambulism, fugue, and multiple personality.

Relationship Between Dissociative Reactions and Conversion Reactions

In the *Diagnostic and Statistical Manual of Mental Disorders* both conversion reactions and dissociative reactions are considered to be types of hysterical neurosis.[2] The latter is rather vaguely defined in the manual as a neurosis "characterized by an involuntary psychogenic loss or disorder of function. Symptoms characteristically begin and end suddenly in emotionally charged situations and are symbolic of the underlying conflicts. Often they can be modified by suggestion alone." It is apparent that one can easily regard both conversion reactions and dissociative reactions as being hysterical neuroses under this definition, since both are characterized by involuntary loss or disorder of functions. However, it may be possible to discern a more specific and essential linkage between them. Pierre Janet, who is generally credited with introducing the term and concept of dissociative reaction (in the modern sense), attempted to do so.

Janet states:

> One of the chief conceptions that has directed my first researches on hysteria is that of the importance of fixed ideas in this disease: many of the most apparent symptoms recognized in the attacks, the somnambulisms, the disturbances of motility and sensibility, are but an outer manifestation, an expression of a conviction the patient keeps in his mind.[3]

Babinski referred to hysteria as "pithiatism," emphasizing the importance of suggestibility in the etiology and cure of this condition.[1] In commenting on the theories of pithiatism, Janet observes:

> In these theories, the hysterical phenomena have the great character, common to all of them and existing in all of them, that they are the result of the very idea the patient has of his accident [Janet seems to use the word "accident" to refer to a surface characteristic]: "The hysterical patient," M. Bernheim already said, "realizes her accident as she conceives it." This view is really interesting and has surely some preciseness, for there is not any organic disease nor even any other mental disease in which matters go in this way. Nobody will maintain that in a maniacal fit the patient is agitated because he is thinking of agitation.

Janet goes on to indicate the importance of the patient's "driving back" (repressing) certain ideas or recollections which then become unconscious and are later manifested in the various pathologic disturbances. He wisely reminds his reader that hysterics are very suggestible people and that the clinical characteristics of this disorder depend somewhat on the milieu in which it is studied. He thus alluded to the interesting likelihood that the neurologic atmosphere of the Clinic of the Sâlpetrière may account for the dramatic paralyses, anesthesias, and hysterical seizures so frequently described by Charcot.[3]

Janet also points out that we really do not understand why some patients are hysterical and other people, confronted by seemingly similar circumstances or conflicts, are not. He indicates that the patient with hysterical propensities tends to repress (drive back) thoughts and feelings rather readily, that he tends to have a "contraction of consciousness," that he "transforms into automatic wills and beliefs the tendencies which are mo-

mentarily the strongest." Why the hysterical patient has these fundamental characteristics or how he developed them, we still do not know.

In the hysterical disorders, conversion reaction and dissociative reaction, the patient is unconsciously giving expression to an idea (or group of ideas) through his behavior or symptoms. In conversion reaction he is giving expression to the idea that he is sick. As noted in the preceding section, his enactment of the sick role depends on his knowledge of the illness which he is unconsciously simulating and on the symbolic requirements of the underlying psychic conflict. In dissociative reactions, the patient gives expression to a variety of other ideas, such as the notion that certain events have not occurred (amnesia) or that he is someone else (multiple personality). As one would expect, it is not uncommon to find a history of dissociative and conversion symptoms in the same person.

Hysterical psychosis is difficult to categorize since it is a condition in which the individual is unconsciously enacting the role of a sick person (mental or emotional illness) and, in doing so, can make use of the mechanism of dissociation. The same can be said for hysterical attacks mimicking epilepsy.

Ganser's syndrome is a classic example of hysterical psychosis. This condition, also called the "nonsense syndrome," refers to the development of ludicrously inappropriate, "crazy" behavior in individuals who have been accused of a crime and who are awaiting trial. The symptomatology is often bizarre. For example, a soldier on KP duty in Korea, upon the entrance of his commanding officer, carefully cut a small hole in the roof of the tent and pushed through it the potato he had been peeling; he gave nonsensically "crazy" answers to questions, such as labeling his hand as his foot. As is often true in dealing with hysterical conditions, especially those occurring in situations in which the individual has much to gain, it is extremely difficult to rule out conscious malingering. It is thought that this condition is essentially a rather unsophisticated, unconscious mimicry of psychosis.

In other instances of hysterical psychosis, the patient's enactment of the psychotic role may more closely simulate a schizophrenic or affective illness than in the case of the Ganser syndrome. As a rule, the hysterical psychosis has a good prognosis, usually remitting in a few days or weeks.

It should be noted that the hysterical psychosis, in pure form, is quite rare. It is much more common to encounter patients who show some evidence of schizophrenic illness but who also, under certain circumstances, may appear to embellish upon their psychotic state in rather dramatic ways. This is often done unconsciously and with purpose. When this is done, ie, when the psychotic person is "laying it on thick," his illness can be said to have hysterical features which, incidentally, are thought to indicate a relatively favorable prognosis.

The strange behavior encountered in young women of medieval times who were possessed by devils or who were "bewitched," and the bizarre behavior of primitive tribesmen who believe themselves affected by malevolent ghosts are examples of culturally determined types of hysterical psychosis.

The Major Dissociative Reactions

As was noted in the earlier example, minor and clinically unimportant examples of dissociation are commonly seen. Three of the major dissociative reactions, viz, somnambulism, amnesia, and fugue, are not rare. Multiple personality is exceedingly rare, but fascinating.

Somnambulism. The sleepwalker appears to be more or less oblivious to his immediate surroundings, ie, he may not spontaneously acknowledge the presence of others or even respond to statements or questions put directly to him. In this condition, it appears that there is a massive dissociation of thoughts and feelings, leaving only a remnant of the personality for carrying out behavior. In addition, there is selective denial of perception of the immediate environment. It is as though his attention is so narrowly fixed, in a manner analogous to "gun-barrel vision," on something known only to him that he effectively ignores all distracting stimuli. In this respect the somnambulist strongly resembles someone in a hypnotic trance. And yet, the sleepwalker is obviously perceiving his environment but in a highly selective fashion, for typically he does not bump into objects or fall from heights. He may proceed to a given destination and wake up, or he may return to bed and sleep in a more conventional style for the rest of the night.

It is most unlikely that the sleepwalker is dreaming, since one of the characteristics of the state of dreaming is absence of coordinated motor activity. Recent studies, in fact, suggest that sleepwalking occurs only in association with electroencephalographic patterns characteristic of nondreaming sleep.[4]

It is not uncommon for the person who engages in repeated episodes of sleepwalking to repeat essentially the same activities during each episode, like Lady Macbeth washing her hands, or seeming to, in her sleep. It is sometimes possible for the observer to infer what idea or ideational complex is given expression in the particular somnambulistic acts, just as did the doctor who observed Lady Macbeth. When the somnambulist awakens he is unaware of what he did when sleepwalking, as if he had actually been asleep.

Amnesia and Fugue. In hysterical amnesia, the patient is unable to remember facts about himself or past experiences that are ordinarily readily available to conscious recall. A common characteristic of this type of forgetting is its selective nature; facts forgotten are the individual's name or that of someone important to him, his residence, or his place of business. In very dramatic cases the patient may have seemingly forgotten everything from his past, but the inconsistency of this is apparent in his retention of language along with customs or conventions of his culture.

Fugue refers to a state of amnesia during which the individual flees his customary environment. Characteristically, the flight is not only a geographic one, entailing his leaving home and traveling to a distant place, but also includes an escape from his own identity. Upon recovering, the patient is unaware of how he arrived at whereever he is or of any of the intervening events.

Generally speaking, amnesia and fugue appear to be motivated either by the desire to fulfill a suppressed wish or to escape from an intolerable conflict or both.

Multiple Personality. This is an extremely rare condition in which amnesia for one or more groupings of personality characteristics occurs intermittently and alternately. Each grouping is sufficiently complex to comprise a distinct personality. The most famous literary example, of course, is Stevenson's Dr. Jekyll and Mr. Hyde. In this country, Prince wrote extensively in the early 1900's about multiple personality; his famous case is Miss Beauchamp.[5] In our own time, Thigpen and Cleckley have described their experiences in a very interesting book, *The Three Faces of Eve*.[6] They describe Eve White as a quiet, properly behaved, devoted wife

and mother who feels troubled and has headaches. Occasionally, and without warning, her counterpart, Eve Black, emerges for varying periods of time. She is a flirtatious, saucy, impish, hedonistic, devil-may-care person, who, though aware of Eve White's existence, specifically disclaims identity with her and considers herself neither a wife nor a mother. Eve White is unaware of Eve Black's existence and has the experience of "waking up" in situations into which she has gotten herself as Eve Black. Her bewilderment as to how she arrived there is similar to that of the fugue victim "coming to" in the emergency room of a hospital.

The reader is referred to the works of Thigpen and Cleckley and Prince for further details of their clinical and therapeutic experiences with multiple personality.

Differential Diagnosis

When the physician encounters a patient who presents with symptoms suggestive of a dissociative reaction, it is important that he rule out the presence of organic brain disease and underlying psychosis, notably schizophrenia.

In many instances, patients with organic brain damage, regardless of etiology, show evidence of impairment of intellectual functioning. Characteristically, these patients have greater difficulty in remembering recent events than those of the remote past. The faulty memory is apt to be spotty, the patient having an incomplete rather than total loss of recall for recent experiences or recently acquired information. This is in contrast with the amnesia of the dissociative patient, who cannot recall a specific period of his life or some specific information such as his name, but whose memory is otherwise usually intact. Furthermore, when the organic brain damage is sufficient to cause memory impairment, there are usually other signs of intellectual deficit such as disorientation, especially for time (day, month, or year), along with impaired concentration and inability to do simple calculations, and labile, shallow affect. Dysarthria, aphasia, visual hallucinations, and nocturnal exacerbation of symptoms may also occur in organic brain syndrome. Specific neurologic deficits, sensory or motor, may be present. When evidence of organicity is found on clinical examination, further investigation utilizing psychologic testing, electroencephalography, arteriography, pneumoencephalography, and other studies may be useful in determining localization and etiology of the underlying lesion. Although the organic brain syndrome, acute or chronic, may be caused by a wide variety of etiologic agents, it is important to keep in mind that acute trauma, ie, a blow to the head, may result in a dazed condition with amnesia, with or without a transient loss of consciousness.

It is also important to rule out psychomotor epilepsy, which may be characterized by recurrent periods of automatic behavior, or of psychic seizures with paroxysms of complex behavior such as fits of running, aggression, or uninhibited sexual acts. Recall of the seizure experience is usually faulty but not completely absent. Patients with psychomotor epilepsy sometimes have a history of grand mal seizures, and the electroencephalogram may reveal a characteristic ictal or interictal pattern.

It is not uncommon for schizophrenic patients to develop conversion and dissociative symptoms. Therefore, the physician should be alert to the possibility that hysterical symptoms are masking an underlying psychosis. The physician should be alert to the presence of Bleuler's fundamental symptoms of schizophrenia such as loosening of associations, ambivalence, inappropriateness of affect, and autism, as well as of the more obvious features of hallucinations and bizarre delusions.

Treatment

The patient with amnesia should be examined carefully in order to rule out organic factors, as noted in the preceding section. If it appears likely that the amnesia is on a psychologic basis (dissociative reaction), the patient should be informed that the physician fully expects his memory to return and that it is not uncommon for a person to develop temporary amnesia under situations of stress. The patient should be encouraged to talk about himself as freely as possible, with the interviewer tacitly suggesting to him that this will help him to revive his memory but that if this is insufficient, medicines are available that are usually effective. If the interview and suggestion in the fully awake state do not prove effective, and if prompt recall is deemed necessary, an amytal interview or hypnosis is indicated. It is interesting that the patient, when under the influence of sodium amytal or hypnosis, may respond to suggestion by the interviewer and retrieve his memory with or without a catharsis of feelings related to the events that precipitated the amnesia. Once recall occurs, depression with suicidal preoccupation, or schizophrenic illness, must be ruled out immediately.

After recovery from the acute phase of the illness, it is important that the patient be referred for follow-up psychotherapy.

As a rule, the symptom of somnambulism does not require, in itself, therapeutic intervention. However, sleepwalking, when persistent, should be considered indicative of underlying emotional problems, and the patient should be encouraged to seek psychiatric evaluation and possible therapy. Fugue and multiple personality indicate serious problems requiring psychotherapeutic intervention.

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