reprinted from

CLINICAL MEDICINE

JOHN A. SPITTELL, JR., M.D.
Editor

MEDICAL DEPARTMENT

HARPER & ROW, PUBLISHERS
PHILADELPHIA

1817

36

Dissociative Reactions

Lee C. Park and John B. Imboden

A human may respond in a number of ways to a situation of intense anxiety that is due to inner conflict. If he cannot deal with the anxiety consciously, he may push an unbearable memory, feeling, or wish out of his awareness in such a manner that it remains irretrievable under ordinary circumstances. This is called *repression* and occurs to some degree in everyone. In some individuals, repression is not complete enough to relieve the anxiety, which may continue even though awareness of the cause of the anxiety is blocked. If the anxiety remains quite strong, some individuals develop additional "defense mechanisms" to further control the tension and support the repression. In neuroses, these mechanisms are in themselves so predominant that they impair an individual's functioning.

Dissociation, one of these defense mechanisms, involves a sudden splitting off (dissociation) and repression of a significant part of the personality from a person's awareness such that there is an actual alteration of the functioning conscious state and/or a memory loss for a significant period of time in the recent past; these changes are sufficient to be obvious to someone who knows the individual but are not necessarily obvious to a stranger. The remaining conscious part of the personality may then act out a wish-fulfilling role. Dissociative states, as distinguished from the enduring features of repression alone, are "emergency" defenses which tend to appear suddenly when an individual is in great psychologic crisis, last for only moments to weeks, and end rather abruptly. Major clinical syndromes considered to be dissociative states include amnesia, somnambulism, fugue, and multiple personality.

Lee C. Park is Associate Professor of Psychiatry, Johns Hopkins University School of Medicine, and is affiliated with Johns Hopkins Hospital, Baltimore, and The Sheppard and Enoch Pratt Hospital, Towson, Maryland.

John B. Imboden is Associate Professor of Psychiatry, Johns Hopkins University School of Medicine, is Psychiatrist-in-Chief, Sinai Hospital, and is affiliated with Johns Hopkins Hospital and Sinai Hospital, Baltimore.

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 (1). The term *dissociative reaction* 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 the two. Janet (2), who is generally credited with introducing the term and concept of *dissociative reaction* (in the modern sense), attempted to do so:

> 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.

Babinski and Froment referred to hysteria as *pithiatism*, emphasizing the importance of suggestibility in the etiology and cure of this condition (3). In commenting on the theories of pithiatism, Janet (2) 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 alludes to the interesting likelihood that the neurologic atmosphere of the Clinic of Salpetriere may account for the dramatic paralyses, anesthesias, and hysterical seizures so frequently described by Charcot (2).

Janet also points out that we really do not understand why some individuals are hysterical and other people, confronted by seemingly similar circumstances or conflicts, are not. He indicates that the patient with hysterical propensities tends to "drive back" thoughts and feelings rather readily, that he tends to have a "contraction of consciousness," and that he "transforms into automatic wills and beliefs the tendencies which are momentarily the strongest." Why the hysterical patient has these fundamental characteristics or how he developed them, we still do not know.

In 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 physically ill, and 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), that he is someone else (fugue, multiple personality), that he is asleep (somnambulism), that he is mentally ill (hysterical psychosis), or that he has an organically based behavioral disorder (hysterical epilepsy). As one would expect, it is not uncommon to find a history of dissociative and conversion symptoms in the same person.

THE MAJOR DISSOCIATIVE REACTIONS

Minor and clinically unimportant examples of dissociation, such as the dynamically motivated "forgetting" of a specific name or event, are commonly seen, but the major dissociative reactions occur infrequently. Multiple personality, for example, is exceedingly rare, but fascinating.

Somnambulism

The somnambulist 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 directed to him. In this condition, there appears to be 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 the somnambulist's attention is so narrowly fixed, in a manner analogous to "gunbarrel vision," on something known only to him that he effectively ignores all distracting stimuli. In this respect, the behavior in somnambulism strongly resembles that in a hypnotic trance, at one time referred to as *artificial somnambulism*. Yet the somnambulist is obviously perceiving his environment but in a highly selective fashion, for typically he does not bump into objects or fall from heights. Many cases of apparent somnambulism may actually be manifestations of psychomotor epilepsy (4).

Sleepwalking, which most often occurs in childhood and adolescence, has usually been considered the most common form of somnambulism. However, Nemiah (5) distinguishes it from somnambulism on the basis that sleepwalking occurs in association with electroencephalographic patterns characteristic of deep (stages 3 and 4) nondreaming sleep.

It is not uncommon for the person who engages in repeated episodes of somnambulism 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. When the somnambulist "awakens" he is usually, but not always, unaware of what he did.

Amnesia and Fugue

The patient with hysterical amnesia, is unable to remember facts about himself or 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 the language and customs or conventions of his culture. Due to the anxiety-relieving nature of the amnesia, the patient may show a characteristic lack of concern or "belle indifference" regarding his condition. In some cases of amnesia the individual experiences himself at an earlier point in his life with amnesia for all subsequent events.

Fugue refers to a state of amnesia during which the individual flees his customary environment. Characteristically, the individual's flight not only is a geographic one, entailing his leaving home and traveling to a distant place, but also includes an escape from his own identity. On recovering, the patient is unaware of how he arrived at wherever he is or of any of the intervening events. Automatic writing involves structured behavior which may occur in the presence of otherwise unaltered consciousness.

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

Multiple Personality

Multiple personality is an extremely rare condition (only approximately 100 cases have been reported [5]) in which amnesia for one or more groupings of personality characteristics occurs intermittently and alternately. Each grouping is sufficiently complex to comprise a distinct functioning personality. The "splitting" which occurs in borderline personality structures may be developmentally related to multiple personality manifestations. The most famous literary example, of course, is Stevenson's *Dr. Jekyll and Mr. Hyde*. In the United States, Prince wrote extensively in the early 1900s about multiple personality; his famous case is Miss Beauchamp (6). In our own time, Thigpen and Cleckley have described their experiences in *The Three Faces of Eve* (7). 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, although 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 that she has gotten herself into as Eve Black. Her bewilderment as to how she arrived in these situations 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.

Depersonalization Disorder

In depersonalization disorders there are episodes in which the individual experiences an alteration of his perception of himself such that his sense of reality changes. He may feel strange, unreal, mechanical, outside of himself. He may experience derealization, ie, people and objects about him seem different or unreal. These symptoms often precipitate a fear of going insane. Unless the symptoms are secondary to a more serious disorder, however, the individual retains intact reality testing, and the symptoms gradually disappear.

Dissociative Delirium and Hysterical Psychosis

Alteration of consciousness due to dissociation may result in a confused, dreamlike clouding of consciousness resembling delirium. The patient may report feelings of depersonalization or deja-vu or may appear to be in a trancelike state. In hysterical psychosis there is a disintegration of the functioning personality which can mimic schizophrenia, with the sudden onset of confusion, hallucinations, and delusions. However, the manifestations of hysterical psychosis, as opposed to those of schizophrenia, usually remit in a few days or weeks, and there is a history of much better adaptation to life than in the case of schizophrenia.

It should be noted that hysterical psychosis, in

pure form, is quite rare. It is more common to encounter patients who show some evidence of schizophrenic illness but who also, under certain circumstances, appear to embellish on 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.

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, upon the entrance of the commanding officer, a soldier on KP duty in Korea 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. 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.

Münchausen syndrome, although not necessarily always involving dissociation, is a condition in which lonely, dependent, medically knowledgeable individuals repeatedly hospitalize themselves for factitious symptoms which are so similar to those of medical illnesses that repeated surgical and other serious procedures are performed. There may be mysterious bleeding, manufactured fever, and other "obvious" signs of organicity. Again, the problem of unconscious mechanisms and conscious malingering can be entwined. Physicians should be alert to this possibility whenever there are multiple hospitalizations without clear diagnoses.

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.

Dissociative symptoms typically have a relatively abrupt onset and termination, are variable, last moments to weeks, serve a psychologic purpose which the careful questioner may be able to perceive, and often can be altered by suggestion. The patient characteristically is not very upset by his condition (la belle indifference).

In many instances, patients with organic brain damage, regardless of etiology, show generalized 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 a total loss of recall for recent experiences or recently acquired information, and improvement tends to be quite gradual. The amnesia of the patient with organic brain damage is in contrast to that of the dissociative patient; the latter patient cannot recall a specific period of his life or some specific information such as his name, but his 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, 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, either sensory or motor, may be present. When evidence of organicity is found on clinical examination, further investigation utilizing psychologic testing, electroencephalography, arteriography, and other radiologic 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 remember that acute trauma, eg, a blow to the head, may result in a dazed condition with amnesia, with or without a transient loss of consciousness or other obvious manifestation of organicity.

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 a history of schizoid adjustment and 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. Psychologic testing may help to clarify schizophrenic potential.

TREATMENT

The patient with amnesia should be examined carefully in order to rule out organic factors. 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 retrieve 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. However, efforts at prompt recall should generally be avoided if underlying schizophrenia is definitely suspected. It is interesting that the patient under the influence of 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.

It is important that after recovery from the acute phase of the illness, the amnesic patient be referred for follow-up psychotherapy. It must be remembered that significant dissociative symptoms usually reflect enduring emotional problems and that the symptoms could readily return if the patient is not helped via psychotherapy to become consciously aware of and then to deal constructively with these problems.

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

REFERENCES

1. Diagnostic and Statistical Manual of Mental Disorders, ed 2. Washington, DC: American Psychiatric Association, 1968
2. Janet P: The Major Symptoms of Hysteria. New York: Macmillan, 1920, pp XI–XIII
3. Babinski J, Froment J: Hysteria of Pithiatism and Reflex Nervous Disorder in the Neurology of War. London: Univ London Press, 1918
4. Kolb LC: Noyes' Modern Clinical Psychiatry. Philadelphia: Saunders, 1977
5. Nemiah JC: Psychoneurotic disorders. In Nicholi AM, Jr: The Harvard Guide to Modern Psychiatry. Cambridge: Harvard Univ Press, 1978
6. Prince M: The Dissociation of a Personality. New York: Longmans, Green, 1908
7. Thigpen CH, Cleckley HM: The Three Faces of Eve. New York: McGraw-Hill, 1957