Based on one case of dissociative disorder: a conceptual review

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A propósito de un caso de trastorno disociativo: una revisión conceptual

Summary

Based on the description of a clinical case treated by the authors, and diagnosed of dissociative disorder, a review of the diagnosis of dissociative disorder and its polemics is carried out. The authors discuss concepts such as dissociation and hysteria, their historic evolution and their relationships. Some modern cognitive theories on dissociative disorders and their relationship or opposition to psychodynamic theories are presented. The differences between dissociation and repression with these two different approaches are also mentioned. The authors conclude that at the present time important questions must be solved in the area of dissociative disorders in order to progress in the psychiatric knowledge of dissociative processes.

Key words: *Dissociation. Hysteria. Repression. Conversion.*

Resumen

A partir de la descripción de un caso clínico visto por los autores, con diagnóstico de trastorno disociativo, se realiza una revisión del tema de estos trastornos y de las polémicas que lo acompañan. Se presta atención a los conceptos de disociación e histeria, su evolución histórica y sus relaciones. Se mencionan también algunas teorías explicativas actuales desde el modelo cognitivo y su posible relación u oposición con las teorías psicodinámicas, resaltando la diferencia, desde estos distintos enfoques, entre disociación y represión. En las conclusiones se señala que en el campo de los disociativo hay todavía problemas importantes a los que enfrentarse para avanzar en el conocimiento psiquiátrico de este grupo de trastornos.

Palabras clave: *Disociación. Histeria. Represión. Conversión.*

The clinical case presented is that of a 22 year old male patient, single, who has been living with his partner for ten months. He is a vocational education student and works (he works in his father's restaurant). His family brought him to the Emergency Service of the University Hospital of the Canary Islands suffering from a picture having a sudden onset in the last two weeks consisting in speech disorders; he is no longer fluent, his speech is faltering, he fragments words and occasionally he is not capable of pronouncing them. At other times, he is echolalic, or articulates the words or some sentences perfectly. Simultaneously, there are behavior disorders, characterized by puzzled look, aggressiveness and shouts, with episodes of decreased awareness level, hyperextension of the neck and right limbs, hyperventilation, tachycardia, sweating and mydriasis as well as active eye closure.

There is no somatic or psychiatric background of interest. There is no toxic consumption, and no family background of interest. The family supplies information that suggests the presence of obsessive personality traits (hyperresponsible, meticulous, very neat, etc.) and of dependency, describing the patient as very introverted. In addition, the appearance of important stressors stand out in the last weeks on the academic and laboral level and especially in relationship to important difficulties in his partner relationship which, seemingly, is threatening to break up. One week before coming to the hospital, he was seen by the psychiatrist on duty of another hospital center due to, as it is stated, «anxious symptoms» and by a private neurologist who advises a study from the organic point of view. He is admitted to the Neurology Service with diagnostic suspicion of encephalitis.

An extensive battery of tests in search or organic disease, including general and neurological examination, hemogram, biochemistry, proteinogram, immunoglobulins, folic acids, vitamin B12, thyroid hormones, toxic determination, HIV serology, hepatitis and syphilis, blood culture and urine culture, vasculitic profile, CSF, EEG, chest X-ray, cranial CT scan and cranial MRI was performed, all without findings of interest.

The Neurology Service requested assessment from the Psychiatry referral team. In the first psychopathological examination, the patient was observed to be conscious, it not being possible to assess orientation, and his speech was completely incoherent and disintegrated. Inappropriate behaviors and possible sensoperceptive disorders in form of visual and auditory hallucinations. Mixed in-

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somnia in the previous days. During admission, there were pseudoepileptic episodes, with intense anxiety, hyperventilation, psychomotor agitation and disinhibited attitudes, and he had to be physically tied down. Some evolution was observed, and he slowly became calmer and it was possible to establish communication with him, although he showed special speech, with primitive syntactic constructions (verbal forms in infinitive, for example). In the successive examinations, occasional false recognitions were manifested, the patient was not hypothymic and no psychotic symptoms were observed. He also refused to eat occasionally.

The Neurology Service considered that it had reasonably ruled out organic brain disease and sent the patient to the Psychiatry Service. In the first assessment there, the patient was conscious, disoriented in time, it not being possible to evaluate orientation in space. The patient did not collaborate much in the interview, had induced, very poor, and almost monosyllabic speech. There was no impression of relevant depressive mood or anxiety. There was very scarce affective resonance, and he showed very little expressiveness and psychomotor slowdown. Psychopathology of the psychotic sphere was not manifested. There was no impression of confusional syndrome or of perplexity but rather of a certain indifference and of almost being disconnected with the setting.

As the time passed in his stay in Psychiatry, during which no behavior disorders occur, he collaborated progressively more. His speech became more adequate, although it was never spontaneous. He reported partial amnesia in the recent weeks, especially on the behavior disorders causing his admission. He had great difficulty to speak of his environmental problem, especially of his partner relationship. Slowly, some hypothymia and anxiety appeared. There was extreme suspiciousness at some times, that did not seem to have a delusional character, being closer to obsessive doubt.

During the interviews, he placed emphasis on his problems, especially on his affective relationship, where the greatest difficulties seem to exist according to the information provided by his family. The patient attempts to avoid the questions, but progressively feels capable of speaking about it, recognizing the existing problem and showing a congruent hypothymic affect, abandoning his previous coldness. In one interview, he begins by stating, without any affective modulation, that he feels «happy.» After returning to the subject, he begins to cry, transmitting great sadness while saying he is «broken and devastated». Characteristically after the interviews, he returns to his usual coldness and hypomimia after leaving the office.

In the following weeks, he was more and more dysphoric and anxious about being hospitalized, demanding discharge. After a series of permissions that passed satisfactorily, the family reported that he had practically become normal. His speech was coherent, although limited, with mild impairments in articulation. There was still a certain difficulty in concentration. Discharge is given with outpatient follow-up. Approximately two months later, he was seen by a private psychiatrist, observing an «ad integrum» recovery.

During his admission, a personality evaluation was performed, according to the Millon Clinical Multiaxial Inventory II (MCMI-II), observing compulsive (rigid) and dependent personality, with paranoid characteristics and anxious and hysteriform symptoms. The projection of forming his own identity, of diffuse limits, that can lead to experiencing depersonalization, loss of reality and probably dissociation under the action of strong stressors in the characteristics of the interpersonal relationship appears.

Psychopharmacological treatment was based on benzodiazepines (diazepam, until 30 mg, for the first three weeks) that were progressively reduced and antipsychotics (risperidone up to 2 mg, the first two weeks) that were discontinued when he was transferred to the Psychiatry Service. Intermuscular antipsychotic treatment (haloperidol) was used in the episodes of psychomotor agitation. Treatment on discharge was 5 mg/day of diazepam.

The diagnostic judgment, since he had been seen by the referral team, was dissociative disorder. Differential diagnosis of psychotic disorder was proposed, but the thorough psychopathologic examination and later evolution make us tend to diagnose, according to the ICD-10 criteria, a mixed dissociative (conversion) disorder (F44.7).

Commenting on the concept of dissociation, and according to Baños, Belloch and Ruipérez[1], the first thing that must be stressed when we speak about dissociative disorders is their nosological characteristic. This characteristic is already present in the name itself of the disorder, that implies a specific mechanism which would explain the disorders observed (dissociation). As Kihlstrom[2,3] points out, it would be necessary to begin by explaining what the concept of dissociation includes. A possible definition, according to Spiegel[4] would be «the structured separation of the mental processes (for example, thoughts, emotions, conatoin, memory and identity) that are normally integrated». The older background of this concept would be found in the religious practices associated with the curing of souls, mesmerism, animal magnetism and hypnosis, but its origin would be found, according to Ellenberger[5] in the so-called first dynamic psychiatry, medical movement found between 1775 and 1900.

Pierre Janet[6,7] identified the elemental structures of the mental system as «psychological automatisms». For this classic author, each automatism represented a complex act, that was preceded by an idea, and was accompanied by an emotion and adjusted to external (environmental) or internal (intrapsychic) circumstances. That is, each automatism joined cognition, emotion and motivation with action. In this way, these automatisms would be similar to that which present day authors such as Anderson[8] have called «production systems» or «productions» These are cognition-action units that are carried out as a response to appropriate contextual signs. According to Janet, in the explanation given by Baños, Belloch and Ruipérez[1],

the complete list of elemental psychological automatisms of a normal person is united in a single and unified flow of consciousness, accessible to the phenomenic introspective consciousness and voluntary control. Under certain circumstances, one or more automatisms could divide the rest, functioning outside of awareness and independently of voluntary control. Janet[6,7] called this *désagrégation*, that is translated into English as *dissociation*, thus establishing the Spanish word. This concept is different from repression, maintained by Freud[9] and his followers, Janet considering that repression was one more of the possible mechanisms of dissociation. Later on, this distinction would return.

The functioning of these dissociated psychological automatisms provide the mechanism for the hysteric symptoms: it produces ideas, images and behaviors that interfere in the flow of conscious thinking and action, and its capacity to «process information» is responsible, for example, for the paradoxical capacity of the hysterical blind or deaf to manage well in their environment. The Janet postulates[6,7] are very extensive and suffer from methodological problems, but their scarce diffusion is also due to the great predominance and influence of the Freudian approaches, the so-called second dynamic psychiatry, that emphasizes sex, aggression, dreams and repression.

In a recent study, Leal Cercós[10] defines dissociation, according to Putnam[11] as a process that produces an alteration in thoughts, feelings or actions of an individual, so that, certain information is not associated or integrated with other information during a period of time, causing a series of clinical and behavioral phenomena with memory and identity disorders. As Vallejo[12] states, these disorders, which affect the integrating function of identity, memory or consciousness, generally have a sudden appearance and brief duration (days, weeks).

Gastó[13] has analyzed the psychopathological characteristics of dissociation, describing them as: low or fluctuating level of attention, disorientation, puzzlement, perceptive disorders (auditory, visual), passive and automatic behaviors, emotional explosions, complete amnesia of the episodes, absence of confusional states and perservation of the sensorial reactivity. The duration of the symptoms is variable and can be induced by suggestions or environmental changes.

According to Leal Cercós[10], dissociative experiences appear with greater frequency in childhood-youth ages. They are more frequent in women and have a relationship with child traumatic situations, above all sexual abuses. In addition, it often occurs that the dissociative disorders in general are preceded immediately by traumatic psychologic stressors. Dissociation, as conversion, produces a primary benefit as protection against the trauma and escape from a painful reality, and is adaptative. Its continued use (by repeated traumas, for example) can cause a generalization of the dissociative mechanisms to different stressors, and the appearance of dissociative disorder itself, which can include, on the other hand, different secondary benefits.

An important aspect is that the dissociation is considered, from the very beginning, as one of the mechanisms of hysteria and thus both concepts are inseparable over history, the dissociative disorders recorded in the present classifications being a part of that which was classically considered as hysteria.

The term hysteria does not exist in the present diagnostic classifications, DSM-IV[14] and ICD-10[15], however it persists, in a significant way, in the daily language of the psychiatrist (not to mention in the general population). As Leal Cercós[10] states, the term is etymologically inadequate and is full of negative connotations, many times being identified with factitious disorders or simple simulation. Slater[16] observed how this diagnosis changed with time in almost all the cases in the follow-up of a group of patients diagnosed of hysteria. Studies of this type led to the official death of the term, distributing the patients by disorders located in different epigraphs of the classifications used and whose validity is also doubtful. As Halligan and David[17] remember, the controversy is largely due to the fact a fully accepted explanation for the psychological mechanisms of dissociation and conversion does not exist yet.

As Baños[1] points out, one of the most successful attempts to explain the dissociation mechanism, subjacent to all these disorders, was carried out by Hilgard[18-21]. This author proposed a «neodissociative» theory, based on the consideration that the «mental apparatus» is made up of a combination of cognitive structures (that would be similar to the Janet automatisms) that supervise, organize and control thought and action (they would be faculties, as perception and memory, or modalities as vision, audition, etc.). Each structure looks for or avoids *inputs* and facilities or inhibits *outputs*, being located in a hierarchical organization and being intercommunicated. The upper part of the hierarchy would be occupied by the cognitive structure in charge of the executive functions of supervision and control, this structure being the one that provides phenomenic awareness and intentionality. Under certain circumstances, the executive control can interrupt integration and hierarchical organization of the lower levels, so that structures appear that continue to perform their functions independently from one another or independently of the executive control. In one word, dissociated.

As Kihlstrom[2,3] points out, in spite of its similarities, there are certain differences between dissociated mind proposed by theories of this type and Freudian unconsciousness. The defenders of these first theories[18-21]state that unconscious mental contents are not limited to primitive impulses or to aggressive or sexual ideas and that unconscious mental processes are not qualitatively different from the conscious ones, also maintaining that this restriction of the consciousness is not necessarily caused by defense purposes in the face of conflict or anxiety. On the contrary, the psychodynamic orientation[9] states that dissociation characteristically appears as defense, as possible escape, against any conflict, conscious or not.

In any case, it is clear that the concepts of dissociation and repression are not synonymous and refer to different

ideas; repression acts on unacceptable fantasies or ideas, located in an inaccessible unconsciousness, while dissociation, as has been described by Hilgard[18-21] refers to the disconnection between different ideas or emotions and is only partially or alternatively outside of consciousness. In any event, the comparison between these concepts is epistemologically tricky, since they come from different paradigms: Freudian repression belongs to the psychoanalytic paradigm and dissociation, as proposed by this theory, is a concept of cognitive paradigm.

As a conclusion, it should be stated that there is still little information and many doubts in the field of dissociative disorders and of hysteria in general and there are with important problems that must be faced. In the first place, a clear conceptual problem exists, because we define dissociation as lack of integration between different mental processes, and we are far from having a clear and universally accepted definition for many of them (for example, awareness itself). And in the second place, the nosologic problem: hysteria fluctuates between non-existence in the classification manuals and the overflowing that it often produces in the daily clinical situation, between attempts to eliminate it in the theory and the temptation of overdiagnosing it in practice. It is not spoken about nowadays, speaking instead of dissociative or conversive or somatomorph disorders, however, the impression sometimes exists that, no matter how hard we try to eliminate it or fragment it, hysteria insists on existing.

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