Dissociative Spectrum Disorders in the Primary Care Setting

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Dissociative disorders have a lifetime prevalence of about 10%. Dissociative symptoms may occur in acute stress disorder, posttraumatic stress disorder, somatization disorder, substance abuse, trance and possession trance, Ganser's syndrome, and dissociative identity disorder, as well as in mood disorders, psychoses, and personality disorders. Dissociative symptoms and disorders are observed frequently among patients attending our rural South Carolina community mental health center. Given the prevalence of mental illness in primary care settings and the diagnostic difficulties encountered with dissociative disorders, such illness may be undiagnosed or misdiagnosed in primary care settings.

We developed an intervention model that may be applicable to primary care settings or helpful to primary care physicians. Key points of the intervention are identification of dissociative symptoms, patient and family education, review of the origin of the symptoms as a method of coping with trauma, and supportive reinforcement of cognitive and relaxation skills during follow-up visits. ***S***ymptom recognition, ***E***ducation of the family, ***L***earning new skills, and ***F***ollow-up may be remembered by the mnemonic device SELF. We present several cases to illustrate dissociative symptoms and our intervention. Physicians and other professionals using the 4 steps and behavioral approaches will be able to better recognize and triage patients with dissociative symptoms. Behaviors previously thought to be secondary to psychosis or personality disorders may be seen in a new frame of reference, strengthening the therapeutic alliance while reducing distress and acting-out behaviors.

(Primary Care Companion J Clin Psychiatry 2000;2:37–41)

Received Nov. 18, 1999; accepted March 14, 2000. From the Coastal Empire Community Mental Health Center, Beaufort, S.C.

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North American interest in dissociative disorders has surged from the early 1980s to the present. Recent studies in North America found that these disorders have a lifetime prevalence of about 10%; dissociative identity disorder (DID; formerly multiple personality disorder) constitutes only about 1% of that figure.[1] It is estimated that 6% to 10% of the general population experience episodes of dissociation not secondary to abuse.[2] The surprisingly high prevalence of dissociative disorders prompts this review.

Coastal Empire Community Mental Health Center (CECMHC), in Beaufort, S.C., serves a 50% white and 50% African American population in a poor, predominately rural part of South Carolina. Many of our center's clients reside on North Carolina's Outer Banks islands and maintain voodoo-derived beliefs in spirits, sorcery, hags (a threatening image that may "ride" an individual), rooting (placing a spell on an individual), and the use of amulets and charms to ward off evil. Voodoo possession, a culturally sanctioned phenomenon occurring in normal individuals, involves trance-like behavior with an alteration of perception, memory, and identity.[3] Goodman[4] holds that glossolalia (speaking in tongues) among religious groups in the region is an artifact of a culturally approved dissociative trance state. Issues of "honor" and a tendency to quickly resort to violence to resolve conflict result in homicide rates among the highest in the United States. The juxtaposition of strong moral-religious and violent, good-versus-evil themes may foster intense conflicting emotions. These issues, combined with high poverty rates and associated early emotional, physical, or sexual abuse or neglect, are associated with the development of dissociative defense mechanisms that may persist throughout individuals' lives.

The frequent occurrence of bizarre symptoms and dangerous acting-out behavior among our patients prompted the development of our approach. Severe acting-out, overt psychosis, or situations involving a danger to self or others may require hospitalization. However, we are often able to manage patients in their natural setting using the SELF (***S***ymptom recognition, ***E***ducation of the family, ***L***earning new skills, and ***F***ollow-up) approach, initiated in the first contact with the patient and/or family.

SYMPTOM RECOGNITION

DSM-IV dissociative disorders are described in Table 1. The DSM-IV[5] notes that dissociative disorder not otherwise specified (NOS) includes disruption of consciousness, memory, identity, or perception of the environment but does not meet the criteria for any specific dissociative disorder. The affected individual does not have 2 or more distinct personality states or significant amnesia. Dissociative amnesia is an inability to recall important personal information, usually of traumatic nature, that is too exten-

Table 1. General Description of DSM-IV Dissociative Disorders[a]

Disorder	Area of Disruption	Description
Dissociative amnesia	Memory	Inability to recall important personal information, usually of a traumatic or stressful nature, too extensive to be explained by ordinary forgetfulness
Dissociative fugue	Memory, identity	Sudden, unexpected travel away from home or one's customary place of work, accompanied by inability to recall one's past and confusion about personal identity or the assumption of a new identity
Dissociative	Identity, memory	Presence of 2 or more distinct identities or personality states that recurrently take control of the identity disorder individual's behavior accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness
Depersonalization disorder	Perception, consciousness	Persistent or recurrent feeling of being detached from one's mental processes or body that is accompanied by intact reality testing

[a]Adapted from DSM-IV.[5]

sive to be explained by normal forgetfulness. Amnesia may be localized (surrounding an event), selective (partial), generalized (involving one's entire life), continuous (having a fixed beginning with continuation to the present), or systematized (involving only certain categories of information). The latter 3 types are less common.

Dissociative symptoms occur in acute stress disorder, posttraumatic stress disorder (PTSD), and somatization disorder as well as in alcohol and substance abuse. These dissociative symptoms are usually not manifest within distinct and developed personalities. They may take the form of ego-disruptive behavioral states.[6] Dissociative disturbances are by definition not due to a substance or a medical condition such as complex partial seizures. They are said to also occur in the face of perceived danger and may begin as early as 6 months of age.[7]

These dissociative disorders encompass dissociation in persons subjected to intense, coercive persuasion. Trance (a state of detachment from one's physical surroundings as in contemplation or daydreaming) and possession trance (replacement of the customary sense of personal identity by a new identity, attributed to the influence of a spirit, power, deity, or other person and associated with stereotyped "involuntary" movements or amnesia) are dissociative phenomena.[1] Loss of consciousness not due to a general medical condition as well as Ganser's syndrome (amnesia and hallucinations of hysterical origin marked by senseless answers to questions and absurd acts) commonly associated with dissociative amnesia or fugue are also included in this diagnostic category.

DID is characterized by the fragmentation of an individual's identity into 2 or more distinct personalities, which recurrently take control of the person's behavior, as well as inability to recall important personal information more extensive than ordinary forgetfulness.[5] Differential diagnosis in adults includes comorbid disorders, such as somatization disorder, PTSD, seizures, and amnesia. Pseudoseizures and conversion phenomena are both reported to share similar psychological processes with dissociative disorders.[8,9] Schizophrenia, schizoaffective disorder, and bipolar and unipolar mood disorders must also be ruled out. In fact, dissociative symptoms, dissociative disorder NOS, and DID may all occur in the presence of these diagnoses. Substance abuse populations are reported to have high levels of dissociative experiences, and substance abuse is reported to be high among DID patients.[10,11]

Ellason et al.,[12] Giese et al.,[13] and Ganaway[14] all report on the high levels of comorbidity of dissociative disorder NOS and DID with borderline and other personality disorders. Atlas and Wolfson[15] found that borderline adolescents evidenced significant dissociation and depression. These reports suggest that the clinician should be wary of diagnosing discrete dissociative syndromes in the presence of other psychiatric diagnoses.

Dissociative auditory hallucinations, unlike schizophrenic hallucinations, are most often described as "voices in one's head" (rather than outside the individual) talking, arguing, directing, or commenting on one's actions and do not have the "disintegrated quality" and disorganization of schizophrenic hallucinations.[16] In one study,[17] about half of the patients with DID had been diagnosed and treated for schizophrenia. A review of our clinic records confirmed past diagnoses and treatment for both schizoaffective and bipolar disorders among our dissociative patients.

EDUCATION OF PATIENT AND FAMILY

When dissociative features are noted, the patient and family are educated about the symptoms. In our center, these symptoms most commonly involve a dazed or daydreaming state (of which the client is aware or that is observed by others) or a loss of time (the patient may drive or go to a destination without recalling it or knowing why the trip was made) along with other criteria up to and including frank DID features.

Ganaway observed that DID patients "are continually moving in and out of hypnotic trance states."[14(p208)] He found in a group of 82 individuals that virtually all met special criteria for Spiegel and colleagues' Grade Five Syndrome (highly hypnotizable).[18] The high incidence of trance states ascertained by either history or their emergence in treatment sessions has prompted us to educate

our patients about them in our earliest contacts. Bliss[19] and Butler et al.[20] note that the ability to self-induce a trance state is central to development of dissociative symptoms and DID. This is compatible with our clinical experience and supports our cognitive approach with these patients.

Our patients also experience dissociative symptoms in the perceptual area. These include conversion reactions, flashbacks, self-mutilation, depersonalization (feeling outside the self), derealization (setting or people seem unreal), lack of behavioral control such as lashing out at someone without warning, the dissociation of affect (as in acute stress disorder, binge eating, identity confusion or alteration, finding unrecognized possessions, and age regression), and other dissociative symptoms described in the literature.[21]

The origin of the symptoms as a method of coping with past trauma (sexual, physical, or neglect), overwhelming affect, or present boredom, loneliness, interpersonal conflict, or anxiety in a patient's life is explained to the individual and his or her family. We point out that the trance state or other symptoms may be innate or learned and that the patient can, over time, develop more control over these experiences.

Dissociative symptoms may occur in normal individuals in stressful circumstances; these spontaneously improve, but patients may benefit from short-term treatment with an anxiolytic medication. In patients with psychiatric disorders, medication approaches should address the primary disorder. Concurrent diagnoses such as anxiety disorder, depressive disorder, bipolar affective disorder, schizophrenia, or schizoaffective disorder should be managed with anxiolytics, antidepressants, mood stabilizers, or neuroleptics as indicated. For example, our patient in case 1 (see below) was essentially psychotic and self-destructive when interviewed, but benefited remarkably from adequate doses of a neuroleptic medication. Brief psychotherapies for crisis intervention in addition to supportive treatment and medications greatly reduce the anxiety that drives the dissociative symptoms.[22]

Dissociative symptoms occur frequently in patients with borderline personality disorder who may be depressed or anxious or experience brief psychotic symptoms, which warrant appropriate medications. Education of the patient and family about the nature of the symptoms and the role of medication will dispel the mystery and sense of helplessness they experience.

LEARNING NEW SKILLS

We educate our patients that they are not "crazy" and can learn to identify the precipitants of trance state or other dissociative phenomena and develop more adaptive coping skills. This involves teaching patients to make a conscious effort to remain in touch with reality and develop new coping skills such as assertion (countering a learned submissive response and expressing his or her own wishes instead), relaxation (a positive use of the autohypnotic trance), and rationalization to deal with stressful situations.

Basic relaxation responses to anxiety include deep inhalation to a count of 4 for 4 breaths. Other self-relaxation approaches include repeating an important word while breathing slowly in and out as well as visualizing a peaceful scene while breathing deeply and quietly.

Ross[22] holds that the primary task of the DID patient during childhood is survival through maintaining emotional attachment to an ambivalently held parent-perpetrator by intrapsychic splitting. This is consistent with the development of alternate personalities. The persistence of the attachment need in the adult is seen in the battered spouse who maintains her dependence on the perpetrator at any cost. In treatment, transference and acting out is understood in analytic terms, but cognitive approaches are primary tools. Ross uses the victim-perpetrator-rescuer model and emphasizes that the children identify with the aggressor and, by shifting the bad object inside themselves, feel they potentially have control of the abuse.

Well-defined psychodynamic, cognitive, and hypnotic therapy models for treatment of DID have been developed and described in the literature.[21,23,24] These approaches comprise integrative techniques, generally involving lengthy dynamic and insight-oriented therapies. Our model differs in offering a structured, brief, crisis-oriented management for the dissociative individual and his or her family.

Clinicians will be aware that these patients often have basic personality issues and conflicts as well as problems with attachment and dependency. However, acute therapy should focus on current stressors, avoiding expression of undue interest in any dramatic symptom presentation. This focus diminishes transference-based elaboration of alternate identities or other dissociative phenomena.

FOLLOW-UP CONTACT

Our follow-up contact consists of brief sessions to determine that symptoms are in remission and to monitor medication effects. We review assertion and relaxation approaches to deal with problems and stress. Recognition and support for progress in dealing with problems is important in these sessions to build confidence. These sessions may be continued at intervals for several months or interrupted with the assurance that the patient may return if necessary.

The physician provides consultation to the patient's social worker, nurse, or other medical professional working with the patient and family as well as ongoing medication management as necessary. Periodic crises with symptom exacerbation are not uncommon; the patient is often strug-

gling with a maladaptive coping style developed over a lifetime. This pattern is recognized in other disorders such as diabetes and congestive heart failure. Undue pessimism is not warranted.

CASE REPORTS

Three cases illustrate our results using the SELF model to engage our patients and modify their behavior over time.

Case 1

A 43-year-old married white woman was treated at CECMHC for DSM-IV major depression and personality disorder NOS, with dependent, borderline, and dissociative features. She had had 4 state hospital admissions in the first year of her treatment in CECMHC because of depressed mood, diminished interest in activities, poor energy, feelings of worthlessness, suicidal ideation, and auditory hallucinations. During a dissociative episode, she slapped her alcoholic husband with no recall of the event. He was actively drinking and had life-threatening liver disease. This along with fear of losing the husband by death and ensuing isolation and financial problems were precipitating factors in the patient's symptomatology.

After 4 years of treatment in our clinic with multiple neuroleptics, minor tranquilizers, antidepressant medications, and supportive management that included participation in an incest group, the patient was noted to have scratches on her extremities that she indicated occurred in a trance state during which she wandered through the woods. She experienced trance states while bowling or during road monotony when driving. Other dissociative phenomena included memory loss for childhood events in general, current time loss, derealization, depersonalization, and periodic behavioral lack of control.

We suggested that she could assume more control of her dissociative symptoms, which began during early sexual abuse by a grandfather, and we described her trances as self-induced hypnotic states that originally protected her from overwhelming trauma. She said our view was reassuring to her, relieving anxiety about the "crazy" nature of the experience, which she recognized was the same state she entered during periods of somnambulism.

We explained to her that several therapies could help her diminish the power of the dissociative responses. She declined participation in group therapy, choosing brief supportive sessions incorporating assertion and relaxation techniques with her case manager and medication (alprazolam, 0.25 mg every 8 hours) monitoring at quarterly intervals. The dissociative symptoms did not resurface during the 3 years since our original discussion.

Case 2

Dissociative symptoms may emerge in the context of active interpersonal or situational difficulties. A demure 42-year-old recently separated black woman with a DSM-IV diagnosis of schizoaffective disorder, bipolar type (symptoms included hypomanic periods, hallucinations, depression, low energy, death wishes, and recent suicide attempt) was taking risperidone, 3 mg twice daily; sertraline, 50 mg daily; and clonazepam, 1 mg twice daily, and presented with a barking, guttural utterance (staccato in nature), yelling obscenities and intimidating remarks ("There's a male demon inside me!").

Between these outbursts, she spoke in a well-modulated voice, expressing concern about her bizarre behavior. We advised that she had charge of the altered state in which the symptoms occurred (a possession trance), and it was suggested that the symptoms would subside. Her altered state was likened to those induced in television performances, under which the hypnotized subjects may engage in behaviors totally unlike their usual demeanors.

Although outbursts occurred initially every few seconds, they abated during our supportive and educational interview, indicating to the patient and her sister (present in the session) how readily the symptoms were modified. Two days later, the patient reported by phone that the symptoms were much improved.

She denied sexual/physical abuse and did not present pervasive, persistent, alternate personalities or other dissociative symptoms subsequent to her possession trance. She resisted group therapy, but continued on treatment with her original medication and in periodic supportive treatment with her case manager with no recurrence of her possession trance. She moved from the area 4 months later. The DSM-IV diagnosis of personality disorder NOS with dependent, avoidant, and dissociative features was added.

If her symptoms had only been secondary to her schizoaffective disorder, the risperidone should have prevented them. A major psychosis should not have remitted so strikingly in one session with supportive and educational approaches.

Case 3

A 33-year-old single black woman who had depressed mood was referred by her probation officer after a charge of shoplifting. The patient stated, "an alternate personality tells me I'm ugly and to hurt myself, drink, take drugs, and steal things." A sutured 6-inch wound on her left shoulder was inflicted at the alternate personality's command. She made the host personality (who presents for treatment over 50% of the time, nearly always bears the legal name, and has certain depressed/anxious features and suffers both psychophysiologic symptoms and time loss or time distortion),[25] break a glass in her hand and told her to burn her apartment. The patient saw "a shadow, ghosts, or a man in a tree at night."

The patient denied physical or sexual abuse as a child, although she endorsed many dissociative symptoms, in-

cluding trance states, time loss, depersonalization, the familiar seeming strange, and finding clothes she did not recall purchasing. The patient did not endorse racing thoughts, great confidence or energy, pressure of speech, decreased need for sleep, excessive spending, or irritability, which might suggest a cycling or mixed bipolar state. There was a history of periodic cocaine abuse. A pattern of neglect and isolation in her childhood persisted to the present, and she lived alone in poverty, isolated from her family, enduring her frightening symptoms and the acting out associated with the presence of her alternate personalities.

Because the patient initially had no therapeutic alliance with her psychiatrist and case manager, and because the patient's powerful, sadistic alternate personality could instruct the patient to mutilate herself, we did not initially suggest that the host personality could control the alternate personality or resist her commands. She was advised that she was not "crazy" and could feel better over time. She declined psychoeducational group therapy, but accepted haloperidol, 75 mg intramuscularly every 2 weeks, for her extreme personality fragmentation and mirtazapine, 30 mg daily, for her depression along with supportive management and noted "the medicine makes me [the host personality] strong," although her alternate personality was still present.

Three years later, while she was taking olanzapine, 10 mg daily (because of the onset of tardive dyskinesia on haloperidol), and mirtazapine, 30 mg daily, her dissociative symptoms and depression were in complete remission. She met DSM-IV criteria for personality disorder NOS, with dissociative, borderline, and dependent features.

SUMMARY AND CONCLUSION

Cases similar to those described may be seen in the primary care office or the emergency room. These patients may elect collaborative management in primary care where primary care physicians have good relationships with psychiatrists. Those who have less severe symptoms or presentations related to acute stress or loss may only need the supportive care and patient education that informed primary care clinicians could provide. Spiegel and colleagues[18] note that better outcomes may be expected in individuals with higher levels of ego integration, greater psychological mindedness, and better ability to restrain acting-out impulses.

The 3 patients presented above had limited ego strength and insight and were impulsive, but all remained in supportive and medication therapy over months to years, voicing benefit from their treatment. Patients with dissociative symptoms may be seen by physicians in any specialty; addressing their symptoms using the SELF model reassures the patient and family, enhances trust, and may reduce treatment resistance and acting out.

Drug names: alprazolam (Xanax and others), clonazepam (Klonopin and others), haloperidol (Haldol and others), mirtazapine (Remeron), olanzapine (Zyprexa), risperidone (Risperdal), sertraline (Zoloft).

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