Psychopathology Assignment on Dissociative Disorders

Dissociative identity disorder & Depersonalization-derealization disorder

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Collégial international Sainte-Anne

350-102-RE: General Psychology

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April 1st, 2022

Introduction

In every-day ordinary life, especially in the repetitive and routine-heavy society we live in, it is not uncommon to dissociate or "zone out" when we perform the same mind-numbing banal tasks day after day. These periods of dissociation are only ever short-lived, as we seemingly always "snap back to reality". However, this begs the question: what if these periods of banal dissociation were not short-lived, nor banal? What if these dissociations became disruptive in daily life? An individual experiencing such would be clinically diagnosed with a dissociative disorder. According to the American Psychiatric Association (2013), dissociative disorders are characterized by "a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior." This paper will be presenting an in-depth description of Dissociative identity disorder (DID) and Depersonalization-derealization disorder (DDD).

A. History and origin

Who discovered the disorder?

The first modern descriptions of DID and its symptoms were published by Petetain in 1787, whereas the first true attempt at delineating a specific disorder that encapsulates these phenomena was made by Eberhardt Gmelin in 1791 under the label of *umgetauschte persönlichkeit* or exchanged personality (Kluft, 1996). The concept of "depersonalization" appeared in the late 19th century, where it was first used in a technical sense by Ludovic Dugas (Sierra & Berrios, 1997).

When was it added to the DSM?

Although the disorder had been in the DSM prior to 1994, that is when it was officially named Dissociative Identity Disorder, replacing the former "Multiple Personalities Disorder'' (American

Psychiatry Association, 2013).

Prevalence: statistics in Canada, are women or men more affected?

Although the actual percentages vary from sources, the BC Division of the Canadian Mental Health Association suggests that an accurate estimation would be 0.4% of the population, whilst other sources state a prevalence of around 1% of the adult population (Ross, 1991; Dorahy et al., 2014). As the empirical literature on DID accumulates, the rate of frequency becomes more and more questioned. Women are also more likely to be diagnosed with DID because it is caused by extreme childhood trauma such as repeated sexual abuse, which women are unfortunately more prone to. Regarding DDD, lifetime prevalence in the United States and akin countries (including Canada) sits at approximately 2%, widely ranging from 0.8% to 2.8%; there does not seem to be a difference in prevalence between women and men (American Psychiatric Association, 2013).

To which of the DSM-V axes does it belong?

Personality disorders belong to the second axis in the DSM-V, so both DID and Derealization/Depersonalization Disorders belong in Axis II (American Psychiatry Association, 2013).

B. Causes and risk factors

Biological factors

Dissociative identity disorder is linked to a small hippocampus and amygdala; in one MRI study, a patient with DID was reported to have a smaller hippocampus and amygdala respectively smaller by 19.2% and 31.6% than those of a healthy patient (Vermetten et al., 2006). However, it is highly likely that this difference in volumes may also be heavily attributable to comorbid PTSD. The hippocampus plays a major role in learning and memory, whereas the amygdala forms the core of

a neural system for processing fearful and threatening stimuli, which includes the activation of fear-related behaviors in response to said fearful and threatening stimuli. The literature does not support any evidence of DID or DDD being necessarily inheritable.

Psychological factors

Since DID is a chronic post-traumatic disorder caused by developmentally stressful events in childhood, people who have experienced this trauma are more likely to feel more alienation and isolation, which would infringe them from truly understanding themselves, which would in turn exacerbate depersonalization and derealization (Şar et al., 2017). Furthermore, cognitive processes such as memory and the construction of self-identity are heavily disrupted by DID; if identity is partly formed through the perceived ownership of past memories, but they are compartmentalized and isolated, then this breakdown between memory and sense of self is a significant cause of DID (Şar et al., 2017). This all applies to DDD as well; an earlier age of abuse, an increased duration of abuse and parental abuse itself correlate with a higher severity of dissociative symptoms (Vonderlin et al., 2018).

Social/environmental factors

Dissociative identity disorder especially develops when a child is exposed to a chaotic lifestyle marked by coercion and overt severe physical and/or sexual abuse or to a family with a neglectful and disorganized attachment style and misattuned communication styles (Şar et al., 2017). Childhood trauma is also highly predictive of DDD, where the emotional abuse exhibited by either or both parental figures onto the person is a leading cause (Simeon et al., 2001). Living in a highly individualistic society is also factor correlated with a higher vulnerability to depersonalization; individualistic cultures are characterized by hypersensitivity to threat and by an external locus of control and frequency of depersonalization during panic is much lower in nonwestern countries

(Sierra-Siegert & David, 2007).

C. Diagnostic and treatments

Specific criteria needed to diagnose an individual with a disorder, based on the DSM-V

First off, the doctor evaluating the patient will perform tests to rule out any biological factors or physical conditions that may be the cause for the segmented amnesia, factors such as head injuries, brain leisures, or intoxication. If the physical causes are ruled out, a mental health specialist will be consulted for closer examination. Many features of DID can be influenced by cultural backgrounds, so one must make sure that the dissociation is not voluntary, as can be seen in certain meditative practices. The disorder will then be diagnosed accordingly to the known symptoms of DID and to a given person's background.

The official diagnostic criteria for Dissociative identity disorder are (American Psychiatry Association, 2013):

A. Disruption of identity with two or more distinct personalities. This disruption is defined by a marked discontinuity in sense of self and sense of agency and alterations in: affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. The disruption may either be observed by the individual or others and can be described as an experience of possession in differing cultures.
B. Frequently being unable to recall everyday events, important personal information and/or traumatic events that are inconsistent with ordinary forgetting.
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The disturbance is not a normal part of a broadly accepted cultural or religious practice.
E. The symptoms are not attributable to the physiological effects of a substance or any other

medical condition.

As for Depersonalization/derealization disorder, the diagnostic criteria are (American Psychiatry Association, 2013):

A. Presence of recurrent experiences of either depersonalization, derealization, or both.
B. During depersonalization/derealization, reality testing remains intact. The patient is still capable of knowing when and where they are in reality without confusing it with fantasy.
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The symptoms are not attributable to the physiological effects of a substance or any other medical condition.
E. The disturbance is not better explained by another mental disorder, such as schizophrenia, panic disorder, major depressive disorder, acute stress disorder, PTSD, or another dissociative disorder.

Symptoms expressed by the disorder and the available treatments

Dissociative identity disorder comprises episodes of amnesia and differing forms of identities. As previously stated, the amnesia must be unusual and episodical for it to be linked to DID; there will be gaps in the memory of past personal events, lapses in memory of current everyday events and well-learned skills and, eventually, the person with DID will discover evidence of actions they have done but have no memory of doing (Spiegel, 2021). Furthermore, the different identities that a person with DID will assume will either be in the possession form or in the nonpossession form. The former is when the different identities are overtly apparent to outside observers as if another person has taken over (e.g. the person's behavior drastically changes) and the latter is when the different identities are more stealthy to outside observers while the person feels detached from certain aspects of themselves (e.g. opinions changing in an erratic and uncontrollable manner while feeling like said opinions do not belong to the person).

Depersonalization consists of the experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions. Perceptual alterations, a distorted sense of time and emotional/physical numbing fall under this category. Derealization consists of the experiences of unreality or detachment with respect to surroundings. Experiencing objects or individuals as seeming unreal or dreamlike falls under this category (American Psychiatry Association, 2013)

For both of these disorders, psychotherapy is the main and most effective treatment. DID may never disappear, whereas DDD can disappear without any treatment in place (Spiegel, 2021). Regarding coexisting symptoms of anxiety and/or depression, drug therapy may be invoked to relieve them.

Comorbidity rates

The comorbidity rates for both DID and DDD are significant. It is not uncommon to see the following disorders and diseases concomitantly with them both: Post Traumatic Stress Disorder, Major Depressive Disorder, Bipolar Disorders (particularly Bipolar II), Psychotic Disorders (including schizophrenia), Personality Disorders (especially B.P.D.), Substance/Medication-induced Disorders (addictions), Conversion Disorders (Functional Neurological Symptom Disorders), Seizure Disorders (especially Complex Partial Seizures), Factitious and Malingering Disorders.

Most effective treatment plan in treating & managing

Dissociative disorder experts recommend a structured, stage-oriented and carefully staged treatment consisting of three phases: (1) skill building in development and maintenance of safety from dangerousness to self or others and other high-risk behaviors, (2) trauma-based cognitive

therapy, (3) unification of self states (Brand et al., 2012).

Effectiveness of treatments

Over time, patients showed significant reductions in dissociation, PTSD, distress, depressive symptoms, hospitalizations, suicide attempts, self-harm, and so on (Brand et al., 2013). Out of 16 dissociative disorder treatment studies and four case studies that used standardized measures, around 16.7% to 33% of DID patients had fully integrated their dissociated self states (Brand et al., 2009). It is worth noting that integrating one's dissociated self states is an arduous and painstaking task that requires a lot of mental labor and acceptance.

C. Presentation of Case Studies

Dissociative identity disorder

A 55-year-old Caucasian woman with a comorbid bipolar disorder and a history of substance use exhibits seven different personalities (Rehan et al., 2018). These seven personalities include, but are not limited to: a moody seven-year-old child, a teenager with violent outbursts, and a male person marked by a change in voice and behavior (dressing, language, perception of male body parts, choices of friends, and attraction towards females). She was brought to knowledge about this fragmentation of personalities by people around her informing her. She felt most comfortable in her default personality or (host alter): the 55-year-old female. Whenever she did transition towards another personality, this was done at any time in an involuntary and anxiety-inducing manner; stressful situations and situations of substance abuse (marijuana or cocaine) were more likely to trigger another personality.

Judging from the subject's different expressions of personality and her current problems with substance abuse and her comorbid bipolar disorder, it is highly likely that she experienced severe

physical and sexual abuse during her childhood and teenage life; her mental regression to the state of an angsty child or to that of a rebellious teenager may plausibly signify a coping mechanism that she may have developed over the years in conjunction with her social environment.

Psychotherapy with cognitive behavioral therapy addressing stress and substance use disorder was included in the treatment, alongside dual treatment of drug therapy with the goal of calming her down and easing her stress. After six months of treatment, her condition was not very different, but the escitalopram that she was prescribed seemed to have helped with her anxiety. It is impossible to know the patient's current state. Nevertheless, she was further followed up for the next year after the study was conducted and the treatment was ongoing by 2018.

Depersonalization-derealization disorder

A 42-years-old housewife from India, coming from a rural background with little formal education complained about her stomach always feeling empty in spite of adequate food and water intake for the past 7 months (Kethawath et al., 2021). Eventually, she would not even be able to experience the sensation of walking as she was performing the action itself; these experiences would range in span from a few minutes all the way to a few hours. After some time, this apathy and numbness even spread to her emotions and sexual libido – she would act appropriately in the context of a given situation, but she would feel nothing, as if none of it was real. The lack of sensation had taken such a toll on the woman that she had asked her family to kill her, as she argued that death was better than living in such a state.

The causes that triggered this specific case are unknown. Nonetheless, the causes of Depersonalization-derealization disorder include: being emotionally abused or neglected during childhood, being physically abused, witnessing domestic violence, having had a severely impaired

or mentally ill parent, having had a loved one die unexpectedly or severe stress (Spiegel, 2021). A probable cause to the woman's triggering of symptoms could be attributed to a past traumatic experience regarding violence towards her or towards a loved one. While never stated nor implied, we could make the hypothesis of the subject being the victim of domestic violence; India is known for being a heavily patriarchal society.

As for her treatment, she was given escitalopram for her depressive symptoms and benzodiazepines for her occasional sleep disturbances. After 2 weeks, her symptoms had considerably improved after 6 months of being discharged from the health clinic, her improved state seemed to be sustained.

Conclusion

In closing, while experiencing dissociative episodes is a quite common occurrence in everyday life, living with a dissociative disorder is not. The implications regarding why one might be diagnosed for DID or DDD are certainly unsettling, as the human brain has particular defense mechanisms when its host is confronted with traumatic experiences; this especially includes the omission of past traumatic memories. Thus, in conjunction with other comorbid disorders and underlying conditions, it is logical to assume that dissociative disorders are an expanded version of the brain coping in an unfortunately corrupted way.

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