Somatoform and Dissociative Disorders

Brian was spending Saturday sailing with his wife, Helen. The water was rough but well within what they considered safe limits. They were having a wonderful time and really didn’t notice that the sky was getting darker, the wind blowing harder, and the sailboat becoming more difficult to control. After a few hours of sailing, they found themselves far from shore in the middle of a powerful and dangerous storm.

The storm intensified very quickly. Brian had trouble controlling the sailboat amidst the high winds and wild waves. He and Helen tried to put on the safety jackets they had neglected to wear earlier, but the boat turned over before they were finished. Brian, the better swimmer of the two, was able to swim back to the overturned sailboat, grab the side, and hold on for dear life, but Helen simply could not overcome the rough waves and reach the boat. As Brian watched in horror and disbelief, his wife disappeared from view.

After a time, the storm began to lose its strength. Brian managed to right the sailboat and sail back to shore. Finally he reached safety, but the personal consequences of this storm were just beginning. The next days were filled with pain and further horror: the Coast Guard finding Helen’s body . . . conversations with friends . . . self-blame . . . grief . . . and more.

Compounding this horror, the accident had left Brian with a severe physical impairment—he could not walk properly. He first noticed this terrible impairment when he sailed the boat back to shore, right after the accident. As he tried to run from the sailboat to get help, he could hardly make his legs work. By the time he reached the nearby beach restaurant, all he could do was crawl. Two patrons had to lift him to a chair, and after he told his story and the authorities were alerted, he had to be taken to a hospital.

At first Brian and the hospital physician assumed that he must have been hurt during the accident. One by one, however, the hospital tests revealed nothing—no broken bones, no spinal damage, nothing. Nothing that could explain such severe impairment.

By the following morning, the weakness in his legs had become near paralysis. Because the physicians could not pin down the nature of his injuries, they decided to keep his activities to a minimum. He was not allowed to talk long with the police. Someone else had to inform Helen’s parents of her death. To his deep regret, he was not even permitted to attend Helen’s funeral.

The mystery deepened over the following days and weeks. As Brian’s paralysis continued, he became more and more withdrawn, unable to see more than a few friends and family members and unable to take care of the many unpleasant tasks attached to Helen’s death. He could not bring himself to return to work or get on with his life. Almost from the beginning, Brian’s paralysis had left him self-absorbed and drained of emotion, unable to look back and unable to move forward.

In the previous two chapters you saw how stress and anxiety can negatively affect functioning. Indeed, anxiety is the key feature of disorders such as generalized anxiety disorder, phobias, panic disorder, and obsessive-compulsive disorder. And stress can produce the lingering reactions seen in acute stress disorder, posttraumatic stress disorder, and psychophysiological disorders.

Two other kinds of disorders are commonly linked to stress and anxiety—somatoform disorders and dissociative disorders. Somatoform disorders are problems that appear to be medical but are actually caused by psychosocial factors. Unlike
psychophysiological disorders, in which psychosocial factors interact with genuine physical ailments, the somatoform disorders are psychological disorders masquerading as physical problems. Similarly, dissociative disorders are patterns of memory loss and identity change that are caused almost entirely by psychosocial factors rather than physical ones.

The somatoform and dissociative disorders have much in common. Both, for example, may occur in response to severe stress, and both have traditionally been viewed as forms of escape from that stress. In addition, a number of individuals suffer from both a somatoform and a dissociative disorder (Brown et al., 2007). Indeed, theorists and clinicians often explain and treat the two groups of disorders in similar ways.

Somatoform Disorders

Think back to Brian, the young man whose tragic boating accident left him unable to walk. As medical test after test failed to explain his paralysis, physicians became convinced that the cause of his problem lay elsewhere.

When a physical ailment has no apparent medical cause, doctors may suspect a somatoform disorder, a pattern of physical complaints with largely psychosocial causes. People with such disorders do not consciously want or purposely produce their symptoms; like Brian, they almost always believe that their problems are genuinely medical (Phillips, Fallon, & King, 2008). In some somatoform disorders, known as hysterical somatoform disorders, there is an actual change in physical functioning. In others, the preoccupation somatoform disorders, people who are healthy mistakenly worry that there is something physically wrong with them.

What Are Hysterical Somatoform Disorders?

People with hysterical somatoform disorders suffer actual changes in their physical functioning. These somatoform disorders are often hard to distinguish from genuine medical problems (Phillips et al., 2008). In fact, it is always possible that a diagnosis of hysterical disorder is a mistake and that the patient’s problem has an undetected organic cause (Aybek et al., 2008; Merskey, 2004). DSM-IV-TR lists three hysterical somatoform disorders: conversion disorder, somatization disorder, and pain disorder associated with psychological factors.

Conversion Disorder In conversion disorder, a psychosocial conflict or need is converted into dramatic physical symptoms that affect voluntary motor or sensory functioning (see Table 6–1). Brian, the man with the unexplained paralysis, would probably receive this particular diagnosis. The symptoms often seem neurological, such as paralysis, blindness, or loss of feeling (APA, 2000). One woman developed dizziness in apparent response to her unhappy marriage:

A 46-year-old married housewife . . . described being overcome with feelings of extreme dizziness, accompanied by slight nausea, four or five nights a week. During these attacks, the room around her would take on a “shimmering” appearance, and she would have the feeling that she was “floating” and unable to keep her balance. Inexplicably, the attacks almost always occurred at about 4:00 p.m. She usually had to lie down on the couch and often did not feel better until 7:00 or 8:00 p.m. After recovering, she generally spent the rest of the evening watching TV; and more often than not, she would fall asleep in the living room, not going to bed in the bedroom until 2:00 or 3:00 in the morning.
The patient had been pronounced physically fit by her internist, a neurologist, and an ear, nose, and throat specialist on more than one occasion. Hypoglycemia had been ruled out by glucose tolerance tests.

When asked about her marriage, the patient described her husband as a tyrant, frequently demanding and verbally abusive of her and their four children. She admitted that she dreaded his arrival home from work each day, knowing that he would comment that the house was a mess and the dinner, if prepared, not to his liking. Recently, since the onset of her attacks, when she was unable to make dinner he and the four kids would go to McDonald’s or the local pizza parlor. After that, he would settle in to watch a ballgame in the bedroom, and their conversation was minimal. In spite of their troubles, the patient claimed that she loved her husband and needed him very much.

(Spitzer et al., 1981, pp. 92–93)

Most conversion disorders begin between late childhood and young adulthood; they are diagnosed at least twice as often in women as in men (Abbey, 2005; APA, 2000). They usually appear suddenly, at times of extreme stress, and last a matter of weeks. Some research suggests that people who develop this disorder tend to be generally suggestible; many are highly susceptible to hypnotic procedures, for example (Roelofs et al., 2002). Conversion disorders are thought to be quite rare, occurring in at most 5 of every 1,000 persons.
Sheila baffled medical specialists with the wide range of her symptoms:

Sheila reported having abdominal pain since age 17, necessitating exploratory surgery that yielded no specific diagnosis. She had several pregnancies, each with severe nausea, vomiting, and abdominal pain; she ultimately had a hysterectomy for a “tipped uterus.” Since age 40 she had experienced dizziness and “blackouts,” which she eventually was told might be multiple sclerosis or a brain tumor. She continued to be bedridden for extended periods of time, with weakness, blurred vision, and difficulty urinating. At age 43 she was worked up for a hiatal hernia because of complaints of bloating and intolerance of a variety of foods. She also had additional hospitalizations for neurological, hypertensive, and renal workups, all of which failed to reveal a definitive diagnosis.

(Spitzer et al., 1981, pp. 185, 260)

Like Sheila, people with somatization disorder have many long-lasting physical ailments that have little or no organic basis (see again Table 6-1). This hysterical pattern, first described by Pierre Briquet in 1859, is also known as Briquet’s syndrome. To receive this diagnosis, a person must have a range of ailments, including several pain symptoms (such as headaches and chest pain), gastrointestinal symptoms (such as nausea and diarrhea), a sexual symptom (such as erectile or menstrual difficulties), and a neurological symptom (such as double vision or paralysis) (APA, 2000). People with somatization disorder usually go from doctor to doctor in search of relief. They often describe their many symptoms in dramatic and exaggerated terms. Most also feel anxious and depressed (Creed, 2009; Fink et al., 2004; APA, 2000).

Between 0.2 and 2.0 percent of all women in the United States may experience a somatization disorder in any given year, compared to less than 0.2 percent of men (North, 2005; APA, 2000). The disorder often runs in families; as many as 20 percent of the close female relatives of women with the disorder also develop it. It usually begins between adolescence and young adulthood.

A somatization disorder lasts much longer than a conversion disorder, typically for many years (Yutzy, 2007). The symptoms may fluctuate over time but rarely disappear.

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Mind over matter

The opposite of hysterical disorders—although again demonstrating the power of psychological processes—are instances in which people “ignore” pain or other physical symptoms. Here a London performance artist manages to smile comfortably at onlookers while her skin is being pierced with sharp hooks that help suspend her from the ceiling above. Her action was part of a 2008 protest to end shark finning—the practice of cutting off a shark’s fin and throwing its still living body back into the sea so that the fins can be used in the production of shark fin soup (a food delicacy) and other goods.
completely without therapy (Abbey, 2005). Two-thirds of individuals with this disorder in the United States receive treatment for their physical ailments from a medical or mental health professional in any given year (Regier et al., 1993).

**Pain Disorder Associated with Psychological Factors** When psychosocial factors play a central role in the onset, severity, or continuation of pain, patients may receive a diagnosis of **pain disorder associated with psychological factors** (see again Table 6-1). Patients with a conversion or somatization disorder may also experience pain, but it is the key symptom in this disorder.

Although the precise prevalence has not been determined, pain disorder associated with psychological factors appears to be fairly common (Creed, 2009). The disorder may begin at any age, and women seem more likely than men to experience it (APA, 2000). Often it develops after an accident or during an illness that has caused genuine pain, which then takes on a life of its own. Laura, a 36-year-old woman, reported pains that went far beyond the usual symptoms of her tubercular disease, called sarcoidosis:

_Before the operation I would have little joint pains, nothing that really bothered me that much. After the operation I was having severe pains in my chest and in my ribs, and those were the type of problems I’d been having after the operation, that I didn’t have before. . . . I’d go to an emergency room at night, 11:00, 12:00, 1:00 or so. I’d take the medicine, and the next day it stopped hurting, and I’d go back again. In the meantime this is when I went to the other doctors, to complain about the same thing, to find out what was wrong; and they could never find out what was wrong with me either. . . .

. . . At certain points when I go out or my husband and I go out, we have to leave early because I start hurting. . . . A lot of times I just won’t do things because my chest is hurting for one reason or another. . . . Two months ago when the doctor checked me and another doctor looked at the x-rays, he said he didn’t see any signs of the sarcoid then and that they were doing a study now, on blood and various things, to see if it was connected to sarcoid. . . . (Green, 1985, pp. 60–63)"

**Hysterical vs. Medical Symptoms** Because hysterical somatoform disorders are so similar to “genuine” medical ailments, physicians sometimes rely on oddities in the patient’s medical picture to help distinguish the two (Phillips et al., 2008; Kirmayer & Looper, 2007). The symptoms of a hysterical disorder may, for example, be at odds with the way the nervous system is known to work (APA, 2000). In a conversion symptom called **glove anesthesia**, numbness begins sharply at the wrist and extends evenly right to the fingertips. As Figure 6-1 shows, real neurological damage is rarely as abrupt or evenly spread out.

The physical effects of a hysterical disorder may also differ from those of the corresponding medical problem. For example, when paralysis from the waist down, or paraplegia, is caused by damage to the spinal cord, a person’s leg muscles may atrophy, or waste away, unless physical therapy is applied. People whose paralysis is the result of a conversion disorder, in contrast, do not usually experience atrophy. Perhaps they exercise their muscles without being aware that they are doing so. Similarly, people with conversion blindness have fewer accidents than people who are organically blind, an indication that they have at least some vision even if they are unaware of it.

**Hysterical vs. Factitious Symptoms** Hysterical somatoform disorders are different from patterns in which individuals are purposefully producing or faking medical symptoms. A patient may, for example, _malinger_—intentionally fake illness to achieve some external gain, such as financial compensation (Phillips et al., 2008). Or a patient may intentionally produce or fake physical symptoms simply out of a wish to be a patient; that is, the motivation for assuming the sick role may be the role itself. Physicians would then decide that the patient is displaying a **factitious disorder**.
People with a factitious disorder often go to extremes to create the appearance of illness (Phillips et al., 2008). Many give themselves medications secretly. Some inject drugs to cause bleeding. High fevers are especially easy to create. In one study of patients with long-standing mysterious fever, more than 9 percent were eventually diagnosed with factitious disorder (Feldman, Ford, & Reinhold, 1994). People with a factitious disorder often research their supposed ailments and are impressively knowledgeable about medicine.

Psychotherapists and medical practitioners often become angry at people with a factitious disorder, feeling that these individuals are, among other issues, wasting their time. Yet people with this disorder, like most persons with psychological disorders, feel they have no control over their problem, and they often experience great distress.

Munchausen syndrome is the extreme and long-term form of factitious disorder. It is named after Baron Munchausen, an eighteenth-century cavalry officer who

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**Munchausen Syndrome by Proxy**

Jennifer had been hospitalized 200 times and undergone 40 operations. Physicians removed her gallbladder, her appendix and part of her intestines, and inserted tubes into her chest, stomach and intestines. (The 9-year-old from Florida) was befriended by the Florida Marlins and served as a poster child for health care reform, posing with Hillary Rodham Clinton at a White House rally. Then police notified her mother that she was under investigation for child abuse. Suddenly, Jennifer’s condition improved dramatically. In the next nine months, she was hospitalized only once, for a viral infection. Experts said Jennifer’s numerous baffling infections were “consistent with someone smearing fecal matter” into her feeding line and urinary catheter.

(CAETE & BECK, 1996)

Cases like Jennifer’s have horrified the public and called attention to Munchausen syndrome by proxy. This disorder is caused by a caregiver who uses various techniques to induce symptoms in a child—giving the child drugs, tempering with medications, contaminating a feeding tube, or even smothering the child, for example. The illness can take almost any form, but the most common symptoms are bleeding, seizures, asthma, comas, diarrhea, vomiting, “accidental” poisonings, infections, fevers, and sudden infant death syndrome (Leamon et al., 2007; Feldman, 2004).

Between 6 and 30 percent of the victims of Munchausen syndrome by proxy die as a result of their symptoms, and 8 percent of those who survive are permanently disfigured or physically impaired (Ayoub, 2006; Mitchell, 2001). Psychological, educational, and physical development are also affected (Libow & Schreier, 1998; Libow, 1995). The syndrome is very hard to diagnose and may be more common than clinicians once thought (Feldman, 2004; Rogers, 2004). The parent (usually the mother) seems to be so devoted and caring that others sympathize with and admire her. Yet the physical problems disappear when child and parent are separated. In many cases siblings of the sick child have also been victimized (Ayoub, 2006).

What kind of parent carefully inflicts pain and illness on her own child? The typical Munchausen mother is emotionally needy: She craves the attention and praise she receives for her devoted care of her sick child (Noeker, 2004). She may have little social support outside the medical system. Often the mothers have a medical background of some kind—perhaps having worked formerly in a doctor’s office. They typically deny their actions, even in the face of clear evidence, and refuse to undergo therapy (Bluglass, 2001). Law enforcement authorities approach Munchausen syndrome by proxy as a crime—a carefully planned form of child abuse (Slovenko, 2006; Mart, 2004). They almost always require that the child be separated from the mother (Ayoub, 2006). At the same time, a parent who resorts to such actions is seriously disturbed and greatly in need of clinical help. Thus clinical researchers and practitioners must now work to develop clearer insights and more effective treatments for such parents and their young victims.
journeyed from tavern to tavern in Europe telling fantastical tales about his supposed military adventures (Ford, 2005; Feldman, 2004). In a related disorder, Munchausen syndrome by proxy, or factitious disorder by proxy, parents make up or produce physical illnesses in their children, leading in some cases to repeated painful diagnostic tests, medication, and surgery.

What Are Preoccupation Somatoform Disorders?

Hypochondriasis and body dysmorphic disorder are preoccupation somatoform disorders. People with these problems misinterpret and overreact to bodily symptoms or features no matter what friends, relatives, and physicians may say. Although preoccupation disorders also cause great distress, their impact on one’s life differs from that of hysterical disorders.

Hypochondriasis People who suffer from hypochondriasis unrealistically interpret bodily symptoms as signs of a serious illness (see Table 6–2). Often their symptoms are merely normal bodily changes, such as occasional coughing, sores, or sweating. Although some patients recognize that their concerns are excessive, many do not.

Although hypochondriasis can begin at any age, it starts most often in early adulthood, among men and women in equal numbers. Between 1 and 5 percent of all people experience the disorder (Bouman, 2008; APA, 2000). As with pain disorder associated with psychological factors, physicians report seeing many cases (Mitchell, 2004). As many as 7 percent of all patients seen by primary care physicians may display hypochondriasis (Asmundson & Taylor, 2008). For most patients, the symptoms rise and fall over the years.

Body Dysmorphic Disorder People who experience body dysmorphic disorder, also known as dysmorphophobia, become deeply concerned about some imagined or minor defect in their appearance (see again Table 6–2). Most often they focus on wrinkles; spots on the skin; excessive facial hair; swelling of the face; or a misshapen nose, mouth, jaw, or eyebrow (McKay, Gosselin, & Gupta, 2008; Veale, 2004). Some worry about the appearance of their feet, hands, breasts, penis, or other body parts. Still others are concerned about bad odors coming from sweat, breath, genitals, or the rectum (Phillips & Castle, 2002). Here we see such a case:

A woman of 35 had for 16 years been worried that her sweat smelled terrible. The fear began just before her marriage when she was sharing a bed with a close friend who said that someone at work smelled badly, and the patient felt that the remark was directed at her. For fear that she smelled, for 5 years she had not gone out anywhere except when accompanied by her husband or mother. She had not spoken to her neighbors for 3 years because she thought she had overheard them speak about her to some friends. She avoided cinemas, dances, shops, cafes, and private homes. . . . Her husband was not allowed to invite any friends home; she constantly sought reassurance from him about her smell. . . . Her husband bought all her new clothes as she was afraid to try on clothes in front of shop assistants. She used vast quantities of deodorant and always bathed and changed her clothes before going out, up to 4 times daily.

(Marks, 1987, p. 371)

It is common in our society to worry about appearance (see Figure 6–2 on the next page). Many teenagers and young adults worry about acne, for instance. The concerns of people with body dysmorphic disorder, however, are extreme. Sufferers may severely limit contact with other people, be unable to look others in the eye, or go to great lengths to conceal their “defects”—say, always wearing sunglasses to cover their supposedly misshapen eyes (Phillips, 2005). As many as half of people with this disorder seek plastic surgery or
dermatology treatment, and often they feel worse rather than better afterward (McKay et al., 2008). One study found that 30 percent of participants with body dysmorphic disorder were housebound and 17 percent had attempted suicide (Phillips et al., 1993).

Most cases of body dysmorphic disorder begin during adolescence. Often, however, people don’t reveal their concerns for many years (McKay et al., 2008). Up to 5 percent of people in the United States—including many college students—suffer from the disorder (Ovsiew, 2006; Miller, 2005). Clinical reports suggest that it may be equally common among women and men (APA, 2000).

What Causes Somatoform Disorders?

Theorists typically explain the preoccupation somatoform disorders much as they explain anxiety disorders (Bouman, 2008; Noyes, 2008, 2003, 2001). Behaviorists, for example, believe that the fears found in hypochondriasis and body dysmorphic disorder are acquired through classical conditioning or modeling (Marshall et al., 2007). Cognitive theorists suggest that people with the disorders are so sensitive to and threatened by bodily cues that they come to misinterpret them (Williams, 2004).

In contrast, the hysterical somatoform disorders—conversion, somatization, and pain disorders—are widely considered unique and in need of special explanations. The ancient Greeks believed that only women had hysterical disorders. The uterus of a sexually ungratified woman was supposed to wander throughout her body in search of fulfillment, producing a physical symptom wherever it lodged. Thus Hippocrates suggested marriage as the most effective treatment for such disorders. Today’s leading explanations for hysterical somatoform disorders come from the psychodynamic, behavioral, cognitive, and multicultural models. None has received much research support, however, and the disorders are still poorly understood (Kirmayer & Looper, 2007; Yutzy, 2007).

![Figure 6-2](image)

“Mirror, mirror, on the wall...” People with body dysmorphic disorder are not the only ones who have concerns about their appearance. Surveys find that in our appearance-conscious society, many individuals regularly think about and try to change the way they look (Noonan, 2003; Kimball, 1993; Poretz & Sinrod, 1991; Weiss, 1991; Simmon, 1990).
The Psychodynamic View

As you read in Chapter 1, Freud’s theory of psychoanalysis began with his efforts to explain hysterical symptoms. Indeed, he was one of the few clinicians of his day to treat patients with these symptoms seriously, as people with genuine problems. After studying hypnosis in Paris, Freud became interested in the work of an older physician, Josef Breuer (1842–1925). Breuer had successfully used hypnosis to treat a woman he called Anna O., who suffered from hysterical deafness, disorganized speech, and paralysis. Critics have since questioned whether Anna’s ailments were entirely hysterical and whether Breuer’s treatment helped her as much as he claimed (Ellenberger, 1972). But on the basis of this and similar cases, Freud (1894) came to believe that hysterical disorders represented a conversion of underlying emotional conflicts into physical symptoms.

Observing that most of his patients with hysterical disorders were women, Freud centered his explanation of hysterical disorders on the needs of girls during their phallic stage (ages 3 through 5). At that time in life, he believed, all girls develop a pattern of desires called the Electra complex: Each girl experiences sexual feelings for her father and at the same time recognizes that she must compete with her mother for his affection. However, aware of her mother’s more powerful position and of cultural taboos, the child typically represses her sexual feelings and rejects these early desires for her father.

Freud believed that if a child’s parents overreact to her sexual feelings—with strong punishments, for example—the Electra conflict will be unresolved and the child may reexperience sexual anxiety throughout her life. Whenever events trigger sexual feelings, she may experience an unconscious need to hide them from both herself and others. Freud concluded that some women hide their sexual feelings by unconsciously converting them into physical symptoms.

People almost everywhere want to be attractive, and they tend to worry about how they appear in the eyes of others. At the same time, these concerns take different forms in different cultures.

Whereas people in Western society worry in particular about their body size and facial features, women of the Padaung tribe in Myanmar focus on the length of their neck and wear heavy stacks of brass rings to try to extend it. Many of them seek desperately to achieve what their culture has taught them is the perfect neck size. Said one, “It is most beautiful when the neck is really long. . . . I will never take off my rings. . . . I’ll be buried in them” (Mydans, 1996).

Similarly, for centuries women of China, in response to the preferences of men in that country, worried greatly about the size and appearance of their feet and practiced foot binding to stop the growth of these extremities (Wang Ping, 2000). In this procedure, which began in the year 900 and was widely practiced until it was outlawed in 1911, young girls were instructed to wrap a long bandage tightly around their feet each day, forcing the four toes under the sole of the foot. The procedure, which was carried out for about two years, caused the feet to become narrower and smaller. Typically the practice led to serious medical problems and poor mobility, but it did produce the small feet that were considered attractive.

Western society also falls victim to such cultural influences. Recent decades have witnessed staggering increases in such procedures as rhinoplasty (reshaping of the nose), breast augmentation, and body piercing—all reminders that cultural values greatly influence each person’s ideas and concerns about beauty, and in some cases may set the stage for body dysmorphic disorder.
Most of today’s psychodynamic theorists take issue with Freud’s explanation of hysterical disorders, particularly his notion that the disorders can always be traced to an unresolved Electra conflict (Verhaeghe, Vanheule, & de Rick, 2007; Hess, 1995). They continue to believe, however, that sufferers of these disorders have unconscious conflicts carried forth from childhood, which arouse anxiety, and that the individuals convert this anxiety into “more tolerable” physical symptoms (Brown et al., 2005).

Psychodynamic theorists propose that two mechanisms are at work in hysterical somatoform disorders—primary gain and secondary gain (van Egmond, 2003). People achieve primary gain when their hysterical symptoms keep their internal conflicts out of awareness. During an argument, for example, a man who has underlying fears about expressing anger may develop a conversion paralysis of the arm, thus preventing his feelings of rage from reaching consciousness. People achieve secondary gain when their hysterical symptoms further enable them to avoid unpleasant activities or to receive sympathy from others. When, for example, a conversion paralysis allows a soldier to avoid combat duty or conversion blindness prevents the breakup of a relationship, secondary gain may be at work. Similarly, the conversion paralysis of Brian, the man who lost his wife in the boating accident, seemed to help him avoid many painful duties after the accident, from telling his wife’s parents of her death to attending her funeral and returning to work.

The Behavioral View Behavioral theorists propose that the physical symptoms of hysterical disorders bring rewards to sufferers (see Table 6-3). Perhaps the symptoms remove the individuals from an unpleasant relationship or bring attention from other people (Whitehead et al., 1994). In response to such rewards, the sufferers learn to display the symptoms more and more prominently. Behaviorists also hold that people who are familiar with an illness will more readily adopt its physical symptoms (Garralda, 1996). In fact, studies find that many sufferers develop their hysterical symptoms after they or their close relatives or friends have had similar medical problems (Marshall et al., 2007). Clearly, the behavioral focus on rewards is similar to the psychodynamic idea of secondary gains.

Like the psychodynamic explanation, the behavioral view of hysterical disorders has received little research support. Even clinical case reports only occasionally support this position. In many cases the pain and upset that surround the disorders seem to outweigh any rewards the symptoms may bring.

The Cognitive View Some cognitive theorists propose that hysterical disorders are forms of communication, providing a means for people to express emotions that would otherwise be difficult to convey (Mitchell, 2004). Like their psychodynamic colleagues, these theorists hold that the emotions of patients with hysterical disorders are being converted into physical symptoms. They suggest, however, that the purpose of the conversion is not to defend against anxiety but to communicate extreme feelings—anger, fear, depression, guilt, jealousy—in a “physical language” that is familiar and comfortable for the patient (Koh et al., 2005).

According to this view, people who find it particularly hard to recognize or express their emotions are candidates for a hysterical disorder. So are those who “know” the language of physical symptoms through firsthand experience with a genuine physical ailment. Because children are less able to express their emotions verbally, they are particularly likely to develop physical symptoms as a form of communication (Dhossche et al., 2002). Like the other explanations, this cognitive view has not been widely tested or supported by research.

The Multicultural View Clinicians often use the term somatization when referring generally to the development of somatic symptoms in response to personal distress, the key feature of hysterical somatoform disorders. Somatization of any kind is considered inappropriate in Western countries (So, 2008; Escobar, 2004). Some theorists believe,
however, that this position reflects a bias held by Western clinicians—a bias that sees somatic symptoms as an inferior way of dealing with emotions (Moldavsky, 2004; Fábrega, 1990).

In fact, the transformation of personal distress into somatic complaints is the norm in many non-Western cultures (Draguns, 2006; Kleinman, 1987). In such cultures, somatization is viewed as a socially and medically correct—and less stigmatizing—reaction to life's stressors.

Studies have found very high rates of somatization in non-Western medical settings throughout the world, including those in China, Japan, and Arab countries (Matsumoto & Juang, 2008). Individuals in Latin countries seem to display the greatest number of somatic symptoms (Escobar, 2004, 1995; Escobar et al., 1998, 1992). Even within the United States, people from Hispanic cultures display more somatic symptoms in the face of stress than do other populations.

In Chapter 5 you saw that posttraumatic stress disorder may be more common among Hispanic Americans than among other ethnic groups in the United States (see page 143). Interestingly, however, research clarifies that this trend exists only among Hispanic Americans who were born in the United States or have lived in the United States for a number of years (Escobar, 2004, 1998). Indeed, recent Latin immigrants display a lower rate of posttraumatic stress disorder than do other individuals throughout the country. It may be that recent immigrants, not yet influenced by the Western bias against somatization, react to traumatic events with familiar somatic symptoms and that those symptoms help prevent the onset of a full-blown posttraumatic stress disorder.

The lesson to be learned from such multicultural findings is not that somatic reactions to stress are superior to psychological ones or vice versa, but rather, once again, that reactions to life's stressors are often influenced by one's culture. Overlooking this point can lead to knee-jerk mislabels or misdiagnoses.

A Possible Role for Biology Although hysterical somatoform disorders are, by definition, thought to result largely from psychological and sociocultural factors, the impact of biological processes should not be overlooked (Ovsiew, 2006). To understand this point, consider first what researchers have learned about placebos and the placebo effect.

For centuries physicians have observed that patients suffering from many kinds of illnesses, from seasickness to angina, often find relief from placebos, substances that have no known medicinal value (Price, Finniss, & Benedetti, 2008; Brody, 2000). Some studies have raised questions about the actual number of patients helped by placebos (Hróbjartsson & Gotzsche, 2006, 2001), but it is generally agreed that such “pretend” treatments do bring help to many people.

Why do placebos have a medicinal effect? Theorists used to believe that they operated in purely psychological ways—that the power of suggestion worked almost magically.
upon the body. More recently, however, researchers have found that a belief or expectation can trigger certain chemicals throughout the body into action, and these chemicals then may produce a medicinal effect (Price et al., 2008). The body chemicals most often mentioned are hormones and lymphocytes, chemicals that you observed at work in Chapter 5, and endorphins, natural opioid substances that you will read about in Chapter 10. Howard Brody, a leading theorist on the subject, compares the placebo effect to visiting a pharmacy:

> Our bodies are capable of producing many substances that can heal a wide variety of illnesses, and make us feel generally healthier and more energized. When the body simply secretes these substances on its own, we have what is often termed “spontaneous healing.” Some of the time, our bodies seem slow to react, and a message from outside can serve as a wake-up call to our inner pharmacy. The placebo response can thus be seen as the reaction of our inner pharmacies to that wake-up call.

(Brody, 2000, p. 61)

If placebos can “wake up” our inner pharmacies in this way, perhaps traumatic events and related concerns or needs are doing the same thing (although in a negative way) in cases of conversion disorder, somatization disorder, or pain disorder associated with psychological factors. That is, such events and reactions may, in fact, be triggering our inner pharmacies and setting in motion the bodily symptoms of hysterical somatoform disorders.

### How Are Somatoform Disorders Treated?

People with somatoform disorders usually seek psychotherapy only as a last resort. They fully believe that their problems are medical and at first reject all suggestions to the contrary (Asmundson & Taylor, 2008). When a physician tells them that their problems have no physical basis, they often go to another physician. Eventually, however, many patients with these disor-
Individuals with preoccupation somatoform disorders—hypochondriasis and body dysmorphic disorder—typically receive the kinds of treatment that are applied to anxiety disorders, particularly obsessive-compulsive disorder. Studies reveal, for example, that patients with either of the preoccupation disorders often improve considerably when treated with the same antidepressant drugs that are helpful in cases of obsessive-compulsive disorder (Bouman, 2008; McKay et al., 2008).

Similarly, in one study, 17 patients with body dysmorphic disorder were treated with exposure and response prevention—the behavioral approach that often helps persons with obsessive-compulsive disorder. Over the course of four weeks, the clients were repeatedly reminded of their perceived physical defects and, at the same time, prevented from doing anything to help reduce their discomfort (for example, checking their appearance) (Neziroglu et al., 2004, 1996). By the end of treatment, these individuals were less concerned with their “defects” and spent less time checking their body parts and avoiding social interactions. Increasingly, this behavioral approach is being successfully combined with a cognitive approach that also helps clients with body dysmorphic disorder identify, test, and change their distorted thoughts about their appearance and social impact (Sarwer et al., 2004; Geremia & Neziroglu, 2001).

Cognitive-behavioral therapies of this kind are also being applied to cases of hypochondriasis. Here, therapists repeatedly point out bodily variations to clients while, at the same time, preventing them from seeking their usual medical attention. In addition, the therapists guide the clients to identify and change the illness-related beliefs that are helping to maintain their disorder. Once again, such approaches are receiving promising research support (Bouman, 2008; Greeven et al., 2007).

Treatments for hysterical somatoform disorders—conversion, somatization, and pain disorders—often focus on the cause of the disorder (the trauma or anxiety behind the physical symptoms) and apply the same kinds of techniques used in cases of posttraumatic stress disorder, particularly insight, exposure, and drug therapies. Psychodynamic therapists, for example, try to help individuals with hysterical disorders become conscious of and resolve their underlying fears, thus eliminating the need to convert anxiety into physical symptoms (Hawkins, 2004). Alternatively, behavioral therapists use exposure treatments: They expose clients to features of the horrific events that first triggered their physical symptoms, expecting that the individuals will become less anxious over the course of repeated exposures and, in turn, more able to face those upsetting events directly rather than through physical channels (Stuart et al., 2008). And biological therapists use antianxiety drugs or certain antidepressant drugs to help reduce the anxiety of clients with hysterical disorders (Eifert et al., 2008; Han et al., 2008).

Other therapists try to address the physical symptoms of the hysterical disorders rather than the causes, applying techniques such as suggestion, reinforcement, or confrontation (Yutzy, 2007). Those who employ suggestion offer emotional support to patients and tell them persuasively (or hypnotically) that their physical symptoms will soon disappear (Elkins & Perfect, 2007; Moene et al., 2002). Therapists who take a reinforcement approach arrange the removal of rewards for a client’s “sick” behaviors and an increase of rewards for healthy behaviors (North, 2005). And therapists who take a confrontational approach try to force patients out of the sick role by straightforwardly telling them that their symptoms are without medical basis (Sjolie, 2002).

Researchers have not fully evaluated the effects of these particular approaches on hysterical disorders (Cianna-Fedoroff & Sperry, 2005). Case studies suggest, however, that conversion disorder and pain disorder respond better than somatization disorder to therapy and that approaches using a confrontational strategy are less helpful than suggestion and reinforcement interventions (Miller, 2004).
Dissociative Disorders

Most of us experience a sense of wholeness and continuity as we interact with the world. We perceive ourselves as being more than a collection of isolated sensory experiences, feelings, and behaviors. In other words, we have an identity, a sense of who we are and where we fit in our environment. Others recognize us and expect certain things of us. But more important, we recognize ourselves and have our own expectations, values, and goals.

Memory is a key to this sense of identity, the link between our past, present, and future. Our recall of past experiences, although not always precisely accurate, helps us react to present events and guides us in making decisions about the future. We recognize our friends and relatives, teachers and employers, and respond to them in appropriate ways. Without a memory, we would always be starting over; with it, life moves forward.

People sometimes experience a major disruption of their memory. They may, for example, lose their ability to remember new information they just learned or old information they once knew well. When such changes in memory lack a clear physical cause, they are called dissociative disorders. In such disorders, one part of the person’s memory typically seems to be dissociated, or separated, from the rest.

There are several kinds of dissociative disorders. The primary symptom of dissociative amnesia is an inability to recall important personal events and information. A person with dissociative fugue not only forgets the past but also travels to a new location and may assume a new identity. Dissociative identity disorder, also known as multiple personality disorder, have two or more separate identities that may not always be aware of each other’s thoughts, feelings, and behavior.

Several memorable books and movies have portrayed dissociative disorders. Two of the best known are The Three Faces of Eve and Sybil, each about a woman with multiple personalities. The topic is so fascinating that most television drama series seem to include at least one case of dissociation every season, creating the impression that the disorders are very common (Pope et al., 2007). Many clinicians, however, believe that they are rare.
DSM-IV-TR also lists depersonalization disorder as a dissociative disorder. People with this problem feel as though they have become detached from their own mental processes or body and are observing themselves from the outside. Because memory problems are not a central feature of this disorder, it will not be discussed here.

As you read through the remainder of this chapter, keep in mind that dissociative symptoms are often found in cases of acute or posttraumatic stress disorder. Recall from Chapter 5 that sufferers of these disorders may feel dazed or have trouble remembering things. When such symptoms occur as part of a stress disorder, they do not necessarily indicate a dissociative disorder, in which the dissociative symptoms dominate. On the other hand, research suggests that a number of people with one of these disorders also develop the other as well (Bremner, 2002).

Dissociative Amnesia

At the beginning of this chapter you met the unfortunate man named Brian. As you will recall, Brian developed a conversion disorder after a traumatic boating accident in which his wife was killed. To help examine dissociative amnesia, let us now revisit that case, changing the reactions and symptoms that Brian develops in the aftermath of the traumatic event.

Brian was spending Saturday sailing with his wife, Helen. The water was rough but well within what they considered safe limits. They were having a wonderful time and really didn’t notice that the sky was getting darker, the wind blowing harder, and the sailboat becoming more difficult to control. After a few hours of sailing, they found themselves far from shore in the middle of a powerful and dangerous storm.

The storm intensified very quickly. Brian had trouble controlling the sailboat amidst the high winds and wild waves. He and Helen tried to put on the safety jackets they had neglected to wear earlier, but the boat turned over before they were finished. Brian, the better swimmer of the two, was able to swim back to the overturned sailboat, grab the side, and hold on for dear life, but Helen simply could not overcome the rough waves and reach the boat. As Brian watched in horror and disbelief, his wife disappeared from view.

After a time, the storm began to lose its strength. Brian managed to right the sailboat and sail back to shore. Finally he reached safety, but the personal consequences of this storm were just beginning. The next days were filled with pain and further horror: the Coast Guard finding Helen’s body . . . discussions with authorities . . . breaking the news to Helen’s parents . . . conversations with friends . . . self-blame . . . grief . . . and more. On Wednesday, four days after that fateful afternoon, Brian collected himself and attended Helen’s funeral and burial. It was the longest and most difficult day of his life. Most of the time, he felt as though he were in a trance.

Soon after awakening on Thursday morning, Brian realized that something was terribly wrong with him. Try though he might, he couldn’t remember the events of the past few days. He remembered the accident, Helen’s death, and the call from the Coast Guard after they had found her body. But just about everything else was gone, right up through the funeral. At first he had even thought that it was now Sunday, and that his discussions with family and friends and the funeral were all ahead of him. But the newspaper, the funeral guestbook, and a phone conversation with his brother soon convinced him that he had lost the past four days of his life.
In this revised scenario, Brian is reacting to his traumatic experience with symptoms of dissociative amnesia. People with this disorder are unable to recall important information, usually of an upsetting nature, about their lives (APA, 2000). The loss of memory is much more extensive than normal forgetting and is not caused by physical factors (see Table 6–4). Often an episode of amnesia is directly triggered by a specific upsetting event (McLeod et al., 2004).

Dissociative amnesia may be localized, selective, generalized, or continuous. Any of these kinds of amnesia can be triggered by a traumatic experience such as Brian’s, but each represents a particular pattern of forgetting. Brian was suffering from localized amnesia.
the most common type of dissociative amnesia, in which a person loses all memory of events that took place within a limited period of time, almost always beginning with some very disturbing occurrence. Recall that Brian awakened on the day after the funeral and could not recall any of the events of the past difficult days, beginning after the boating tragedy. He remembered everything that happened up to and including the accident. He could also recall everything from the morning after the funeral onward, but the days in between remained a total blank. The forgotten period is called the amnestic episode. During an amnestic episode, people may appear confused; in some cases they wander about aimlessly. They are already experiencing memory difficulties but seem unaware of them. In the revised case, for example, Brian felt as though he were in a trance on the day of Helen’s funeral.

People with selective amnesia, the second most common form of dissociative amnesia, remember some, but not all, events that occurred during a period of time. If Brian had selective amnesia, he might remember certain conversations with friends but perhaps not the funeral itself.

In some cases the loss of memory extends back to times long before the upsetting period. Brian might awaken after the funeral and find that, in addition to forgetting events of the past few days, he could not remember events that occurred earlier in his life. In this case, he would be experiencing generalized amnesia. In extreme cases, Brian might not even remember who he was and might fail to recognize relatives and friends.

In the forms of dissociative amnesia discussed so far, the period affected by the amnesia has an end. In continuous amnesia, however, forgetting continues into the present. Brian might forget new and ongoing experiences as well as what happened before and during the tragedy. Continuous forgetting of this kind is actually quite rare in cases of dissociative amnesia but not, as you will see in Chapter 15, in cases of organic amnesia.

All of these forms of dissociative amnesia are similar in that the amnesia interferes mostly with a person’s memory of personal material. Memory for abstract or encyclopedic information usually remains. People with dissociative amnesia are as likely as anyone else to know the name of the president of the United States and how to write, read, or drive a car.

Clinicians do not know how common dissociative amnesia is (Pope et al., 2007), but they do know that many cases seem to begin during serious threats to health and safety, as in wartime and natural disasters (Cardena & Gleaves, 2007). Combat soldiers often report memory gaps of hours or days, and some forget personal information, such as
their names and addresses (Bremner, 2002). It appears that childhood abuse, particularly child sexual abuse, can also sometimes trigger dissociative amnesia; indeed, the 1990s witnessed many reports in which adults claimed to recall long-forgotten experiences of childhood abuse. In addition, dissociative amnesia may occur under more ordinary circumstances, such as the sudden loss of a loved one through rejection or death or guilt over certain actions (for example, an extramarital affair) (Koh et al., 2000).

The personal impact of dissociative amnesia depends on how much is forgotten. Obviously, an amnestic episode of two years is more of a problem than one of two hours. Similarly, an amnestic episode during which a person’s life changes in major ways causes more difficulties than one that is quiet.

**Dissociative Fugue**

People with a **dissociative fugue** not only forget their personal identities and details of their past lives but also flee to an entirely different location (see again Table 6–4). Some individuals travel a short distance and make few social contacts in the new setting (APA, 2000). Their fugue may be brief—a matter of hours or days—and end suddenly. In other cases, however, the person may travel far from home, take a new name, and establish a new identity, new relationships, and even a new line of work. Such people may also display new personality characteristics; often they are more outgoing (APA, 2000). This pattern is seen in the century-old case of the Reverend Ansel Bourne:

> On January 17, 1887, [the Reverend Ansel Bourne, of Greene, R.I.] drew $551 dollars from a bank in Providence with which to pay for a certain lot of land in Greene, paid certain bills, and got into a Pawtucket horsecar. This is the last incident which he remembers. He did not return home that day, and nothing was heard of him for two months. He was published in the papers as missing, and foul play being suspected, the police sought in vain his whereabouts. On the morning of March 14th, however, at Norristown, Pennsylvania, a man calling himself A. I. Brown who had rented a small shop six weeks previously, stocked it with stationery, confectionery, fruit and small articles, and carried on his quiet trade without seeming to any one unnatural or eccentric, woke up in a fright and called in the people of the house to tell him where he was. He said that his name was Ansel Bourne, that he was entirely ignorant of Norristown, that he knew nothing of shop-keeping, and that the last thing he remembered—it seemed only yesterday—was drawing the money from the bank, etc. in Providence. . . . He was very weak, having lost apparently over twenty pounds of flesh during his escapade, and had such a horror of the idea of the candy-store that he refused to set foot in it again.

*(James, 1890, pp. 391–393)*

Approximately 0.2 percent of the population experience dissociative fugue. Like dissociative amnesia, a fugue usually follows a severely stressful event (Cardena & Gleave, 2007; APA, 2000). Some adolescent runaways may be in a state of fugue (Loevenstein, 1991). Like cases of dissociative amnesia, fugues usually affect personal memories rather than encyclopedic or abstract knowledge (Maldonado & Spiegel, 2007).

Fugues tend to end abruptly. In some cases, as with Reverend Bourne, the person “awakens” in a strange place, surrounded by unfamiliar faces, and wonders how he or she got there. In other cases, the lack of personal history may arouse suspicion. Perhaps a traffic accident or legal problem leads police to discover the false identity; at other times friends search for and find the missing person. When people are found before their state of fugue has ended, therapists may find it necessary to ask them many questions
about the details of their lives, repeatedly remind them who they are, and even begin psychotherapy before they recover their memories. As these people recover their past, some forget the events of the fugue period (APA, 2000).

The majority of people who experience dissociative fugue regain most or all of their memories and never have a recurrence. Since fugues are usually brief and totally reversible, individuals tend to experience few aftereffects. People who have been away for months or years, however, often do have trouble adjusting to the changes that have occurred during their flights. In addition, some people commit illegal or violent acts in their fugue state and later must face the consequences.

**Dissociative Identity Disorder (Multiple Personality Disorder)**

Dissociative identity disorder is both dramatic and disabling, as we see in the case of Eric:

*Dazed and bruised from a beating, Eric, 29, was discovered wandering around a Daytona Beach shopping mall on Feb. 9. . . . Transferred six weeks later to Daytona Beach’s Human Resources Center, Eric began talking to doctors in two voices: the childish rhythms of “young Eric,” a dim and frightened child, and the measured tones of “older Eric,” who told a tale of terror and child abuse. According to “older Eric,” after his immigrant German parents died, a harsh stepfather and his mistress took Eric from his native South.*

*The Flores family of Wichita, Kansas received an early Christmas present this year when their beloved dog Bear, who had disappeared in November of 1997, made it back home in time for Thanksgiving in 2003. Jeanie Flores looked out the window of her house two days before Thanksgiving to see a dog that looked exactly like Bear standing outside. She recalls thinking, “Oh my God. I think that’s my dog!” She called the dog; and he responded.

Jeanie burst into tears, then called her husband Frank and told him she thought Bear was really home. Frank Flores rushed home and, after seeing the dog, agreed with his wife that the brindle lab-chow mix was indeed their Bear. One of the family’s neighbors told them she had spotted Bear a little earlier, walking around and carefully scrutinizing the houses.

A veterinarian who examined Bear said that although his paws were red and sore in spots, probably from pounding the pavement, he only weighed one pound less than when he disappeared. It appeared that someone had been taking care of him.

Bear had disappeared in 1997 about one month after the Flores family had moved to a new neighborhood. Jeanie let him out for exercise one night, and he never came back. “I waited up all night for him, and he never came home,” she said.

At the time, Bear’s ID tag had not yet been updated with his new address. The desperate family put up signs, canvassed their old neighborhood, ran ads in the paper, and visited shelters, but, tragically, the dog that Mr. Flores had brought home as a puppy in 1990 seemed to have disappeared without a trace.

Since his extraordinary return home six years later, Bear has been catching up on his sleep and getting re-acquainted with his family, which includes a son who was not yet born when the dog disappeared.

The Flores family said they just wish that Bear could tell them where he’s been all this time. “Where was he? We don’t know how rough a life he’s had,” Frank Flores said.*
Dissociative identity disorder is a disorder in which a person develops two or more distinct personalities. Also known as multiple personality disorder.

Subpersonalities are the two or more distinct personalities found in individuals suffering with dissociative identity disorder. Also known as alternate personalities.

### DSM Checklist

**Dissociative Identity Disorder (Multiple Personality Disorder)**

1. The presence of two or more distinct identities or personality states.
2. Control of the person’s behavior recurrently taken by at least two of these identities or personality states.
3. An inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

*Based on APA, 2000.*

A person with dissociative identity disorder, or multiple personality disorder, develops two or more distinct personalities, often called subpersonalities or alternate personalities, each with a unique set of memories, behaviors, thoughts, and emotions (see Table 6-5). At any given time, one of the subpersonalities takes center stage and dominates the person’s functioning. Usually one subpersonality, called the primary, or host, personality, appears more often than the others.

The transition from one subpersonality to another, called switching, is usually sudden and may be dramatic (APA, 2000). Eric, for example, twisted his face, growled, and yelled obscenities while changing personalities. Switching is usually triggered by a stressful event, although clinicians can also bring about the change with hypnotic suggestion (APA, 2000).

Cases of dissociative identity disorder were first reported almost three centuries ago (Rieber, 2002). Many clinicians consider the disorder to be rare, but some reports suggest that it may be more common than was once thought (Sar et al., 2007; APA, 2000). Most cases are first diagnosed in late adolescence or early adulthood, but, more often than not, the symptoms actually began in early childhood after episodes of abuse (often sexual abuse), perhaps even before the age of 5 (Maldonado & Spiegel, 2007; Roe-Sepowitz et al., 2007). Women receive this diagnosis at least three times as often as men (APA, 2000).

### How Do Subpersonalities Interact?

How subpersonalities relate to or recall one another varies from case to case. Generally, however, there are three kinds of relationships. In *mutually amnesic relationships*, the subpersonalities have no awareness of one another (Ellenberger, 1970). Conversely, in *mutually cognizant patterns*, each subpersonality is well aware of the rest. They may hear one another’s voices and even talk among themselves. Some are on good terms, while others do not get along at all.

In *one-way amnesic relationships*, the most common relationship pattern, some subpersonalities are aware of others, but the awareness is not mutual (Huntjens et al., 2005). Those who are aware, called *co-conscious subpersonalities*, are “quiet observers” who watch the actions and thoughts of the other subpersonalities but do not interact with them. Sometimes while another subpersonality is present, the co-conscious personality makes itself known through indirect means, such as auditory hallucinations (perhaps a voice giving commands) or “automatic writing” (the current personality may find itself writing down words over which it has no control).
Investigators used to believe that most cases of dissociative identity disorder involved two or three subpersonalities. Studies now suggest, however, that the average number of subpersonalities per patient is much higher—15 for women and 8 for men (APA, 2000). In fact, there have been cases in which 100 or more subpersonalities were observed. Often the subpersonalities emerge in groups of two or three at a time.

In the case of “Eve White,” made famous in the book and movie The Three Faces of Eve, a woman had three subpersonalities—Eve White, Eve Black, and Jane (Thigpen & Cleckley, 1957). Eve White, the primary personality, was quiet and serious; Eve Black was carefree and mischievous; and Jane was mature and intelligent. According to the book, these three subpersonalities eventually merged into Evelyn, a stable personality who was really an integration of the other three.

The book was mistaken, however; this was not to be the end of Eve’s dissociation. In an autobiography 20 years later, she revealed that altogether 22 subpersonalities had come forth during her life, including 9 subpersonalities after Evelyn. Usually they appeared in groups of three, and so the authors of The Three Faces of Eve apparently never knew about her previous or subsequent subpersonalities. She has now overcome her disorder, achieving a single, stable identity, and has been known as Chris Sizemore for over 30 years (Sizemore, 1991).

**How Do Subpersonalities Differ?** As in Chris Sizemore’s case, subpersonalities often exhibit dramatically different characteristics. They may also have their own names and different identifying features, abilities and preferences, and even physiological responses.

**IDENTIFYING FEATURES** The subpersonalities may differ in features as basic as age, gender, race, and family history, as in the famous case of Sybil Dorsett. Sybil’s dissociative identity disorder has been described in fictional form (in the novel *Sybil*) but is based on the real case of a patient named Shirley Ardell Mason, from the practice of psychiatrist Cornelia Wilbur (Schreiber, 1973). Sybil displayed 17 subpersonalities, all with different identifying features. They included adults, a teenager, and a baby named Ruthie; two were male, named Mike and Sid. Sybil’s subpersonalities each had particular images of themselves and of each other. The subpersonality named Vicky, for example, saw herself as an attractive blonde, while another, Peggy Lou, was described as a pixie with a pug nose. Mary was plump with dark hair, and Vanessa was a tall redhead with a willowy figure.

**ABILITIES AND PREFERENCES** Although memories of abstract or encyclopedic information are not usually affected in dissociative amnesia or fugue, they are often disturbed in dissociative identity disorder. It is not uncommon for the different subpersonalities to have different abilities: One may be able to drive, speak a foreign language, or play a musical instrument, while the others cannot (Coons & Bowman, 2001; Coons et al., 1988). Their handwriting can also differ. In addition, the subpersonalities usually have different tastes in food, friends, music, and literature. Chris Sizemore (“Eve”) later pointed out, “If I had learned to sew as one personality and then tried to sew as another, I couldn’t do it. Driving a car was the same. Some of my personalities couldn’t drive” (Sizemore & Pirillo, 1977, p. 4).

**PHYSIOLOGICAL RESPONSES** Researchers have discovered that subpersonalities may have physiological differences, such as differences in autonomic nervous system activity, blood pressure levels, and allergies (Putnam, Zahn, & Post, 1990). One study looked at the brain activities of different subpersonalities by measuring their *evoked potentials*—that is, brain-response patterns recorded on an electroencephalograph (Putnam, 1984). The brain pattern a person produces in response to a specific stimulus (such as a flashing light) is usually unique and consistent. However, when an evoked potential test was administered to four subpersonalities of each of 10 people with dissociative identity disorder, the results were dramatic. The brain-activity pattern of each subpersonality was unique, showing the kinds of variations usually found in totally different people.

**How Common Is Dissociative Identity Disorder?** As you have seen, dissociative identity disorder has traditionally been thought of as rare. Some researchers even argue...
Real or not real?
False claims of dissociation are sometimes used to excuse bad deeds or cover up illegal acts. In 2007, former teacher John Darwin walked into a police station and said that he had no memory of the events that had taken place in his life since his disappearance five years earlier while canoeing off Britain’s coast. An investigation revealed, however, that his disappearance was a case of life insurance fraud. Shortly after Darwin had been declared dead, he and his wife had collected the insurance money, paid off their debts, and moved to Panama. Here a police officer holds up the photo Darwin had used on a fake passport.

How Do Theorists Explain Dissociative Disorders?
A variety of theories have been proposed to explain dissociative disorders. Older explanations, such as those offered by psychodynamic and behavioral theorists, have not received much investigation (Merenda, 2008). However, newer viewpoints, which combine cognitive, behavioral, and biological principles and highlight such factors as state-dependent learning and self-hypnosis, have captured the interest of clinical scientists.

The Psychodynamic View
Psychodynamic theorists believe that dissociative disorders are caused by repression, the most basic ego defense mechanism: People fight off anxiety by unconsciously preventing painful memories, thoughts, or impulses from reaching awareness. Everyone uses repression to a degree, but people with dissociative disorders are thought to repress their memories excessively (Fayek, 2002).

In the psychodynamic view, dissociative amnesia and fugue are single episodes of massive repression. In each of these disorders, a person unconsciously blocks the memory of an extremely upsetting event to avoid the pain of facing it (Turkington & Harris, 2009, 2001). Repressing may be their only protection from overwhelming anxiety.

In contrast, dissociative identity disorder is thought to result from a lifetime of excessive repression (Brenner, 2009, 1999; Wang & Jiang, 2007). Psychodynamic theorists believe that continuous use of repression is motivated by traumatic childhood events, particularly abusive parenting. Children who experience such traumas may come to fear the dangerous world they live in and take flight from it by pretending to be another person who is looking on safely from afar. Abused children may also come to fear the impulses that they believe are the reasons for their excessive punishments. Whenever they experience “bad” thoughts or impulses, they unconsciously try to disown and deny them by assigning them to other personalities.

that many or all cases are iatrogenic—that is, unintentionally produced by practitioners (Loewenstein, 2007; Piper & Merskey, 2005, 2004). They believe that therapists create this disorder by subtly suggesting the existence of other personalities during therapy or by explicitly asking a patient to produce different personalities while under hypnosis. In addition, they believe, a therapist who is looking for multiple personalities may reinforce these patterns by displaying greater interest when a patient displays symptoms of dissociation.

These arguments seem to be supported by the fact that many cases of dissociative identity disorder first come to attention while the person is already in treatment for a less serious problem. But such is not true of all cases; many people seek treatment because they have noticed time lapses throughout their lives or because relatives and friends have observed their subpersonalities (Putnam, 2000, 1988, 1985).

The number of people diagnosed with dissociative identity disorder has been increasing (Sar et al., 2007; Casey, 2001). Although the disorder is still uncommon, thousands of cases have now been diagnosed in the United States and Canada alone. Two factors may account for this increase. First, a growing number of today’s clinicians believe that the disorder does exist and are willing to diagnose it (Merenda, 2008; Lalonde et al., 2002, 2001). Second, diagnostic procedures tend to be more accurate today than in past years. For much of the twentieth century, schizophrenia was one of the clinical field’s most commonly applied diagnoses. It was applied, often incorrectly, to a wide range of unusual behavioral patterns, perhaps including dissociative identity disorder (Turkington & Harris, 2009, 2001). Under the stricter criteria of recent editions of the DSM, clinicians are now more accurate in diagnosing schizophrenia, allowing more cases of dissociative identity disorder to be recognized (Welburn et al., 2003). In addition, several diagnostic tests have been developed to help detect dissociative identity disorder (Cardena, 2008). Despite such changes, however, many clinicians continue to question the legitimacy of this category (Lalonde et al., 2002, 2001).
Most of the support for the psychodynamic position is drawn from case histories, which report such brutal childhood experiences as beatings, cuttings, burnings with cigarettes, imprisonment in closets, rape, and extensive verbal abuse. Yet some individuals with dissociative identity disorder do not seem to have experiences of abuse in their background (Bliss, 1980). Moreover, child abuse appears to be far more common than dissociative identity disorder. Why might only a small fraction of abused children develop this disorder?

The Behavioral View  Behaviorists believe that dissociation is a response learned through operant conditioning (Casey, 2001). People who experience a horrifying event may later find temporary relief when their minds drift to other subjects. For some, this momentary forgetting, leading to a drop in anxiety, increases the likelihood of future forgetting. In short, they are reinforced for the act of forgetting and learn—without being aware that they are learning—that such acts help them escape anxiety. Thus, like psychodynamic theorists, behaviorists see dissociation as escape behavior. But behaviorists believe that a reinforcement process rather than a hardworking unconscious is keeping the individuals unaware that they are using dissociation as a means of escape. Like

“A CLOSER LOOK”

Peculiarities of Memory

Usually memory problems must interfere greatly with a person’s functioning before they are considered a sign of a disorder. Peculiarities of memory, on the other hand, fill our daily lives. Memory investigators have identified a number of these peculiarities—some familiar, some useful, some problematic, but none abnormal (Turkington & Harris, 2009, 2001; Mathews & Wang, 2007; Brown, 2004, 2003).

- Absentmindedness  Often we fail to register information because our thoughts are focusing on other things. If we haven’t absorbed the information in the first place, it is no surprise that later we can’t recall it.

- Déjà vu  Almost all of us have at some time had the strange sensation of recognizing a scene that we happen upon for the first time. We feel sure we have been there before.

- Jamais vu  Sometimes we have the opposite experience: A situation or scene that is part of our daily life seems suddenly unfamiliar. “I knew it was my car, but I felt as if I’d never seen it before.”

- The tip-of-the-tongue phenomenon  To have something on the tip of the tongue is an acute “feeling of knowing”: We are unable to recall some piece of information, but we know that we know it.

- Eidetic images  Some people experience visual afterimages so vividly that they can describe a picture in detail after looking at it just once. The images may be memories of pictures, events, fantasies, or dreams.

- Memory while under anesthesia  As many as 2 of every 1,000 anesthetized patients process enough of what is said in their presence during surgery to affect their recovery. In many such cases, the ability to understand language has continued under anesthesia, even though the patient cannot explicitly recall it.

- Memory for music  Even as a small child, Mozart could memorize and reproduce a piece of music after having heard it only once. While no one yet has matched the genius of Mozart, many musicians can mentally hear whole pieces of music, so that they can rehearse anywhere, far from their instruments.

- Visual memory  Most people recall visual information better than other kinds of information: They easily can bring to their mind the appearance of places, objects, faces, or the pages of a book. They almost never forget a face, yet they may well forget the name attached to it. Other people have stronger verbal memories: They remember sounds or words particularly well, and the memories that come to their minds are often puns or rhymes.
psychodynamic theorists, behaviorists have relied largely on case histories to support their view of dissociative disorders. Moreover, the behavioral explanation fails to explain precisely how temporary and normal escapes from painful memories grow into a complex disorder or why more people do not develop dissociative disorders.

**State-Dependent Learning** If people learn something when they are in a particular situation or state of mind, they are likely to remember it best when they are again in that same condition. If they are given a learning task while under the influence of alcohol, for example, their later recall of the information may be strongest under the influence of alcohol (Overton, 1966). Similarly, if they smoke cigarettes while learning, they may later have better recall when they are again smoking.

This link between state and recall is called state-dependent learning. It was initially observed in experimental animals who learned things while under the influence of certain drugs (Rezayof et al., 2008; Overton, 1966, 1964). Research with human participants later showed that state-dependent learning can be associated with mood states as well: Material learned during a happy mood is recalled best when the participant is again happy, and sad-state learning is recalled best during sad states (de l’Etoile, 2002; Bower, 1981) (see Figure 6–3).

What causes state-dependent learning? One possibility is that arousal levels are an important part of learning and memory. That is, a particular level of arousal will have a set of remembered events, thoughts, and skills attached to it. When a situation produces that particular level of arousal, the person is more likely to recall the memories linked to it. Although people may remember certain events better in some arousal states than in others, most can recall events under a variety of states. However, perhaps people who are prone to develop dissociative disorders have state-to-memory links that are unusually rigid and narrow. Maybe each of their thoughts, memories, and skills is tied exclusively to a particular state of arousal, so that they recall a given event only when they experience an arousal state almost identical to the state in which the memory was first acquired. When such people are calm, for example, they may forget what occurred during stressful times, thus laying the groundwork for dissociative amnesia or fugue.

Similarly, in dissociative identity disorder, different arousal levels may produce entirely different groups of memories, thoughts, and abilities—that is, different subpersonalities (Dorahy & Huntjens, 2007; Putnam, 1992). This could explain why personality transitions in dissociative identity disorder tend to be sudden and stress-related.

**Self-Hypnosis** As you first saw in Chapter 1, people who are hypnotized enter a sleep-like state in which they become very suggestible. While in this state, they can behave, perceive, and think in ways that would ordinarily seem impossible. They may, for example, become temporarily blind, deaf, or insensitive to pain. Hypnosis can also help people remember events that occurred and were forgotten years ago, a capability used by many psychotherapists. Conversely, it can make people forget facts, events, and even their personal identities—an effect called hypnotic amnesia.

The parallels between hypnotic amnesia and dissociative disorders are striking. Both are conditions in which people forget certain material for a period of time yet later remember it. And in both, the people forget without any insight into why they are forgetting or any awareness that something is being forgotten. These parallels have led some theorists to conclude that dissociative disorders may be a form of self-hypnosis in which people hypnotize themselves to forget unpleasant events (Maldonado & Spiegel, 2007, 2003). Dissociative amnesia may occur, for example, in people who, consciously or unconsciously, hypnotize themselves into forgetting horrifying experiences that have recently occurred in their lives. If the self-induced amnesia covers all memories of a person’s past and identity, that person may undergo a dissociative fugue.
Self-hypnosis might also be used to explain dissociative identity disorder. On the basis of several investigations, some theorists believe that this disorder often begins between the ages of 4 and 6, a time when children are generally very suggestible and excellent hypnotic subjects (Kluft, 2001, 1987; Bliss, 1985, 1980). These theorists argue that some children who experience abuse or other horrifying events manage to escape their threatening world by self-hypnosis, mentally separating themselves from their bodies and fulfilling their wish to become some other person or persons. One patient with multiple personalities observed, “I was in a trance often [during my childhood]. There was a little place where I could sit, close my eyes and imagine, until I felt very relaxed just like hypnosis” (Bliss, 1980, p. 1392).

How Are Dissociative Disorders Treated?

As you have seen, people with dissociative amnesia and fugue often recover on their own. Only sometimes do their memory problems linger and require treatment. In contrast, people with dissociative identity disorder usually require treatment to regain their lost memories and develop an integrated personality. Treatments for dissociative amnesia and fugue tend to be more successful than those for dissociative identity disorder, probably because the former disorders are less complex.

How Do Therapists Help People with Dissociative Amnesia and Fugue? The leading treatments for dissociative amnesia and fugue are psychodynamic therapy, hypnotic therapy, and drug therapy, although support for these interventions comes largely from case studies rather than controlled investigations (Maldonado & Spiegel, 2003). Psychodynamic therapists guide patients with these disorders to search their unconscious in the hope of bringing forgotten experiences back to consciousness (Bartholomew, 2000; Loewenstein, 1991). The focus of psychodynamic therapy seems particularly well suited to the needs of people with these disorders. After all, the patients need to recover lost memories, and the general approach of psychodynamic therapists is to try to uncover memories—as well as other psychological processes—that have been repressed. Thus many theorists, including some who do not ordinarily favor psychodynamic approaches, believe that psychodynamic therapy may be the most appropriate treatment for these disorders.

Another common treatment for dissociative amnesia and fugue is hypnotic therapy, or hypnotherapy (see Table 6-6 on the next page). Therapists hypnotize patients and then guide them to recall forgotten events (Degun-Mather, 2002). Given the possibility that dissociative amnesia and fugue may each be a form of self-hypnosis, hypnotherapy...
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may be a particularly useful intervention. It has been applied both alone and in combination with other approaches.

Sometimes intravenous injections of barbiturates such as sodium amobarbital (Amytal) or sodium pentobarbital (Pentothal) are used to help patients with dissociative amnesia and fugue regain lost memories. These drugs are often called “truth serums,” but the key to their success is their ability to calm people and free their inhibitions, thus helping them to recall anxiety-producing events (Fraser, 1993; Kluft, 1988). These drugs do not always work, however, and if used at all, they are likely to be combined with other treatment approaches (Spiegel, 1994).

How Do Therapists Help Individuals with Dissociative Identity Disorder?

Unlike victims of amnesia and fugue, people with dissociative identity disorder do not typically recover without treatment (Maldonado & Spiegel, 2003; Spiegel, 1994). Treatment for this pattern is complex and difficult, much like the disorder itself. Therapists usually try to help the clients (1) recognize fully the nature of their disorder, (2) recover the gaps in their memory, and (3) integrate their subpersonalities into one functional personality (North & Yutzy, 2005; Kihlstrom, 2001).

RECOGNIZING THE DISORDER

Once a diagnosis of dissociative identity disorder is made, therapists typically try to bond with the primary personality and with each of the subpersonalities (Kluft, 1999, 1992). As bonds are formed, therapists try to educate patients and help them to recognize fully the nature of their disorder (Kluft, 2001; Allen, 1993). Some therapists actually introduce the subpersonalities to one another under hypnosis, and some have patients look at videotapes of their other personalities (Ross & Gahan, 1988; Sakheim et al., 1988). Many therapists have also found that group therapy helps to educate patients (Fine & Madden, 2000). In addition, family therapy may be used to help educate spouses and children about the disorder and to gather helpful information about the patient (Kluft, 2001, 2000).

RECOVERING MEMORIES

To help patients recover the missing pieces of their past, therapists use many of the approaches applied in other dissociative disorders, including psychodynamic therapy, hypnotherapy, and drug treatment (Kluft, 2001, 1991, 1985). These techniques work slowly for patients with dissociative identity disorder, as some subpersonalities may keep denying experiences that the others recall (Lyon, 1992). One of the subpersonalities
Dissociative Disorders experience major changes in memory and identity that are not caused by clear physical factors. People with dissociative amnesia are suddenly unable to recall important personal information or past events in their lives. Those with dissociative fugue not only fail to remember their personal identities but also flee to a different location and may establish a new identity. In dissociative identity disorder (multiple personality disorder), people display two or more distinct subpersonalities. The number of people diagnosed with dissociative identity disorder has increased in recent years.

The dissociative disorders are not well understood. Among the processes that have been cited to explain them are extreme repression, operant conditioning, state-dependent learning, and self-hypnosis. The latter two phenomena, in particular, have excited the interest of clinical scientists.

Dissociative amnesia and fugue may end on their own or may require treatment. Dissociative identity disorder typically requires treatment. Approaches commonly used to help people with dissociative amnesia and fugue recover their lost memories are psychodynamic therapy, hypnotic therapy, and sodium amobarbital or sodium pentobarbital. Therapists who treat people with dissociative identity disorder use the same approaches but further focus on trying to help the clients recognize the scope of their disorder, recover the gaps in their memory, and integrate their subpersonalities into one functional personality.

INTEGRATING THE SUBPERSONALITIES

The final goal of therapy is to merge the different subpersonalities into a single, integrated identity. Integration is a continuous process that occurs throughout treatment until patients “own” all of their behaviors, emotions, sensations, and knowledge. Fusion is the final merging of two or more subpersonalities. Many patients distrust this final treatment goal, and their subpersonalities may see integration as a form of death (Kluft, 2001, 1999, 1991). Therapists have used a range of approaches to help merge subpersonalities, including psychodynamic, supportive, cognitive, and drug therapies (Goldman, 1995; Fichtner et al., 1990).

Once the subpersonalities are integrated, further therapy is typically needed to maintain the complete personality and to teach social and coping skills that may help prevent later dissociations. In case reports, some therapists note high success rates (Rothschild, 2009; Coons & Bowman, 2001), but others find that patients continue to resist full integration. A few therapists have in fact questioned the need for full integration.

PUTTING IT TOGETHER

Disorders Rediscovered

Somatoform and dissociative disorders are among the clinical field’s earliest identified psychological disorders. Indeed, as you read in Chapter 1, they were key to the development of the psychogenic perspective. Despite this early impact, the clinical field stopped paying much attention to these disorders during the middle part of the twentieth century. The feeling among many clinical theorists was that the number of such cases was shrinking. And more than a few questioned the legitimacy of the diagnoses.

Much of that thinking has changed in the past two decades. The field’s keen interest in the impact of stress upon health and physical illness has, by association, reawakened interest in somatoform disorders. Similarly, as you will see in Chapter 15, the field has...
The past is never dead, it is not even past.

William Faulkner

There are lots of people who mistake their imagination for their memory.

Josh Billings

greatly intensified its efforts to understand and treat Alzheimer’s disease in recent years, and that work has sparked a broad interest in the operation of memory, including an interest in dissociative disorders.

Over the past 25 years there has been an explosion of research seeking to help clinicians recognize, understand, and treat unexplained physical and memory disorders. Although this research has yet to produce clear insights or highly effective treatments, it has already suggested that the disorders may be more common than clinical theorists had come to believe. Moreover, there is growing evidence that the disorders may be rooted in processes that are already well known from other areas of study, such as overattentiveness to bodily processes, cognitive misinterpretations, state-dependent learning, and self-hypnosis. Given this new wave of research enthusiasm, we may witness significant growth in our understanding and treatment of these disorders in the coming years.

At the same time, many of today’s clinicians worry that the focus on somatoform and dissociative disorders is swinging back too far—that the high degree of interest in them may be creating a false impression of their prevalence or importance (Pope et al., 2007; Piper & Merskey, 2004). Some clinicians note, for example, that physicians are often quick to assign the label “somatoform” to elusive medical problems such as chronic fatigue syndrome and lupus—clearly a disservice to patients with such severe problems and to the progress of medical science. Similarly, a number of clinicians worry that at least some of the many legal defenses based on dissociative identity disorder or other dissociative disorders are contrived or inaccurate. Of course, such possibilities serve to highlight even further the importance of continued investigations into all aspects of the disorders.

1. Why do the terms “hysteria” and “hysterical” currently have such negative connotations in our society, as in “mass hysteria” and “hysterical personality”? pp. 164–169

2. If parents who harm their children are clearly disturbed, as in cases of Munchausen syndrome by proxy, how should society react to them? Which is more appropriate—treatment or punishment? p. 168

3. How might a culture help create cases of body dysmorphic disorder? pp. 169–173

4. Periodically we hear in the news about missing individuals who show up suddenly, claiming to have lost their memories while away. Although disorders such as dissociative amnesia and fugue are listed in DSM-IV-TR, many people greet such explanations with skepticism. Why? pp. 176–181

5. Some accused criminals claim that they have dissociative identity disorder and that their crimes were committed by one of their subpersonalities. If such claims are accurate, what would be an appropriate verdict? pp. 181–187

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1. What are the symptoms of each of the hysterical somatoform disorders? How do practitioners distinguish hysterical disorders from "genuine" medical problems? pp. 164–167


3. List the central features of each of the preoccupation somatoform disorders. pp. 169–170

4. What are the leading explanations and treatments for the somatoform disorders? How well does research support them? pp. 170–176

5. List and describe the different dissociative disorders. pp. 176–184

6. What are four kinds of dissociative amnesia? pp. 177–180

7. What are the different kinds of relationships that the subpersonalities may have in dissociative identity disorder? pp. 182–183

8. Describe the psychodynamic, behavioral, state-dependent learning, and self-hypnosis explanations of dissociative disorders. How well is each supported by research? pp. 184–187

9. What approaches have been used to treat dissociative amnesia and dissociative fugue? pp. 187–188

10. What are the key features of treatment for dissociative identity disorder? Is treatment successful? pp. 188–189

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