Understanding Dissociative Disorders

A Guide for Family Physicians and Health Care Professionals

Marlene E. Hunter, MD

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Introduction

How Did I Get Into This? or, What's a Nice Girl Like You Doing in Such a Psychotherapeutic Minefield?

I saw my first dissociative patient (at least the first one that I recognized) in 1977.

I am a family physician. I had become very interested in the medical and psychological uses of hypnosis in 1972, and within five years it had become a routine part of my everyday practice. When a colleague phoned to say that she was moving out of town and asked if I would accept one of her patients ("I know you're not taking new patients, Marlene, but this woman really needs you"), I agreed.

Thus began a journey that never in my wildest imaginings would I have anticipated—a view into the inner world of the highly dissociative patient. Slowly, I realized that I had another such patient in my very own family practice, and yet another.

She was a pleasant and intelligent patient, and I liked her immediately. In her late twenties, she had a very responsible job in the government offices, which she did well. However, she drove me to distraction, because I never knew where I was at with her. She suffered from terrible headaches; I would prescribe the newest pharmaceutical miracle, she would phone me from work and say, "That medicine is wonderful—why didn't you give it to me earlier?" And then, three hours later, she would be sitting in my office and when she saw me would glare at me and say, "What did you give me that crap for? It isn't worth the paper it's printed on!"

I will call her Jayere, because that is the name I have given her in various papers that I have presented.

Jayere had a documented history of early child abuse. My colleague had done some hypnosis with her and taken her (in hypnosis and at the patient's request) back to a birth experience, in which Jayere reported that she had heard her mother say, "Take the little bitch away."

Now, whether that really happened is not the issue. The issue is that this is what she believed, and if that is how one believes one has been greeted on entering this world, it doesn't bode well for one's future emotional harmony.

In fact, the birth mother deserted the child and the husband when Jayere was three weeks old. The husband, not well educated and in a laboring job, with absolutely no knowledge or experience of children let alone a weeks-old baby, passed her around to various friends so that he could go to work. Ultimately, at the age of thirteen months, she was found on the beach, wrapped in newspaper and left for dead, having been hit in the head with a beer bottle. Bits of beer bottle glass were embedded in her tiny scalp.

She was in several foster homes over the next few years and, at the age of five, was adopted into a family where (as she told me) strict discipline was the order of the day.

As our doctor—patient relationship became established and grew, I became more and more confused. She had had, from previous family doctors, twelve psychiatric referrals. These resulted in twelve diagnoses. I made the thirteenth referral, and thus she received the thirteenth diagnosis—that she had a neurological disorder, not a psychiatric problem. The neurologist, however, said in no uncertain terms that she had a psychiatric problem, not a neurological disorder, although he could not account for the fact that on two separate occasions she had had two distinctly different EEGs.

One day, some months after she had come in to my practice, I was at an American Society of Clinical Hypnosis meeting, where there was an opportunity to discuss problem cases with one of the older

physicians or psychologists. Serendipity found me with a psychiatrist from California, Dr. Donald Schafer, who listened very carefully and asked some pertinent questions. Finally he leaned back in his chair and said, "Have you ever thought of multiple personality disorder?"

I'm sure I blanched. "No," I croaked.

"Well, I think you *should* think about it. She has all the criteria."

So I thought about it. And did nothing. And then, several months later, at another hypnosis meeting, I was listening to Dr. Jack Watkins talking about "MPD" (as it was called then) and I said to myself, "Marlene, why are you refusing to believe your own eyes and ears? He is talking about your own patient."

So, with gritted teeth and feeling scared stiff, I gathered all my courage together at one of my next meetings with Jayere and asked, while she was in hypnosis (we were working on relieving the headaches), "Is there any other part of you who would like to come and speak with me?"

And this entirely different voice gruffly said, "Of course! What took you so long?"

What does "dissociative disorder" mean?

In essence, dissociative disorder means an incredible ability to compartmentalize one's mind—but to the point where, in the adult, it often becomes dysfunctional rather than useful.

The term "multiple personality disorder" did a great injustice to the field of dissociative disorders, in my opinion. Although coined with the best of intentions, it was flamboyant and melodramatic and, as we now know, wrong. Dissociative patients do not have multiple personalities: they have a personality structure that is separated into neat little categories and therefore compartmentalized. My metaphor is of a post office, with many post office

boxes. Some of the boxes are closed, some locked tight, some with doors ajar—but there is *only one post office*.

The new term, *dissociative identity disorder*, is more accurate—and less pejorative. Many patients have all, or almost all, of the post office boxes open: it is then termed DDNOS—*dissociative disorder not otherwise specified*. The terminology alone is enough to send you screaming in the opposite direction.

The professional jargon for my "post office boxes" is *ego states*. We all have ego states: I explain to my patients that I am a slightly different person sitting here in the office than I am at home, different as a wife than I am as a mother, different in the lecture hall than when I'm enjoying myself with my friends. It's normal. I'm lucky, however—all my ego states know each other so all the post office boxes are wide open; indeed, there are only little screens between them instead of metal walls. It is when there are amnesia barriers between the ego states, so that they do not know each other, that we have a true dissociative disorder.

We used to think that all dissociative disorders were the result of severe emotional, sexual, or physical childhood trauma, especially when the child was very young and the trauma was ongoing, and it is sadly true that that is very often the background. However, there has always been the occasional patient in whom we have not been able to attribute the dissociative symptomatology to such a history. Such anomalies have ultimately led to a whole new understand and basis: the *attachment theory*, first described by Dr. J. Bowlby (1969).

This theory proposes that some children, as very tiny babies, do not have the warm experience of learning a sense of positive attachment—in other words, they have a less than perfect sense of security and trust—to the primary caregiver, who is usually the mother. Instead, they may grow up being somewhat ambivalent about it, or even avoid issues that would demand that the mother show her emotional reliability. This does not necessarily imply abuse, or neglect. It could be that the mother is suffering post partum depression, for example, or her husband is going off to war, or the baby itself is in the hospital, or any one of many other possibilities where there is an interference in the normal

Chapter Nine
Comorbid States Associated with Dissociation

Depression

When we are considering and assessing possible comorbid states in patients who have a dissociative disorder, the question sometimes becomes, "Which diagnosis comes first?"

For example, virtually all people who are markedly dissociative, and are diagnosed with DID, will have a depressed ego state. During the time when that ego state is "out", the whole aspect of the patient is one of severe depression. At times, a severely depressed ego state will negatively affect the functioning of the whole system, and is one good reason for prescribing antidepressants, especially the SSRIs. Of course, one runs into the rebellion of other ego states who do not want to take the medication, but the answer there is fairly straightforward: "She needs it, she takes it; if you don't need it, you don't have to take it but the dose must be given to the body so that she can have it."

Depression is also commonly found in patients with DDNOS and those who suffer form PTSD. Once again, we must decide which is the primary diagnosis as far as we are concerned—the PTSD or the depression. This decision has a role in the way therapy is organized, and although this is primarily the purview of the therapist, it is the family physician who monitors the whole patient from a physiological-function standpoint. Discussion with the psychotherapist may be very important; at times therapy needs to be put on hold until the depression is brought under control.

Borderline personality disorder

What a horrible name for a condition that is! It makes the patient think of herself as not quite a person. And BPD patients are treated that way, too: as pariahs, socially, in family life, at work, and in the doctor's office.

There is a large overlap: about 60 percent of patients who are dissociative also fit the criteria for BPD. (On the other hand, it does not go the other way, with 60 percent of borderline personality patients being dissociative.) The reason for the overlap is not hard to find: both stem from the same source—growing up in a highly dysfunctional family. I usually explain to them, to ease their mortification when they are told about the coexisting diagnosis (as one does for assessment purposes, for example) that they simply did not have the opportunity to learn good coping skills when they were small so they are still coping the way they did when they were five years old. Thus, part of the task of therapy is for them to learn new, better ways of coping.

It's an uphill struggle. BPD patients are inevitably cast as manipulative, domineering, demanding, exasperating, and not wanting to get well. All of those apply, except the last one: in fact, they are fiercely anxious to get well. Unfortunately, they haven't learned or understood that getting well is their job and not ours. Ours is to help them; we can't do it for them. As we pursue the goal with them, it is our job to manage our own countertransference. And that may be a challenge!

Suicide and self-harm

As there is usually one ego state who is very depressed, there is also usually one ego state who frequently appears to be suicidal. It may not be the depressed part, but instead a part who truly believes that it would be best for "Mary" (the host) if she were dead and Mary is somehow convinced of the appropriateness of this decision.

Let us look first at the depressed part. Calls from the emergency room to say that the patient has been brought in as a probable suicide attempt are certainly not rare. Such attempts are seldom fatal, however. I think the other parts of the system prevent the suicidal one from carrying out the plan. It is even more common for an ego state who assumes the role of informer to phone and tell you that Mary is planning to kill herself that evening. This call comes, of course, just as you are getting ready to go out to dinner. (All this is avoided for the family physician if the patient calls the therapist, instead, in these situations. You can encourage this. It is not being nasty: it is being realistic. Probably the therapist has better skills than the family physician in dealing with suicidal ideation.)

Staying in the hospital overnight is probably a good idea. The patient is safe, it gives a breathing period, and the other parts of the personality can come to the fore. It must be addressed, however. Otherwise, it is still simmering under the surface and the protectors in the system will come to the conclusion that you don't care.

There is another aspect that appears to be suicidal but in reality is a plan to kill a suffering ego state, in the belief that it will do her a favor, as we saw a little earlier. You may be astonished at how difficult it is to persuade the ego state who is advocating this action, that she (the advocate) would die also. "I'm not her" is the response. It only confirms how disparate their sense of self really is.

Self-harm is also a common feature of dissociative disorders, although it is not so prominent in PTSD. Cutting is the main form, but hitting and burning with cigarettes are also frequently found. The rationale is always the same: "It lets the pain out." The patients always heal well and quickly, often with no medical intervention at all. There is a book called *A Bright Red Scream* (Strong, 1998), which is about self-harm through cutting. I think the title explains it very well.

Patients are often very embarrassed to confess to the self-harm, believing that we will despise them. Here is one place where the family physician can be truly helpful to the patient. Listen

"Primary care physicians and healthcare workers should avidly turn to this succinct guide for easy-to-institute methods to assist a special class of patients—those who are especially difficult to identify and treat. Marlene Hunter is world renowned for her work with medical hypnosis and dissociative disorders. Eminently readable; eminently practical."

Jeffrey K. Zeig, PhD, Director,
The Milton H. Erickson Foundation, www.erickson-foundation.org

"Dissociative disorder" has come to mean an incredible ability to compartmentalize one's mind to a degree which, in the adult, often becomes dysfunctional rather than useful. This book is for all family physicians and mental health professionals who come face to face with the idiosyncrasies of dissociative patients—their problematic ways of responding to medication, the unusual laboratory results, and a multitude of physical and emotional symptoms.

Marlene Hunter, MD offers realistic, practical answers to questions, some of which professionals won't even have thought of asking.

Carefully organized for easy reference, this volume discusses what you can do and what you cannot, where and how to ask for outside help, and how to talk to your patient. More importantly, it explains what leads patients to their own solutions even when these seem utterly unrealistic on the surface.

Family physicians and health care professionals should be the first to recognize these complex disorders. They see the discrepancies, the unexplained and unexplainable symptoms, the distress and, often, the agony. This book will become a beacon for all professionals who want to help their patients and their families come to grips with this debilitating disorder.

Marlene E. Hunter, MD is a family physician who began to work with highly dissociative patients in 1977. She is a Certificant and Fellow of the College of Family Physicians of Canada and a past Associate Clinical Professor at the University of British Columbia in the Department of Family Medicine. She is a past president of the American Society of Clinical Hypnosis, the Canadian Society of Clinical Hypnosis (B. C. Division), the B. C. College of Family Physicians and the International Society for the Study of Dissociation (ISSD).

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