

DISSOCIATING
DISSOCIATION:
A COMMENTARY
ON DR. GARCIA'S
ARTICLE

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A psychiatrist familiar with dissociation has referred to psychiatry as "the study of the diseases of theories" (H. Spiegel, personal communication, 1980). A systematic effort has been made in recent years to distinguish our classification schemes of disease from the various theories which help us understand and treat it. Thus, the *DSM-III* was designed to be atheoretical, based upon the phenomenology of disorders rather than etiology. As noted in Dr. Garcia's paper, this contributed to the demise of the term "neurosis," and produced the dissociation of dissociative from conversion disorders. The argument that a common dissociative mechanism underlay the cognitive and somatic dissociative symptoms yielded to the descriptive approach, which placed greater value on the distinctions between somatic and cognitive presentations in the *DSM-III-R*. As Dr. Garcia notes, the dissociative disorders were accorded their own section, but stripped of conversion disorder, which was classified with the somatoform disorders.

This, in turn, leaves us with a new distinction within the somatoform disorders. Conversion disorder patients present with dramatic somatic manifestations and often strangely little cognitive concern about them, *la belle indifférence*, while in patients with disorders such as hypochondriasis there is little in the way of somatic symptoms and much in the way of cognitive preoccupation with them. Something has been lost in this separation of conversion from dissociation (Nemiah, 1991), primarily recognition of the shifting manifestations of an underlying dissociative disorder. For example, Ross and his colleagues have found an extraordinarily high percentage of conversion symptoms in patients with multiple personality disorder (Ross, Heber, Norton, & Anderson, 1989). This is but one example of a problem that pervades nosological systems designed to clarify distinctions between disorders and differentiate them on the basis of symptom patterns. This has unleashed a torrent of publications on comorbidity. We discovered that our pristine classifications rarely work in nature and that many patients who have common underlying mechanisms have common presentation of symptoms.

Dr. Garcia is also correct in pointing out that one ground for the revived interest in dissociation is the observation that

dissociative symptoms are frequent sequelae of physical and sexual trauma (Spiegel, D., 1984; Putnam, 1986; Spiegel, Hunt, & Dondershine, 1988; Terr, 1991; Kluft, 1984; Frischholz, 1985). One of the things that is strikingly new and exciting in the study of dissociation is the recognition of dissociation as a defense against trauma as it is occurring and the fact that dissociative disorders seem to be chronic post traumatic stress disorders, a response to trauma, especially when inflicted in childhood (Spiegel, D., 1991).

This has led to a proposal from the Dissociative Disorders Work Group for DSM-IV that a new diagnostic category, brief reactive dissociative disorder, be included in the DSM-IV (Spiegel, Spitzer, & Cardena, 1989). This new diagnostic category includes stressor criteria similar to that for post traumatic stress disorder, along with the symptoms such as psychogenic amnesia and withdrawal, stupor, depersonalization and derealization experiences, not connected to conscious recollection of the trauma itself. Furthermore, it is required that these symptoms lead to dysfunction, such as failing to obtain needed legal and medical help in the wake of the trauma. This new category is most similar to the acute stress response category in the *ICD-9* and *ICD-10*, and it fills a gaping hole in the current nosology. An acute response to trauma cannot be called post traumatic stress disorder until a month after the trauma occurs, and the only other available category is one of the adjustment disorders, which hardly describes the magnitude of response to physical trauma. In addition the acute stress reaction category in the *ICD* includes anxiety, hyperactivity and aggressive symptoms.

Other proposed changes for the DSM-IV include revision of psychogenic amnesia to note that it usually occurs after an event of a traumatic or stressful nature, and the amnesia is not required to be of sudden onset. The amnesia requirement has also been reintroduced for multiple personality disorder, both in an effort to make the diagnostic criteria more stringent and out of the observation that amnesia is an almost universal symptom in MPD patients, although they often may not be aware of it (Kluft, 1987; Ross et al., 1989). There has been a proposal for the equivalent of dissociative disorder secondary to organic conditions, tentatively called secondary dissociative disorder. It is possible, that this diagnostic entity will be included in the DSM-IV. What evidence there was that dissociative symptoms occur secondary to an organic disorder such as complex partial seizures, (Bear & Fedio, 1977; Schenk & Bear, 1981) has not been confirmed in more recent reports (Ross et al., 1989; Devinsky, Putnam, Grafman, Bromfield, & Theodore, 1989). The observations of Slater and others (noted in Dr. Garcia's paper) that conver-

sion disorders often follow head trauma does not resolve the etiological question. Head trauma can occur as a result of having a conversion disorder with anesthesia or paralysis. Furthermore, given the fact that many dissociative disorders are now thought to be a response to physical trauma, it is possible that the trauma produces both the conversion or dissociative symptom and the head injury. The head injury may be incidental and not causal in producing the dissociated symptom. However, dissociative symptoms without a trauma history have been observed in some seizure patients.

In summary, the good news is that dissociation is taken more seriously, and recognition of the connection between trauma and dissociation is becoming clearer. The bad news is that in both the *ICD-10* and the *DSM-IV*, conversion is being converted to a somatoform or organic disorder, which may be in some cases but in others it is not. It is to be hoped that there will be some therapeutic integration in *ICD-11* and *DSM-V*. ■

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