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Dissociative Disorders In psychiatry, dissociation is defined as an unconscious defense mechanism involving the segregation of any group of mental or behavioral processes from the rest of the person's psychic activity. Dissociative disorders involve this mechanism so that there is a disruption in one or more mental functions, such as memory, identity, perception, consciousness, or motor behavior. The disturbance may be sudden or gradual, transient or chronic, and the signs and symptoms of the disorder are often caused by psychological trauma. Amnesia brought on by intrapsychic conflict is coded differently from amnesia brought on by a medical condition such as encephalitis. In the latter case, according to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a diagnosis of neurocognitive disorder due to a medical condition would be made; whereas in the former condition, a diagnosis of dissociative amnesia would be made. (See Section 21.4 which discusses neurocognitive disorders brought on by another medical condition [amnesic disorder] for a further discussion of this topic.)

DISSOCIATIVE AMNESIA

The DSM-5 diagnostic criteria for dissociative amnesia are listed in Table 12-1. The main feature of dissociative amnesia is an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by normal forgetfulness. And, as mentioned above, the disorder does not result from the direct physiological effects of a substance or a neurological or other general medical condition. The different types of dissociative amnesia are listed in Table 12-2.

Table 12-1 DSM-5 Diagnostic Criteria for Dissociative Amnesia

Table 12-2 Types of Dissociative Amnesia A 45-year-old, divorced, left-handed, male bus dispatcher was seen in psychiatric consultation on a medical unit. He had been admitted with an episode of chest discomfort, light-headedness, and left-arm weakness. He had a history of hypertension and had a medical admission in the past year for ischemic chest pain, although he had not suffered a myocardial infarction. Psychiatric consultation was called, because the

patient complained of memory loss for the previous 12 years, behaving and responding to the environment as if it were 12 years previously (e.g., he did not recognize his 8-year-old son, insisted that he was unmarried, and denied recollection of current events, such as the name of the current president). Physical and laboratory findings were unchanged from the patient's usual baseline. Brain computed tomography (CT) scan was normal. On mental status examination, the patient

displayed intact intellectual function but insisted that the date was 12 years earlier, denying recall of his entire subsequent personal history and of current events for the past 12 years. He was perplexed by the contradiction between his memory and current circumstances. The patient described a family history of brutal beatings and physical discipline. He was a decorated combat veteran, although he described amnesic episodes for some of his combat experiences. In the military, he had been a champion golden glove boxer noted for his powerful left hand. He was educated about his disorder and given the suggestion that his memory could return as he could tolerate it, perhaps overnight during sleep or perhaps over a longer time. If this strategy was unsuccessful, hypnosis or an amobarbital (Amytal) interview was proposed. (Adapted from a case of Richard J. Loewenstein, M.D., and Frank W. Putnam, M.D.)

Epidemiology Dissociative amnesia has been reported in a range of approximately 2 to 6 percent of the general population. No known difference is seen in incidence between men and women. Cases generally begin to be reported in late adolescence and adulthood. Dissociative amnesia can be especially difficult to assess in preadolescent children because of their more limited ability to describe subjective experience.

Etiology In many cases of acute dissociative amnesia, the psychosocial environment out of which the amnesia develops is massively conflictual, with the patient experiencing intolerable emotions of shame, guilt, despair, rage, and desperation. These usually result from conflicts over unacceptable urges or impulses, such as intense sexual, suicidal, or violent compulsions. Traumatic experiences such as physical or sexual abuse can induce the disorder. In some cases the trauma is caused by a betrayal by a trusted, needed other (betrayal trauma). This betrayal is thought to influence the way in which the event is processed and remembered.

Diagnosis and Clinical Features

Classic Presentation. The classic disorder is an overt, florid, dramatic clinical disturbance that frequently results in the patient being brought quickly to medical

attention, specifically for symptoms related to the dissociative disorder. It is frequently found in those who have experienced extreme acute trauma. It also commonly develops, however, in the context of profound intrapsychic conflict or emotional stress. Patients may present with intercurrent somatoform or conversion symptoms, alterations in consciousness, depersonalization, derealization, trance states, spontaneous age regression, and even ongoing anterograde dissociative amnesia. Depression and suicidal ideation are reported in many cases. No single personality profile or antecedent history is consistently reported in these patients, although a prior personal or family history of somatoform or dissociative symptoms has been shown to predispose individuals to develop acute amnesia during traumatic circumstances. Many of these patients have histories of prior adult or childhood abuse or trauma. In wartime cases, as in other forms of combat-related posttraumatic disorders, the most important variable in the development of dissociative symptoms, however, appears to be the intensity of combat. Table 12-3 presents the mental status evaluation of dissociative amnesia. Table 12-3 Mental Status Examination Questions for Dissociative Amnesia

Nonclassic Presentation. These patients frequently come to treatment for a variety of symptoms, such as depression or mood swings, substance abuse, sleep disturbances, somatoform symptoms, anxiety and panic, suicidal or self-mutilating impulses and acts, violent outbursts, eating problems, and interpersonal problems. Selfmutilation and violent behavior in these patients may also be accompanied by amnesia. Amnesia may also occur for flashbacks or behavioral re-experiencing episodes related to trauma.

Differential Diagnosis The differential diagnosis of dissociative amnesia is listed in Table 12-4. Table 12-4 Differential Diagnosis of Dissociative Amnesia

Ordinary Forgetfulness and Nonpathological Amnesia. Ordinary forgetfulness is a phenomenon that is benign and unrelated to stressful events. In dissociative amnesia, the memory loss is more extensive than in nonpathological amnesia. Other nonpathological forms of amnesia have been described, such as infantile and childhood amnesia, amnesia for sleep and dreaming, and hypnotic amnesia. Dementia, Delirium, and Amnesic Disorders due to Medical Conditions. In patients with dementia, delirium, and amnesic disorders due to medical conditions, the memory loss for personal information is embedded in a far more extensive set of cognitive, language, attentional, behavioral, and memory problems. Loss of memory for personal identity is usually not found without evidence of a marked disturbance in many domains of cognitive function. Causes of organic amnesic disorders include Korsakoff's psychosis, cerebral vascular accident (CVA), postoperative amnesia, postinfectious amnesia, anoxic amnesia, and transient global amnesia. Electroconvulsive therapy (ECT) may also cause a marked temporary amnesia, as well as persistent memory problems in some cases. Here, however, memory loss for autobiographical experience is unrelated to traumatic or overwhelming experiences and

seems to involve many different types of personal experiences, most commonly those occurring just before or during the ECT treatments. Posttraumatic Amnesia. In posttraumatic amnesia caused by brain injury, a history of a clear-cut physical trauma, a period of unconsciousness or amnesia, or both is usually seen, and there is objective clinical evidence of brain injury. Seizure Disorders. In most seizure cases, the clinical presentation differs significantly from that of dissociative amnesia, with clear-cut ictal events and sequelae. Patients with pseudoepileptic seizures may also have dissociative symptoms, such as amnesia and an antecedent history of psychological trauma. Rarely, patients with recurrent, complex partial seizures present with ongoing bizarre behavior, memory problems, irritability, or violence, leading to a differential diagnostic puzzle. In some of these cases, the diagnosis can be clarified only by telemetry or ambulatory electroencephalographic (EEG) monitoring. Substance-Related Amnesia. A variety of substances and intoxicants have been implicated in the production of amnesia. Common offending agents are listed in Table 12-4. Transient Global Amnesia. Transient global amnesia can be mistaken for a dissociative amnesia, especially because stressful life events may precede either disorder. In transient global amnesia, however, there is the sudden onset of complete anterograde amnesia and learning abilities; pronounced retrograde amnesia; preservation of memory for personal identity; anxious awareness of memory loss with repeated, often perseverative, questioning; overall normal behavior; lack of gross neurological abnormalities in most cases; and rapid return of baseline cognitive function, with a persistent short retrograde amnesia. The patient usually is older than 50 years of age and shows risk factors for cerebrovascular disease, although epilepsy and migraine have been etiologically implicated in some cases. Dissociative Identity Disorders. Patients with dissociative identity disorder can present with acute forms of amnesia and fugue episodes. These patients, however, are characterized by a plethora of symptoms, only some of which are usually found in patients with dissociative amnesia. With respect to amnesia, most patients with dissociative identity disorder and those with dissociative disorder not otherwise specified with dissociative identity disorder features report multiple forms of complex amnesia, including recurrent blackouts, fugues, unexplained possessions, and fluctuations in skills, habits, and knowledge. Acute Stress Disorder, Posttraumatic Stress Disorder, and Somatic Symptom Disorder. Most forms of dissociative amnesia are best conceptualized as part of a group of trauma spectrum disorders that includes acute stress disorder,

posttraumatic stress disorder (PTSD), and somatic symptom disorder. Many patients with dissociative amnesia meet full or partial diagnostic criteria for those acute stress disorders or a combination of the three. Amnesia is a criterion symptom of each of the latter disorders.

Malingering and Factitious Amnesia. No absolute way exists to differentiate dissociative amnesia from factitious or malingered amnesia. Malingerers have been noted to continue their deception even during hypnotically or barbiturate-facilitated interviews. A patient who presents to psychiatric attention seeking to recover repressed memories as a chief complaint most likely has a factitious disorder or has been subject to suggestive influences. Most of these individuals actually do not describe bona fide amnesia when carefully questioned, but are often insistent that they must have been abused in childhood to explain their unhappiness or life dysfunction.

Course and Prognosis Little is known about the clinical course of dissociative amnesia. Acute dissociative amnesia frequently spontaneously resolves once the person is removed to safety from traumatic or overwhelming circumstances. At the other extreme, some patients do develop chronic forms of generalized, continuous, or severe localized amnesia and are profoundly disabled and require high levels of social support, such as nursing home placement or intensive family caretaking. Clinicians should try to restore patients' lost memories to consciousness as soon as possible; otherwise, the repressed memory may form a nucleus in the unconscious mind around which future amnesic episodes may develop.

Treatment **Cognitive Therapy.** Cognitive therapy may have specific benefits for individuals with trauma disorders. Identifying the specific cognitive distortions that are based in the trauma may provide an entrée into autobiographical memory for which the patient experiences amnesia. As the patient becomes able to correct cognitive distortions, particularly about the meaning of prior trauma, more detailed recall of traumatic events may occur.

Hypnosis. Hypnosis can be used in a number of different ways in the treatment of dissociative amnesia. In particular, hypnotic interventions can be used to contain, modulate, and titrate the intensity of symptoms; to facilitate controlled recall of dissociated memories; to provide support and ego strengthening for the patient; and, finally, to promote working through and integration of dissociated material. In addition, the patient can be taught self-hypnosis to apply containment and calming techniques in his or her everyday life. Successful use of containment techniques, whether hypnotically facilitated or not, also increases the patient's sense that he or she can more effectively be in control of alternations between intrusive symptoms and amnesia.

Somatic Therapies. No known pharmacotherapy exists for dissociative amnesia other than pharmacologically facilitated interviews. A variety of agents have been used for this purpose, including sodium amobarbital, thiopental (Pentothal), oral benzodiazepines, and amphetamines. Pharmacologically facilitated interviews using intravenous amobarbital or diazepam (Valium) are used primarily in working with acute amnesias and conversion reactions, among other indications, in general hospital medical and psychiatric services. This procedure is also occasionally useful in refractory cases of chronic dissociative amnesia when patients are unresponsive to other interventions. The material uncovered in a pharmacologically facilitated interview needs to be processed by the patient in his or her usual conscious state.

Group Psychotherapy. Time-limited and longer-term group psychotherapies have been reported to be helpful for combat veterans with PTSD and for survivors of childhood abuse. During group sessions, patients may recover memories for which they have had amnesia. Supportive interventions by the group members or the group therapist, or both, may facilitate integration and mastery of the dissociated material.

DEPERSONALIZATION/DEREALIZATION DISORDER Depersonalization is defined as the persistent or recurrent feeling of detachment or estrangement from one's self. The individual may report feeling

like an automaton or watching himself or herself in a movie (Fig. 12-1). Derealization is somewhat related and refers to feelings of unreality or of being detached from one's environment. The patient may describe his or her perception of the outside world as lacking lucidity and emotional coloring, as though dreaming or dead (Fig. 12-2).

FIGURE 12-1 Dissociative states are characterized by feelings of unreality, as evoked in this photograph. (Courtesy of Arthur Tress.)

FIGURE 12-2 Depersonalization/derealization is experienced as a sense of unreality in one's environment or sense of self, as evoked in this double-exposure photograph. (Courtesy of Hayley R. Weinberg.) The current DSM-5 definition of depersonalization disorder is found in Table 12-5. Table 12-5 DSM-5 Diagnostic Criteria for Depersonalization/Derealization Disorder

Epidemiology Transient experiences of depersonalization and derealization are extremely common in normal and clinical populations. They are the third most commonly reported psychiatric symptoms, after depression and anxiety. One survey found a 1-year prevalence of 19 percent in the general population. It is common in seizure patients and migraine sufferers; they can also occur with use of psychedelic drugs, especially marijuana, lysergic acid diethylamide (LSD), and mescaline, and less frequently as a side effect of some medications, such as anticholinergic agents. They have been described after certain types of meditation, deep hypnosis, extended mirror or crystal gazing, and sensory deprivation experiences. They are also common after mild to moderate head injury, wherein little or no loss of consciousness occurs, but they are significantly less likely if unconsciousness lasts for more than 30 minutes. They are also common after life-threatening experiences, with or without serious bodily injury. Depersonalization is found two to four times more in women than in men. **Etiology** Psychodynamic. Traditional psychodynamic formulations have emphasized the disintegration of the ego or have viewed depersonalization as an affective response in defense of the ego. These explanations stress the role of overwhelming painful

experiences or conflictual impulses as triggering events. **Traumatic Stress.** A substantial proportion, typically one third to one half, of patients in clinical depersonalization case series report histories of significant trauma. Several studies of accident victims find as many as 60 percent of those with a lifethreatening experience report at least transient depersonalization during the event or immediately thereafter. Military training studies find that symptoms of depersonalization and derealization are commonly evoked by stress and fatigue and are inversely related to performance. **Neurobiological Theories.** The association of depersonalization with migraines and marijuana, its generally favorable response to selective serotonin reuptake inhibitors (SSRIs), and the increase in depersonalization symptoms seen with the depletion of L-tryptophan, a serotonin precursor, point to serotonergic involvement. Depersonalization is the primary dissociative symptom elicited by the drug-challenge studies described in the section on neurobiological theories of dissociation. These studies strongly implicate the N-methyl-D-aspartate (NMDA) subtype of the glutamate receptor as central to the genesis of depersonalization symptoms. **Diagnosis and Clinical Features** A number of distinct components comprise the experience of depersonalization, including a sense of (1) bodily changes, (2) duality of self as observer and actor, (3) being cut off from others, and (4) being cut off from one's own emotions. Patients experiencing depersonalization often have great difficulty expressing what they are feeling. Trying to express their subjective suffering with banal phrases, such as "I feel dead," "Nothing seems real," or "I'm standing outside of myself,"

depersonalized patients may not adequately convey to the examiner the distress they experience. While complaining bitterly about how this is ruining their life, they may nonetheless appear remarkably undistressed. Ms. R was a 27-year-old, unmarried, graduate student with a master's degree in biology. She complained about intermittent episodes of "standing back," usually associated with anxiety-provoking social situations. When asked about a recent episode, she described presenting in a seminar course. "All of a sudden, I was talking, but it didn't feel like it was me talking. It was very disconcerting. I had this feeling, 'who's doing the talking?' I felt like I was just watching someone else talk. Listening to words come out of my mouth, but I wasn't saying them. It wasn't me. It went on for a while. I was calm, even sort of peaceful. It was as if I was very far away. In the back of the room somewhere—just watching myself. But the person talking didn't even seem like me really. It was like I was watching someone else." The feeling lasted the rest of that day and persisted into the next, during which time it gradually

dissipated. She thought that she remembered having similar experiences during high school, but was certain that they occurred at least once a year during college and graduate school. As a child, Ms. R reported frequent intense anxiety from overhearing or witnessing the frequent violent arguments and periodic physical fights between her parents. In addition, the family was subject to many unpredictable dislocations and moves owing to the patient's father's intermittent difficulties with finances and employment. The patient's anxieties did not abate when the parents divorced when she was a late adolescent. Her father moved away and had little further contact with her. Her relationship with her mother became increasingly angry, critical, and contentious. She was unsure if she experienced depersonalization during childhood while listening to her parents' fights.

(Adapted from a case of Richard J. Loewenstein, M.D., and Frank W. Putnam, M.D.)

Differential Diagnosis The variety of conditions associated with depersonalization complicate the differential diagnosis of depersonalization disorder. Depersonalization can result from a medical condition or neurological condition, intoxication or withdrawal from illicit drugs, as a side effect of medications, or can be associated with panic attacks, phobias, PTSD, or acute stress disorder, schizophrenia, or another dissociative disorder. A thorough medical and neurological evaluation is essential, including standard laboratory studies, an EEG, and any indicated drug screens. Drug-related depersonalization is typically transient, but persistent depersonalization can follow an episode of intoxication with a variety of substances, including marijuana, cocaine, and other psychostimulants. A range of neurological conditions, including seizure disorders, brain tumors, postconcussive syndrome, metabolic abnormalities, migraine, vertigo, and Ménière's disease, have been reported as causes. Depersonalization caused by organic conditions tends to be primarily sensory without the elaborated descriptions and personalized meanings common to psychiatric etiologies.

Course and Prognosis Depersonalization after traumatic experiences or intoxication commonly remits spontaneously after removal from the traumatic circumstances or ending of the episode of intoxication. Depersonalization accompanying mood, psychotic, or other anxiety disorders commonly remits with definitive treatment of these conditions. Depersonalization disorder itself may have an episodic, relapsing and remitting, or chronic course. Many patients with chronic depersonalization may have a course characterized by severe impairment in occupational, social, and personal functioning. Mean age of onset is thought to be in late adolescence or early adulthood in most cases. **Treatment**

Clinicians working with patients with depersonalization/derealization disorder often find them to be a singularly clinically refractory group. Some systematic evidence indicates that SSRI

antidepressants, such as fluoxetine (Prozac), may be helpful to patients with depersonalization disorder. Two recent, double-blind, placebo-controlled studies, however, found no efficacy for fluvoxamine (Luvox) and lamotrigine (Lamictal), respectively, for depersonalization disorder. Some patients with depersonalization disorder respond at best sporadically and partially to the usual groups of psychiatric medications, singly or in combination: antidepressants, mood stabilizers, typical and atypical neuroleptics, anticonvulsants, and so forth. Many different types of psychotherapy have been used to treat depersonalization disorder: psychodynamic, cognitive, cognitive-behavioral, hypnotherapeutic, and supportive. Many such patients do not have a robust response to these specific types of standard psychotherapy. Stress management strategies, distraction techniques, reduction of sensory stimulation, relaxation training, and physical exercise may be somewhat helpful in some patients.

DISSOCIATIVE FUGUE Dissociative fugue was deleted as a major diagnostic category in DSM-5 and is now diagnosed on a subtype (specifier) of dissociative amnesia. Dissociative fugue can be seen in patients with both dissociative amnesia and dissociative identity disorder. The disorder remains a distinct diagnosis in the International Statistical Classification of Diseases and Related Health Problems tenth edition (ICD-10) and is discussed as a discrete entity in Synopsis because of its clinical relevance. Dissociative fugue is described as sudden, unexpected travel away from home or one's customary place of daily activities, with inability to recall some or all of one's past. This is accompanied by confusion about personal identity or even the assumption of a new identity. The disturbance is not due to the direct physiological effects of a substance or a general medical condition. The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Etiology Traumatic circumstances (i.e., combat, rape, recurrent childhood sexual abuse, massive social dislocations, natural disasters), leading to an altered state of consciousness dominated by a wish to flee, are the underlying cause of most fugue episodes. In some cases a similar antecedent history is seen, although a psychological trauma is not present at the onset of the fugue episode. In these cases, instead of, or in addition to, external dangers or traumas, the patients are usually struggling with extreme emotions or impulses (i.e., overwhelming fear, guilt, shame, or intense incestuous, sexual, suicidal, or violent urges) that are in conflict with the patient's conscience or ego ideals. Epidemiology

The disorder is thought to be more common during natural disasters, wartime, or times of major social dislocation and violence, although no systematic data exist on this point. No adequate data exist to demonstrate a gender bias to this disorder; however, most cases describe men, primarily in the military. Dissociative fugue is usually described in adults. Diagnosis and Clinical Features Dissociative fugues have been described to last from minutes to months. Some patients report multiple fugues. In most cases in which this was described, a more chronic dissociative disorder, such as dissociative identity disorder, was not ruled out. In some extremely severe cases of PTSD, nightmares may be terminated by a waking fugue in which the patient runs to another part of the house or runs outside. Children or adolescents may be more limited than adults in their ability to travel. Thus, fugues in this population may be brief and involve only short distances. A teenage girl was continually sexually abused by her alcoholic father and another family friend. She was threatened with perpetration of sexual abuse on her younger siblings if she told anyone about the abuse. The girl became suicidal but felt that she had to stay alive to protect her siblings. She precipitously ran away from home after being raped by her father and several of his friends as a "birthday present" for one of them. She traveled to a part of the city where she had lived previously with the idea that she would find her grandmother with whom she had lived before the

abuse began. She traveled by public transportation and walked the streets, apparently without attracting attention. After approximately 8 hours, she was stopped by the police in a curfew check. When questioned, she could not recall recent events or give her current address, insisting that she lived with her grandmother. On initial psychiatric examination, she was aware of her identity, but she believed that it was 2 years earlier, giving her age as 2 years younger and insisting that none of the events of recent years had occurred. (Courtesy of Richard J. Loewenstein, M.D., and Frank W. Putnam, M.D.) After the termination of a fugue, the patient may experience perplexity, confusion, trance-like behaviors, depersonalization, derealization, and conversion symptoms, in addition to amnesia. Some patients may terminate a fugue with an episode of generalized dissociative amnesia. As the patient with dissociative fugue begins to become less dissociated, he or she may display mood disorder symptoms, intense suicidal ideation, and PTSD or anxiety disorder symptoms. In the classic cases, an alter identity is created under whose auspices the patient lives for a period of time. Many of these latter cases are better classified as dissociative identity disorder or, if using DSM-5, as other specified dissociative disorder with features of dissociative identity disorder.

Differential Diagnosis Individuals with dissociative amnesia may engage in confused wandering during an amnesia episode. In dissociative fugue, however, there is purposeful travel away from the individual's home or customary place of daily activities, usually with the individual preoccupied by a single idea that is accompanied by a wish to run away. Patients with dissociative identity disorder may have symptoms of dissociative fugue, usually recurrently throughout their lives. Patients with dissociative identity disorder have multiple forms of complex amnesias and, usually, multiple alter identities that develop, starting in childhood. In complex partial seizures, patients have been noted to exhibit wandering or semipurposive behavior, or both, during seizures or in postictal states, for which subsequent amnesia occurs. Seizure patients in an epileptic fugue often exhibit abnormal behavior, however, including confusion, perseveration, and abnormal or repetitive movements. Other features of seizures are typically reported in the clinical history, such as an aura, motor abnormalities, stereotyped behavior, perceptual alterations, incontinence, and a postictal state. Serial or telemetric EEGs, or both, usually show abnormalities associated with behavioral pathology. Wandering behavior during a variety of general medical conditions, toxic and substance-related disorders, delirium, dementia, and organic amnesic syndromes could theoretically be confused with dissociative fugue. In most cases, however, the somatic, toxic, neurological, or substance-related disorder can be ruled in by the history, physical examination, laboratory tests, or toxicological and drug screening. Use of alcohol or substances may be involved in precipitating an episode of dissociative fugue. Wandering and purposeful travel can occur during the manic phase of bipolar disorder or schizoaffective disorder. Patients who are manic may not recall behavior that occurred in the euthymic or depressed state and vice versa. In purposeful travel owing to mania, however, the patient is usually preoccupied with grandiose ideas and often calls attention to himself or herself because of inappropriate behavior. Assumption of an alternate identity does not occur. Similarly, peripatetic behavior can occur in some patients with schizophrenia. Memory for events during wandering episodes in such patients may be difficult to ascertain owing to the patient's thought disorder. Patients with dissociative fugue, however, do not demonstrate a psychotic thought disorder or other symptoms of psychosis. Malingering of dissociative fugue can occur in individuals who are attempting to flee a situation involving legal, financial, or personal difficulties, as well as in soldiers who are attempting to avoid combat or unpleasant military duties. No test, battery of tests, or set of procedures exist that invariably

distinguish true dissociative symptoms from those that are malingered. Malingering of dissociative symptoms, such as reports of amnesia for purposeful travel during an episode of antisocial behavior, can be maintained even during hypnotic or pharmacologically facilitated interviews. Many malingerers confess spontaneously or when confronted. In the forensic context, the

examiner should always carefully consider the diagnosis of malingering when fugue is claimed.

Course and Prognosis Most fugues are relatively brief, lasting from hours to days. Most individuals appear to recover, although refractory dissociative amnesia may persist in rare cases. Some studies have described recurrent fugues in most individuals presenting with an episode of dissociative fugue. No systematic modern data exist that attempt to differentiate dissociative fugue from dissociative identity disorder with recurrent fugues.

Treatment Dissociative fugue is usually treated with an eclectic, psychodynamically oriented psychotherapy that focuses on helping the patient recover memory for identity and recent experience. Hypnotherapy and pharmacologically facilitated interviews are frequently necessary adjunctive techniques to assist with memory recovery. Patients may need medical treatment for injuries sustained during the fugue as well as food and sleep. Clinicians should be prepared for the emergence of suicidal ideation or self-destructive ideas and impulses as the traumatic or stressful pre-fugue circumstances are revealed. Psychiatric hospitalization may be indicated if the patient is an outpatient. Family, sexual, occupational, or legal problems that were part of the original matrix that generated the fugue episode may be substantially exacerbated by the time the patient's original identity and life situation are detected. Thus, family treatment and social service interventions may be necessary to help resolve such complex difficulties. When dissociative fugue involves assumption of a new identity, it is useful to conceptualize this entity as psychologically vital to protecting the person. Traumatic experiences, memories, cognitions, identifications, emotions, strivings, self-perceptions, or a combination of these have become so conflicting and, yet, so peremptory that the person can resolve them only by embodying them in an alter identity. The therapeutic goal in such cases is neither suppression of the new identity nor fascinated explication of all its attributes. As in dissociative identity disorder, the clinician should appreciate the importance of the psychodynamic information contained within the alter personality state and the intensity of the psychological forces that necessitated its creation. In these cases, the most desirable therapeutic outcome is fusion of the identities, with the person working through and integrating the memories of the experiences that precipitated the fugue.

DISSOCIATIVE IDENTITY DISORDER Dissociative identity disorder, previously called multiple personality disorder, has been the most extensively researched of all the dissociative disorders. It is characterized by the presence of two or more distinct identities or personality states. The identities or

personality states, sometimes called alters, self-states, alter identities, or parts, among other terms, differ from one another in that each presents as having its own pattern of perceiving, relating to, and thinking about the environment and self, in short, its own personality. It is the paradigmatic dissociative psychopathology in that the symptoms of all the other dissociative disorders are commonly found in patients with dissociative identity disorder: amnesia, fugue, depersonalization, derealization, and similar symptoms. Until about 1800, patients with dissociative identity disorder were mainly seen as suffering from various states of possession. In the early 1800s, Benjamin Rush built on the clinical reports of others and provided a clinical description of the phenomenology of dissociative identity disorder. Subsequently, both Jean-Martin Charcot and Pierre Janet described the symptoms of the disorder and recognized the dissociative nature of the

symptoms. Both Sigmund Freud and Eugen Bleuler recognized the symptoms, although Freud attributed psychodynamic mechanisms to the symptoms and Bleuler considered the symptoms to be reflective of schizophrenia. Perhaps because of an increased appreciation of the problem of child sexual and physical abuse and perhaps because of the cases described in the popular media (The Three Faces of Eve, Sybil), awareness of dissociative identity disorder has increased.

Epidemiology Few systematic epidemiological data exist for dissociative identity disorder. Clinical studies report female to male ratios between 5 to 1 and 9 to 1 for diagnosed cases.

Etiology Dissociative identity disorder is strongly linked to severe experiences of early childhood trauma, usually maltreatment. The rates of reported severe childhood trauma for child and adult patients with dissociative identity disorder range from 85 to 97 percent of cases. Physical and sexual abuse are the most frequently reported sources of childhood trauma. The contribution of genetic factors is only now being systematically assessed, but preliminary studies have not found evidence of a significant genetic contribution.

Diagnosis and Clinical Features The key feature in diagnosing this disorder is the presence of two or more distinct personality states. There are many other signs and symptoms, however, that define the disorder, and because of great diversity, this makes the diagnosis difficult. These are listed in Table 12-6, which describes the many other associated symptoms commonly found in patients with dissociative personality disorder.

Table 12-6
Dissociative Identity Disorder-Associated Symptoms Commonly Found in Dissociative Identity Disorder

Mental Status. A careful and detailed mental status is essential in making the diagnosis. It is easy to mistake patients with this disorder as suffering from schizophrenia, borderline personality disorder, or of outright malingering. Table 12-7 lists the questions clinicians should ask in order to make the proper diagnosis.

Table 12-7
Mental Status Examination Questions for Dissociative Identity Disorder

Process Symptoms

Memory and Amnesia Symptoms. Dissociative disturbances of memory are manifest in several basic ways and are frequently observable in clinical settings. As part of the general mental status examination, clinicians should routinely inquire about experiences of losing time, blackout spells, and major gaps in the continuity of recall for personal information. Dissociative time loss experiences are too extensive to be explained by normal forgetting and typically have sharply demarcated onsets and offsets. Patients with dissociative disorder often report significant gaps in autobiographical memory, especially for childhood events. Dissociative gaps in autobiographical recall are usually sharply demarcated and do not fit the normal decline in autobiographical recall for younger ages.

Ms. A, a 33-year-old married woman employed as a librarian in a school for disturbed children, presented to psychiatric attention after discovering her 5-year-old daughter “playing doctor” with several neighborhood children. Although this event was of little consequence, the patient began to become fearful that her daughter would be molested. The patient was seen by her internist and was treated with antianxiety agents and antidepressants, but with little improvement. She sought psychiatric consultation from several clinicians, but repeated, good trials of antidepressants, antianxiety agents, and supportive psychotherapy resulted in limited improvement. After the death of her father from complications of alcoholism, the patient became more symptomatic. He had been estranged from the family since the patient was approximately 12 years of age, owing to his drinking and associated antisocial behavior. Psychiatric hospitalization was precipitated by the patient’s arrest for disorderly conduct in a nearby city. She was found in a hotel, in revealing clothing, engaged in an altercation with a man. She denied knowledge of how

she had come to the hotel, although the man insisted that she had come there under a different name for a voluntary sexual encounter. On psychiatric examination, the patient described dense amnesia for the first 12 years of her life, with the feeling that her “life started at 12 years old.” She reported that, for as long as she could remember, she had an imaginary companion, an elderly black woman, who advised her and kept her company. She reported hearing other voices in her head: several women and children, as well as her father’s voice repeatedly speaking to her in a derogatory way. She reported that much of her life since 12 years of age was also punctuated by episodes of amnesia: for work, for her marriage, for the birth of her children, and for her sex life with her husband. She reported perplexing changes in skills; for example, she was often told that she played the piano well but had no conscious awareness that she could do so. Her husband reported that she had always been “forgetful” of conversations and family activities. He also noted that, at times, she would speak like a child; at times, she would adopt a southern accent; and, at other times, she would be angry and provocative. She

frequently had little recall of these episodes. Questioned more closely about her early life, the patient appeared to enter a trance and stated, “I just don’t want to be locked in the closet” in a child-like voice. Inquiry about this produced rapid shifts in state between alter identities who differed in manifested age, facial expression, voice tone, and knowledge of the patient’s history. One spoke in an angry, expletive-filled manner and appeared irritable and preoccupied with sexuality. She discussed the episode with the man in the hotel and stated that it was she who had arranged it. Gradually, the alters described a history of family chaos, brutality, and neglect during the first 12 years of the patient’s life, until her mother, also alcoholic, achieved sobriety and fled her husband, taking her children with her. The patient, in the alter identities, described episodes of physical abuse, sexual abuse, and emotional torment by the father, her siblings, and her mother. After assessment of family members, the patient’s mother also met diagnostic criteria for dissociative identity disorder, as did her older sister, who also had been molested. A brother met diagnostic criteria for PTSD, major depression, and alcohol dependence. (Adapted from a case of Richard J. Loewenstein, M.D., and Frank W. Putnam, M.D.) Dissociative Alterations in Identity. Clinically, dissociative alterations in identity may first be manifested by odd first-person plural or third-person singular or plural self-references. In addition, patients may refer to themselves using their own first names or make depersonalized self-references, such as “the body,” when describing themselves and others. Patients often describe a profound sense of concretized internal division or personified internal conflicts between parts of themselves. In some instances, these parts may have proper names or may be designated by their predominate affect or function, for example, “the angry one” or “the wife.” Patients may suddenly change the way in which they refer to others, for example, “the son” instead of “my son.” Other Associated Symptoms. Most patients with dissociative identity disorder meet criteria for a mood disorder, usually one of the depression spectrum disorders. Frequent, rapid mood swings are common, but these are usually caused by posttraumatic and dissociative phenomena, not a true cyclic mood disorder. Considerable overlap may exist between PTSD symptoms of anxiety, disturbed sleep, and dysphoria and mood disorder symptoms. Obsessive-compulsive personality traits are common in dissociative identity disorder, and intercurrent obsessive-compulsive disorder (OCD) symptoms are regularly found in patients with dissociative identity disorder, with a subgroup manifesting severe OCD symptoms. OCD symptoms commonly have a posttraumatic quality: checking repeatedly to be sure that no one can enter the house or the bedroom, compulsive washing to relieve a feeling of being dirty because of abuse, and repetitive counting or singing in the mind to distract from anxiety over being abused,

for example.

Child and Adolescent Presentations. Children and adolescents manifest the same core dissociative symptoms and secondary clinical phenomena as adults. Age-related differences in autonomy and lifestyle, however, may significantly influence the clinical expression of dissociative symptoms in youth. Younger children, in particular, have a less linear and less continuous sense of time and often are not able to self-identify dissociative discontinuities in their behavior. Often additional informants, such as teachers and relatives, are available to help document dissociative behaviors. A number of normal childhood phenomena, such as imaginary companionship and elaborated daydreams, must be carefully differentiated from pathological dissociation in younger children. The clinical presentation may be that of an elaborated or autonomous imaginary companionship, with the imaginary companions taking control of the child's behavior, often experienced through passive influence experiences or auditory pseudohallucinations, or both, that command the child to behave in certain ways. Differential Diagnosis Table 12-8 lists the most common disorders that must be differentiated from dissociative identity disorder. Table 12-8 Differential Diagnosis of Dissociative Identity Disorder Factitious, Imitative, and Malingered Dissociative Identity Disorder. Indicators of falsified or imitative dissociative identity disorder are reported to include those typical of other factitious or malingering presentations. These include symptom exaggeration, lies, use of symptoms to excuse antisocial behavior (e.g., amnesia only for bad behavior), amplification of symptoms when under observation, refusal to allow collateral contacts, legal problems, and pseudologia fantastica. Patients with genuine dissociative identity disorder are usually confused, conflicted, ashamed, and distressed by their symptoms and trauma history. Those with nongenuine disorder frequently show

little dysphoria about their disorder. Course and Prognosis Little is known about the natural history of untreated dissociative identity disorder. Some individuals with untreated dissociative identity disorder are thought to continue involvement in abusive relationships or violent subcultures, or both, that may result in the traumatization of their children, with the potential for additional family transmission of the disorder. Many authorities believe that some percentage of patients with undiagnosed or untreated dissociative identity disorder die by suicide or as a result of their risk-taking behaviors. Prognosis is poorer in patients with comorbid organic mental disorders, psychotic disorders (not dissociative identity disorder pseudopsychosis), and severe medical illnesses. Refractory substance abuse and eating disorders also suggest a poorer prognosis. Other factors that usually indicate a poorer outcome include significant antisocial personality features, current criminal activity, ongoing perpetration of abuse, and current victimization, with refusal to leave abusive relationships. Repeated adult traumas with recurrent episodes of acute stress disorder may severely complicate the clinical course. Treatment Psychotherapy. Successful psychotherapy for the patient with dissociative identity disorder requires the clinician to be comfortable with a range of psychotherapeutic interventions and be willing to actively work to structure the treatment. These modalities include psychoanalytic psychotherapy, cognitive therapy, behavioral therapy, hypnotherapy, and a familiarity with the psychotherapy and psychopharmacological management of the traumatized patient. Comfort with family treatment and systems theory is helpful in working with a patient who subjectively experiences himself or herself as a complex system of selves with alliances, family-like relationships, and intragroup conflict. A grounding in work with patients with somatoform disorders may also be helpful in sorting through the plethora of somatic symptoms with which these patients commonly present. Cognitive Therapy. Many cognitive distortions

associated with dissociative identity disorder are only slowly responsive to cognitive therapy techniques, and successful cognitive interventions may lead to additional dysphoria. A subgroup of patients with dissociative identity disorder does not progress beyond a long-term supportive treatment entirely directed toward stabilization of their multiple multi-axial difficulties. To the extent that they can be engaged in treatment at all, these patients require a long-term treatment focus on symptom containment and management of their overall life dysfunction, as would be the case with any other severely and persistently ill psychiatric patient.

Hypnosis. Hypnotherapeutic interventions can often alleviate self-destructive impulses or reduce symptoms, such as flashbacks, dissociative hallucinations, and passive-influence experiences. Teaching the patient self-hypnosis may help with crises outside of sessions. Hypnosis can be useful for accessing specific alter personality states and their sequestered affects and memories. Hypnosis is also used to create relaxed mental states in which negative life events can be examined without overwhelming anxiety. Clinicians using hypnosis should be trained in its use in general and in trauma populations. Clinicians should be aware of current controversies over the impact of hypnosis on accurate reporting of recollections and should use appropriate informed consent for its use.

Psychopharmacological Interventions. Antidepressant medications are often important in the reduction of depression and stabilization of mood. A variety of PTSD symptoms, especially intrusive and hyperarousal symptoms, are partially medication responsive. Clinicians report some success with SSRI, tricyclic, and monoamine oxidase (MAO) antidepressants, β -blockers, clonidine (Catapres), anticonvulsants, and benzodiazepines in reducing intrusive symptoms, hyperarousal, and anxiety in patients with dissociative identity disorder. Recent research suggests that the α 1-adrenergic antagonist prazosin (Minipress) may be helpful for PTSD nightmares. Case reports suggest that aggression may respond to carbamazepine (Tegretol) in some individuals if EEG abnormalities are present. Patients with obsessive-compulsive symptoms may respond to antidepressants with anti-obsessive efficacy. Open-label studies suggest that naltrexone (ReVia) may be helpful for amelioration of recurrent self-injurious behaviors in a subset of traumatized patients. The atypical neuroleptics, such as risperidone (Risperdal), quetiapine (Seroquel), ziprasidone (Geodon), and olanzapine (Zyprexa), may be more effective and better tolerated than typical neuroleptics for overwhelming anxiety and intrusive PTSD symptoms in patients with dissociative identity disorder. Occasionally, an extremely disorganized, overwhelmed, chronically ill patient with dissociative identity disorder, who has not responded to trials of other neuroleptics, responds favorably to a trial of clozapine (Clozaril).

Electroconvulsive Therapy. For some patients, ECT is helpful in ameliorating refractory mood disorders and does not worsen dissociative memory problems. Clinical experience in tertiary care settings for severely ill patients with dissociative identity disorder suggests that a clinical picture of major depression with persistent, refractory melancholic features across all alter states may predict a positive response to ECT. This response is usually only partial, however, as is typical for most successful somatic treatments in the dissociative identity disorder population. Target symptoms and somatic treatments for dissociative identity disorder are listed in Table 12-9.

Table 12-9 Medications for Associated Symptoms in Dissociative Identity Disorder Adjunctive Treatments Group Therapy. In therapy groups including general psychiatric patients, the emergence of alter personalities can be disruptive to the group process by eliciting excess fascination or by frightening other patients. Therapy groups composed only of patients with dissociative identity disorder are reported to be more successful, although the groups must be

carefully structured, must provide firm limits, and should generally focus only on here-and-now issues of coping and adaptation. Family Therapy. Family or couples therapy is often important for long-term stabilization and to address pathological family and marital processes that are common in patients with dissociative identity disorder and their family members. Education of family and concerned others about dissociative identity disorder and its treatment may

help family members cope more effectively with dissociative identity disorder and PTSD symptoms in their loved ones. Group interventions for education and support of family members have also been found helpful. Sex therapy may be an important part of couples' treatment, because patients with dissociative identity disorder may become intensely phobic of intimate contact for periods of time, and spouses may have little idea how to deal with this in a helpful way. Self-Help Groups. Patients with dissociative identity disorder usually have a negative outcome to self-help groups or 12-step groups for incest survivors. A variety of problematic issues occur in these settings, including intensification of PTSD symptoms because of discussion of trauma material without clinical safeguards, exploitation of the patient with dissociative identity disorder by predatory group members, contamination of that patient's recall by group discussions of trauma, and a feeling of alienation even from these other reputed sufferers of trauma and dissociation. Expressive and Occupational Therapies. Expressive and occupational therapies, such as art and movement therapy, have proved particularly helpful in treatment of patients with dissociative identity disorder. Art therapy may be used to help with containment and structuring of severe dissociative identity disorder and PTSD symptoms, as well as to permit these patients safer expression of thoughts, feelings, mental images, and conflicts that they have difficulty verbalizing. Movement therapy may facilitate normalization of body sense and body image for these severely traumatized patients. Occupational therapy may help the patient with focused, structured activities that can be completed successfully and may help with grounding and symptom management. Eye Movement Desensitization and Reprocessing (EMDR). EMDR is a treatment that has recently been advocated for adjunctive treatment of PTSD. There are disagreements in the literature about the usefulness and efficacy of this modality of treatment, and published efficacy studies are discrepant. No systematic studies have been done in dissociative identity disorder patients using EMDR. Case reports suggest that some dissociative identity disorder patients may be destabilized by EMDR procedures, especially those with acutely increased PTSD and dissociative symptoms. Some authorities believe that EMDR can be used as a helpful adjunct for later phases of treatment in well-stabilized dissociative identity disorder outpatients. The International Society for the Study of Trauma and Dissociation dissociative identity disorder treatment guidelines suggest that EMDR only be used in this patient population by clinicians who have taken advanced EMDR training, are knowledgeable and skilled in phasic trauma treatment for dissociative disorders, and have received supervision in the use of EMDR in dissociative identity disorder. OTHER SPECIFIED OR UNSPECIFIED DISSOCIATIVE DISORDER

The category of dissociative disorder covers all of the conditions characterized by a primary dissociative response that do not meet diagnostic criteria for one of the other DSM-5 dissociative disorders. Dissociative Trance Disorder Dissociative trance disorder is manifest by a temporary, marked alteration in the state of consciousness or by loss of the customary sense of personal identity without the replacement by an alternate sense of identity. A variant of this, possession trance, involves single or episodic alternations in the state of consciousness, characterized by the exchange of the person's customary identity with a new identity usually attributed to a spirit,

divine power, deity, or another person. In this possessed state, the individual exhibits stereotypical and culturally determined behaviors or experiences being controlled by the possessing entity. There must be partial or full amnesia for the event. The trance or possession state must not be a normally accepted part of a cultural or religious practice and must cause significant distress or functional impairment in one or more of the usual domains. Finally, the dissociative trance state must not occur exclusively during the course of a psychotic disorder and is not the result of any substance use or general medical condition. Brainwashing DSM-5 describes this dissociative disorder as “identity disturbance due to prolonged and intense coercive persuasion.” Brainwashing occurs largely in the setting of political reform, as has been described at length with the Cultural Revolution in communist China, war imprisonment, torture of political dissidents, terrorist hostages, and, more familiarly in Western culture, totalitarian cult indoctrination. It implies that under conditions of adequate stress and duress, individuals can be made to comply with the demands of those in power, thereby undergoing major changes in their personality, beliefs, and behaviors. Persons subjected to such conditions can undergo considerable harm, including loss of health and life, and they typically manifest a variety of posttraumatic and dissociative symptoms. The first stage in coercive processes has been likened to the artificial creation of an identity crisis, with the emergence of a new pseudoidentity that manifests characteristics of a dissociative state. Under circumstances of extreme and malignant dependency, overwhelming vulnerability, and danger to one’s existence, individuals develop a state characterized by extreme idealization of their captors, with ensuing identification with the aggressor and externalization of their superego, regressive adaptation known as traumatic infantilism, paralysis of will, and a state of frozen fright. The coercive techniques that are typically used to induce such a state in the victim have been amply described and include isolation of the subject, degradation, control over all communications and basic daily functions, induction of fear and confusion, peer pressure, assignment of repetitive and monotonous routines, unpredictability of environmental supplies, renunciation of past relationships and values, and various

deprivations. Even though physical or sexual abuse, torture, and extreme sensory deprivation and physical neglect can be part of this process, they are not required to define a coercive process. As a result, victims manifest extensive posttraumatic and dissociative symptomatology, including drastic alteration of their identity, values, and beliefs; reduction of cognitive flexibility with regression to simplistic perceptions of good versus evil and dominance versus submission; numbing of experience and blunting of affect; trance-like states and diminished environmental responsiveness; and, in some cases, more severe dissociative symptoms such as amnesia, depersonalization, and shifts in identity. The treatment of victims of coercion can vary considerably, depending on their particular background, the circumstances involved, and the setting in which help is sought. Although no systematic studies exist in this domain, basic principles involve validation of the traumatic experience and coercive techniques used, cognitive reframing of the events that transpired, exploration of preexisting psychopathology and vulnerabilities (when applicable), and general techniques used in treating posttraumatic and dissociative states. In addition, family interventions and therapy may be required, at least in cases of cult indoctrination, because significant family duress and disruption commonly occur. Recovered Memory Syndrome Under hypnosis or during psychotherapy, a patient may recover a memory of a painful experience or conflict—particularly of sexual or physical abuse—that is etiologically significant. When the repressed material is brought back to consciousness, the person not only may recall the experience but may relive it, accompanied by the appropriate affective response (a process called abreaction).

If the event recalled never really happened but the person believes it to be true and reacts accordingly, it is known as false memory syndrome. The syndrome has led to lawsuits involving accusations of child abuse. However, Thomas E. Gutheil describes memory as a “slender reed—insufficiently strong to bear the weight of a court case.” Even if the memory of abuse is real, the perpetrator is not the present person, but the person of the past. Gutheil does not believe that litigation usually serves the patient’s psychological goals. Clinical attention should probably be directed toward helping patients cast aside the limiting restrictive role of victim and transcend their past traumas, work through them, and try to get on with their lives. Ganser Syndrome Ganser syndrome is a poorly understood condition characterized by the giving of approximate answers (paralogia) together with a clouding of consciousness and is frequently accompanied by hallucinations and other dissociative, somatoform, or conversion symptoms. Epidemiology. Cases have been reported in a variety of cultures, but the overall

frequency of such reports has declined with time. Men outnumber women by approximately 2 to 1. Three of Ganser’s first four cases were convicts, leading some authors to consider it to be a disorder of penal populations and, thus, an indicator of potential malingering. Etiology. Some case reports identify precipitating stressors, such as personal conflicts and financial reverses, whereas others note organic brain syndromes, head injuries, seizures, and medical or psychiatric illness. Psychodynamic explanations are common in the older literature, but organic etiologies are stressed in more recent case studies. It is speculated that the organic insults may act as acute stressors, precipitating the syndrome in vulnerable individuals. Some patients have reported significant histories of childhood maltreatment and adversity. Diagnosis and Clinical Features. The symptom of passing over (*vorbeigehen*) the correct answer for a related, but incorrect one, is the hallmark of Ganser syndrome. The approximate answers often just miss the mark but bear an obvious relation to the question, indicating that it has been understood. When asked how old she was, a 25-year-old woman answered, “I’m not five.” If asked to do simple calculations (e.g., $2 + 2 = 5$); for general information (the capital of the United States is New York); to identify simple objects (a pencil is a key); or to name colors (green is gray), the patient with Ganser syndrome gives erroneous but comprehensible answers. A clouding of consciousness also occurs, usually manifest by disorientation, amnesias, loss of personal information, and some impairment of reality testing. Visual and auditory hallucinations occur in roughly one half of the cases. Neurological examination may reveal what Ganser called hysterical stigmata, for example, a nonneurological analgesia or shifting hyperalgesia. It must be accompanied by other dissociative symptoms, such as amnesias, conversion symptoms, or trance-like behaviors. Differential Diagnosis. Given the reported frequent history of organic brain syndromes, seizures, head trauma, and psychosis in Ganser syndrome, a thorough neurological and medical evaluation is warranted. Differential diagnoses include organic dementia, depressive pseudodementia, the confabulation of Korsakoff’s syndrome, organic dysphasias, and reactive psychoses. Patients with dissociative identity disorder occasionally may also exhibit Ganser-like symptoms. Treatment. No systematic treatment studies have been conducted, given the rarity of this condition. In most case reports, the patient has been hospitalized and has been provided with a protective and supportive environment. In some instances, low doses of antipsychotic medications have been reported to be beneficial. Confrontation or interpretations of the patient’s approximate answers are not productive, but exploration of possible stressors may be helpful. Hypnosis and amobarbital narcosynthesis have also been used successfully to help patients reveal the underlying stressors that preceded the development of the syndrome, with concomitant cessation of the Ganser symptoms.

Usually, a relatively rapid return to normal function occurs within days, although some cases may take a month or more to resolve. The individual is typically amnesic for the period of the syndrome.

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