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THE DISSOCIATIVE CONFABULATORY PROBLEM

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Abstract

Motivation/Background: The dissociative identity disorder implies as central defense the dissociation, that is being more recently studied. With the identification of the importance of this mechanism of functioning, the modern psychiatrists show the interest of this area, not only about the spectrum of the discharge, as was the case in Freud's time. Dissociative identity disorder involves a patient who can function in any registry, be it neurotic, psychotic or disharmonic.
Method: Study of specialized literature, psychodynamic and psychoanalytic psychiatric perspective, psychiatric evaluation, evaluation of intrapsychic dynamics, transfer and countertransference analysis, hypnosis option study.
Results: Psychically, patients function within a DID, with particularities such as the construction of illogisms, reversing the cause with the effect, sliding the speech towards the secondary meanings of the words, sliding easily from general to particular and from abstract to concrete. From the dissociative dimension we find the impersonal speech or the use of several pronouns with reference to the self and the denial of reality as a handy way to deal with the trauma, which we suppose from the register of abuse.
Conclusions: We find several personalities with symbolic meanings, with a deficit of mentalization, sometimes with an emphatic laugh and an attitude of superiority.

Keywords: Dissociative Identity Disorder; Psychotic Functioning; Paraphrenic Area; Abuse; Dissociation of Affective Memories.

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1. Introduction

Dissociative disorders are characterized, first of all, by the failure of the integration functions of memory, consciousness, identity and perception of the environment. Dissociation disturbs the

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sense of self and the memory of events. Psychoanalysis associates the process of dissociation with the phenomena of conversion. Disorders characterized by dissociative phenomena are dissociative identity disorder (multiple personality disorder), depersonalization disorder, dissociative disorder without other specifications, dissociative amnesia (formerly known as psychogenic amnesia) and dissociative escape (formerly referred to as psychogenic escape). [1]

From a clinical point of view, dissociative phenomena are characterized by a sudden onset and ending, while the evolution is uneven and varies. The duration may be short, of several hours, or may last several years. Although they deny the psychological issues, the sick person claims to have some functional deficits. The pulsion is suppressed and the affect is transformed (converted) into a somatic symptom. The release occurs through a sensory or motor symptom. These deficits are not consciously concealed, as they are determined by subconscious psychopathological mechanisms. Patients have histrionic characteristics and are dependent on entourage, so these accusations bring secondary benefits, which arouse the compassion of the entourage and place the subject in the center of attention. [2]

Sometimes, the manifestation model is "imitative", taking over the pathology of other patients in the salon, and sometimes, on the contrary, it is striking "total indifference" to a massive functional deficit. The manifestations of this syndrome are subdivided into: conversational disorders (pseudo-neurological), such as paralysis or paresis, convulsions, anesthesia or skin hypoesthesia, loss of senses (blindness, deafness, anxiety, aphonia, dysphonia) - all exclusively psychogenic (non-neurological) and, respectively, dissociative disorders: dissociative amnesia, dissociative escape, dissociative stupor, dissociative trance, multiple personality disorder, Ganser syndrome - all psychogenic and involving a dissociation of consciousness.

When the memory process is poorly integrated, dissociative amnesia occurs. When the identity is fragmented, together with the dissociative memory, complete amnesia or dissociative identity disorders appear. When living and perceiving the self are disturbed, depersonalization disorders occur. [3]

Dissociative amnesia is characterized by the impossibility of remembering some personally relevant information. The incapacity is most often of traumatic or stressful nature, but it has an extent that cannot be explained by the normal process of forgetfulness. Normally, the lost information should be part of the state of consciousness, the autobiographical memory. Missing information can influence the person's behavior. [4]

In this disease, the gap may consist of several minutes, several hours or days, for one event or more. Most patients are aware that they have forgotten the events for a certain period of time, but other patients are aware of this only when they find out or are confronted with evidence that they have done things they do not remember.

2. Types of Dissociative Amnesia

There are several types of dissociative amnesia:

- Localized amnesia: the inability of the person to recall events from a certain period of time;

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- Selective amnesia: when the person remembers some events from the circumscribed time period, but not all, or remembers the events fragmentarily;
- Generalized amnesia: when the amnesia concerns the whole life of the individual. It is an amnesia that appears less often than the other types;
- Continuous amnesia: the person cannot remember any event that happened after a certain trauma;
- Systematic amnesia: when the information about an object, a person, a kind of event is passed below the activation threshold.

The incidence of dissociative amnesia is not known, but it is most commonly seen in young adults and is associated with traumatic experiences. Many amnesia experiences have been linked to episodes of sexual abuse in childhood, as their memories came back during adulthood. Trauma-induced amnesia can be reversible with treatment, following an event, or by exposure to certain information. These memories have been considered quite controversial, as their accuracy is often unknown. [5]

Dissociative amnesia appears to be caused by stress associated with traumatic experiences or events in which the subject participated (physical or sexual abuse, rape, war, natural disasters) major life stressors (abandonment, death of a loved one, financial distress) or interior conflicts: criminal behavior, unresolvable interpersonal difficulties, and harassment due to guilt or oppression.

The most common and most obvious symptom is memory precariousness over a certain period of time, but it is accompanied by confusion and sometimes depression. Other symptoms depend on the importance of the forgotten ones, their impact on personal problems and conflicts, or the consequences of the forgotten behavior. Some people may be very affected by amnesia, while other people may not be affected by it at all.

Most people affected by dissociative amnesia recover their missing memory. However, there are people who cannot overcome their barriers and cannot reconstruct their absent past. This fact is determined by the patient's life circumstances, by the stressors and conflicts associated with the amnesia as well as by the general psychological adjustment of the patient.

2.1. Complete Dissociative Amnesia

Complete dissociative amnesia or dissociative escape consists of one or more episodes of amnesia in which the loss of identity or the formation of a new identity occurs when leaving home or from work, unexpectedly. The person is unable to recall a part or the whole past, being confused about the previous identity. Complete amnesia can take up to a few hours, weeks, months, and in rare cases, it can be longer. [6]

The person may look normal and not attract attention. They can assume a new identity, a new name, a new address and create complex social interactions in their new life. At one point, however, the person may become confused about his or her identity and become aware of amnesia or may they return to the original identity.

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The causes of this disorder are similar to those of dissociative amnesia. Its incidence is 0.2% but it is more frequent in cases of wars, accidents or natural disasters. Complete amnesia can be faked because it can remove the person from an embarrassing situation, it can absolve him of certain responsibilities.

This dissociative disorder seems to represent the disguised fulfillment of a desire. It is an extreme self-defense mechanism that can remove the person from unbearable stress. It can be associated with rejection or separation problems. Certain complete amnesias seem to protect the person from suicidal or homicidal tendencies. Even if the person does not have symptoms during complete amnesia when it ends, depression, shame, intense conflict, and suicidal or aggressive impulses may occur. The person must face the problems he ran into. Most complete amnesias are short and self-limiting. If an episode lasts longer, they may jeopardize the original identity.

2.2. Disorders of Identity Dissociation (DID)

Disorders of identity dissociation, or multiple personality disorder, are characterized by two or more identities that alternatively drive the person's behavior. They are patterns of stable responses that appear in different contexts. The personalities can be extremely different, differing in their psychological characteristics, brain pattern, response to personality and intelligence tests, and may even have neurophysiological differences. Amnesia is present through the inability to recall important personal information related to some identities.

Sometimes the personalities of the same individual are amnesic with each other, sometimes one of them is dominant and observes the behavior of the other personalities, and sometimes one personality knows another and is amnesic towards the other. Amnesia is not identical for all personalities; what is not known by one personality can be known by another. [7] Personality dissociation is serious and chronic. It is supposed to end more than any other mental disorder through suicide.

As a result of the knowledge of the disorder, the improvement of the diagnostic methods and a better analysis of the inappropriate behaviors from childhood and of their consequences, 3-4% of the acute psychiatric patients, institutionalized but previously undiagnosed, have been diagnosed with this disorder in the last years; a fairly important minority of patients admitted for psychotropic substance abuse. [8]

The causes of dissociative identity disorder are manifold: unbearable stress, dissociation capacity, the defensive cataloging of one or more stages of personal development, lack of education and compassion in response to painful experiences or lack of protection from subsequent painful experiences.

Given that we are not born with a unified identity, the development of the unified identity is hindered in children subjected to abuse of any kind. Advocating abuse of these patients is not always credible, but painful experiences can also include loss, suffering from serious childhood illnesses, war or natural cataclysms. Some children who develop under such defective conditions do not necessarily develop multiple personality, as they may have normal adaptive mechanisms or may be sufficiently protected by adults. [9]

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The successive replacement of the personalities and the accompanying amnesia lead to a chaotic life. Patients report the presence of internal conversations and the voices of other personalities who comment or address them. Also, the person becomes depersonalized - he has the sensation of being unreal, of alienating himself and detaching from his own physical and mental processes; de-realization is also present - it refers to the perception of people or familiar places as foreign or strange or unreal.

2.3. Depersonalization

Depersonalization disorders are characterized by the persistent feeling of being detached from one's own body or mental processes and, usually, the feeling of being an outside observer of one's own life. Depersonalization occurs most often in situations where the person's life is threatened: accidents, aggression, rape, illness or serious injury. Depersonalization may be a symptom of several psychiatric or convulsive disorders. Patients may perceive the world as unreal, dream-like, and have a distorted perception of their own person, body and life. These symptoms may be accompanied by anxiety, panic, and phobia. [10]

Some of those affected by depersonalization can adapt to it and even suppress its effects, but others have chronic anxiety related to mental health, fear regarding going crazy or concerned about the impact of the disorder on the body, and the feeling of alienation of themselves and others. Depersonalization is a transient disorder that can be resolved spontaneously. Recovery can be successful, especially with patients whose symptoms have appeared under extremely stressful conditions.

Unspecified dissociative disorder is a category that includes disorders characterized by dissociative manifestations that do not meet the criteria needed to diagnose one of the previous disorders. It is a category that includes elements of de-realization, in the absence of depersonalization, comatose states not associated with a general medical condition, Gansser syndrome, and the dissociative trance specific to certain cultures. [11]

2.4. Gansser Syndrome

Gansser syndrome was classified as a simulative disorder with psychological symptoms and then classified as a dissociative disorder, unless otherwise specified, although the dissociative disease with predominantly psychological signs and symptoms remains valid. This syndrome is characterized by: approximate responses, approximate calculations, approximate acts, and by the sudden onset and disappearance of hysterical symptoms and stigmas (amnesia, hallucinations, arousal, depression, indifference, perplexity and sensory symptoms and the motor of conversion). The basic element is the altered consciousness: the obscurity, the superficiality and the inconsistency of the content. It is an extremely rare form of dissociation. It has also been called pseudo-dementia because the subject provides meaningless answers to simple questions and misplaces easy and routine activities. It was also called prison psychosis because it was observed and studied in detained patients. Most often it heals spontaneously after the stressful situation is gone. [12]

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2.5. Confabulation

Confabulation is a memory disorder that can occur in patients who have suffered frontal lobe lesions. Confabulation is defined as the narration of the imagination, without any relation to the reality of life events related to the past or present. False memories are either about events that didn't happen, or are real events that happened in the past, but during which the time period is no longer accurate. These memories can even be elaborated and detailed. Unlike the lie, the confabulation is involuntary and unconscious. Confabulation does not occur only in dissociative-conversational disorders. It can be a syndrome of patients who have suffered brain damage, especially of the prefrontal regions. Patients with Korsakoff syndrome typically confabulate by guessing a response or imagining an event. Sometimes confabulation occurs as a result of brain chemistry. False memory syndrome is a disorder in which a person's identity and relationships are affected by incorrect memories, but which the patient strongly believes. The confabulation goes to delirium and paraphernia. [13]

2.6. Paraphrenia

Paraphrenia is characterized by a chronic systematic, hallucinatory delirium. Thinking is invaded by imagination, becomes delusional and leads to the creation of an unreal, fantastic world.
The delusional ideas are grouped into three categories:

- of influence: spiritualism, telepathy, hypnosis, electromagnetic waves,
- persecution: plots, conspiracies,
- of magnification, of fantastic character: prophets, deities.

Systematic paraphrenia involves the slow change of the patient's personality, predominating the delirium of persecution. The patient has hallucinations, especially hearing ones, and has a systematic delirium. Expansive paraprenia (pseudo-maniacal) implies the creation of a delusional system of magnification, megalomania, and erotomania, against the backdrop of an exalted, euphoric disposition, with psychomotor excitation. [14]

Confabulatory paraphrenia is rare. The characteristic element is represented by the memory hallucinations (confabulations). The patients express strange, bizarre, imaginary, mysterious-looking states. The predominant delirium is that of persecution and megalomania. A leitmotif is the delirious idea of filiation. Fantastic paraphrenia is characterized by the appearance of fantastic delusional ideas, not systematized, but with a relatively harmonious personality. Schizophrenia has delusions, hallucinations; paranoia also includes delirium.

The main difference between the dissociative conversational disorders and the other types of disorders mentioned is that in the case of the first category the imagination affects the memory and in the other types the imagination affects the thinking, the perception. All these disorders result in the alienation of oneself and the loss of contact with reality.

3. Conclusions

In the dissociative disorder of identity, dissociation is the main mechanism of those concerned to negotiate with stress. In Kluft's vision we talk about "a pathology of hiding", with confidence in

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these patients being problematic, the maturation processes being rather affected than the traumatic ones.

Ideal is when a therapist refers to multiplicity not as a bizarre aberration, but as an adaptation of a particular person's meaning to a specific, more specific, history, as to a chronic posttraumatic stress syndrome of childhood origin.

From this perspective, the idea of a personality created traumatically outside consciousness does not require an imagination effort, it is a fantasy that involves interaction with developmental challenges.

Recently, the interest in dissociation has increased, intimately linked to the interest in posttraumatic stress disorder. Thus, there has been a rebalancing of psychodynamic psychiatric concentration towards trauma, after a long period of time when it was largely neglected in favor of intrapsychic phantasms.

Dissociative identity disorder involves the inability to evoke important personal information that is too extensive to be explained by common oblivion. Clinical evolution is fluctuating, the median period from the first episode to diagnosis is seven years and frequently associates substance use.
Those concerned may have periods of time in which they function psychotic, attributing the phenomena of external forces that have taken control of them. In the case of schizophrenia, however, patients have a gradual, insidious flattening, accompanied by withdrawal, which does not attract the therapist in strong countertransference.

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