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Dissociation Across the Lifespan

Abstract

Dissociation is a disorder in which people separate themselves from the thoughts associated with traumatic events they have experienced. People can experience dissociative symptoms across the entire developmental lifespan. Traumatic events that produce high levels of PTSD symptomatology can also contribute to the development of a dissociative disorder, especially if the individual experiences dissociative symptoms during the traumatic event. However, high levels of dissociative symptoms has more of an influence on the development of PTSD than PTSD does on the development of dissociative symptoms. Trauma is strongly correlated with the development of dissociative symptoms. A dissociative subtype of PTSD was added to the DSM-V and is expected to account for 10% of all PTSD cases. The chances of developing a dissociative disorder increase if an individual experienced early childhood abuse and neglect. Studies of the elderly who have experienced dissociative symptoms suggest that the passage of time may act as a buffer and a means by which the severity of dissociative symptoms are lessened. Using an individualized approach by gathering specific information from people who suffer from dissociation informs caregivers as to whether confronting trauma directly through journaling or speaking expressively about their trauma is appropriate.

Cover Page Footnote

Don Jones, Psychology, was the faculty supervisor for this Honors contract.

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Human development is concerned with biological and environmental forces that impact human beings over the entire course of their lives. Trauma is an environmental force that most human beings have experienced, and if the trauma is strong enough and/or ongoing it may cause an individual to develop post-traumatic stress disorder (PTSD). Depending on the severity of PTSD, the person could also develop dissociative symptoms. Individuals who experience dissociative symptoms during the time of the traumatic event have a much higher chance of developing chronic PTSD, as well as a dissociative disorder. Dissociation will be examined cross-sectionally by using research gathered from academic journals that specialize in reporting studies, facts gathered, treatment options for, symptoms, and causes of dissociation in young children, adults, and the elderly. Types of trauma will be reviewed to determine how predictive they are in determining whether an individual will develop a dissociative disorder.

Jim Walker (2009) defined dissociation as “an unconscious process in which thoughts, feelings and memories that cause anxiety are either cut off from consciousness or from the associated affect.” Dissociation involves having the ability to separate oneself from the traumatic experiences that one endured. According to Bryant (2007), dissociation is characterized as “alterations in awareness in the context of a traumatic experience,” and causes “disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment.” Individuals who have experienced dissociation can feel emotionally detached from their environment, and experience a sense of mental numbness. Their awareness of their surroundings can decrease, and their brains can fail to properly encode memories of events.

Depersonalization disorder is now labeled as “depersonalization/derealization disorder” because derealization symptoms are usually present in a diagnosis of depersonalization disorder. Derealization is a distortion in perceived reality and can include distortions in the perception of

how fast or slow time is passing. A person experiencing derealization can also experience events as dream-like. Depersonalization occurs when an individual experiences himself as not being whole—as being separated from his body and witnessing himself interact as if he were a third party observer.

People who have been diagnosed with PTSD have been shown to have higher levels of dissociative symptoms and are more susceptible to hypnotism than the general public and other groups of people with nonparallel, psychiatric disorders. People who experience dissociation at the time of trauma have a greater chance of developing chronic PTSD (Bryant, 2007).

Dissociative identity disorder is defined as “disruption of identity characterized by two or more distinct personality states or an experience of possession.” “An experience of possession” was added to account for people from other cultures that are more familiar with such things as demon possession than western cultures are.

The criteria for the diagnosis of dissociative identity disorder were extended to include dissociative amnesia (loss of and/or failure to recall memories) and its frequent occurrence in normal, everyday events as well as traumatic events (Spiegel, 2012). Dissociative amnesia is characterized by the mind failing to integrate memories (usually traumatic or stressful) into the rest of consciousness.

There is also a rare form of dissociative amnesia that affects memory more globally and is not necessarily related only to the stressful, trauma-induced memories. This rare form also consists of the individual experiencing this more globalized dissociative amnesia as engaging in “purposeful travel or bewildered wandering.” This rarer type of dissociative amnesia is now considered a subtype of dissociative amnesia in the DSM-5, instead of being associated with a dissociative fugue diagnosis. (Dissociative fugue will be discussed later).

Post-traumatic stress disorder has a new dissociative subtype, and this subtype is expected to account for 10% of all PTSD cases (Spiegel, 2012). This is noteworthy in that PTSD sufferers commonly express symptoms triggered by an aroused limbic system and suppressed activity in the frontal lobes of the brain, but sufferers expressing symptoms of the dissociative subtype experience opposite brain activity—with a suppressed limbic system and more activity in the frontal lobes, which is indicative of emotion and memory suppression. Leading experts (Spiegel, 2012) in dissociation recognize the dissociative subtype of PTSD as descriptive of an exclusive group of PTSD sufferers and the neurobiological evidence supports this as well as the different responses to treatment experienced by those suffering from the dissociative subtype.

Some people are more prone to respond to trauma by using dissociation than others, and it is argued that dissociation is a way for people to manage the acute pain that the trauma has inflicted upon their psyches by offering a kind of emotional release and blunting that separates their brains from the pain that their body endured, and experiencing themselves as separate from their bodies. Spiegel (2012) offered an example of a rape victim telling her story and how she felt like she was floating above her body and feeling sorry for the person who was being raped, and another girl said that she heard someone screaming and realized that it was herself who was screaming. These stories are characteristic of a person experiencing depersonalization as a coping mechanism for their brain to handle the pain of the trauma. Early life trauma could be very important in understanding how dissociative disorders and PTSD begin. A study conducted by Steuwe, et al. (2012) found that there was a more likely chance of developing dissociative disorders when there was an early childhood history of abuse and neglect.

The individuals who belong to the dissociative subtype of PTSD also frequently experience affective dysregulation, interpersonal and self-perception problems, and more severe

exposure to trauma. Individuals under this subtype also had higher scores on the Dissociative Experiences Scale when they had other disorders related to trauma. A person can have high levels of PTSD and not experience dissociative symptoms, but usually when a person expresses high levels of dissociative symptoms they also experience highly reactive symptoms of PTSD. Because of this, trauma is strongly correlated with the development of dissociative symptoms.

Treatment options for individuals experiencing the dissociative subtype of PTSD differ from those used to treat other groups of PTSD sufferers, and so more effective results depend on correctly identifying this subtype in the individual. Three treatments—psychotherapy, affect and relationship management training, narrative storytelling, and supportive counseling—have been shown to help individuals suffering from PTSD, and that the individuals belonging to the dissociative subtype initially fared better than others low in dissociation when they were exposed to the skills training and narrative storytelling (Spiegel, 2012).

Supportive counseling also worked to maintain the progress that the clients made in therapy. Cognitive processing therapy and completing written accounts of the trauma also worked well for individuals with high dissociation levels, but writing hampered progress for the individuals who experienced low levels of dissociation (Spiegel, 2012). It was speculated that the writing helps the individuals who experience high levels of dissociation to identify and integrate their traumatic memories better. It does not help the individuals with low levels of dissociation to write, because it brings up the trauma in a way that distresses the individual without a method to deal with the distress.

Treatment is geared toward stabilizing mood and teaching emotional regulation while working through the trauma. Trauma and dissociation are linked. Identifying dissociation improves treatment selection and outcome (Spiegel, 2012).

Walker (2009) states that there are two responses to trauma that an individual can have: one involves a hyperarousal response and the other involves dissociation. A person who experiences trauma and suffers from it either focuses on the details of the trauma and their connection to it, or they withdraw from the connections to the trauma through dissociation. When an individual is exposed to severe trauma, physiological changes related to hyperarousal start to occur, such as an increase in heart rate, breathing, and blood pressure; but if the trauma is long-lasting then the individual becomes more susceptible to dealing with the trauma through dissociation (Walker, 2009).

Walker (2009) discussed that people who dissociate shift their focus from their stressful, traumatizing, external environment to their internal world. Walker described this as if the dissociating person is "'playing dead,'" and the person avoids attention and behaves as if he were trying to make himself invisible. Walker stated that children who dissociate display symptoms of "'numbing, avoidance, compliance and restricted affect,'" and also noted that infants who have been traumatized will appear to have a glazed-over look on their faces and will be staring off into space.

Walker related that in child protection assessments there were two types of children who experience dissociation: children who suffered from dissociative amnesia and, more commonly, children who still had the memory of the traumatic event but had expressed some kind of separateness from themselves and the traumatic event.

Dissociation in children was most common when the child was being abused by a caregiver. The reason for this is that the caregiver is mostly, if not always, present and the child cannot escape from the environment, so the child has to turn inward to numb the pain. Child-experienced dissociation is correlated with sexual abuse, and when the child talks about

memories associated with the trauma the child will appear not to be affected by the trauma. This is a perfect example of the withdraw aspect of dissociative behavior. The child is clearly experiencing a numbing effect to the trauma by his lack of physiological responses to the memory of the trauma.

Women who have been sexually abused will often speak of physically being removed from the trauma. A woman who had been sexually abused as a child by her father was abused many times after that by other men, and when describing one of the experiences she said that "'I was there but all lights were off'" (Walker, 2009). This statement was in reference to her experiencing her body as being victimized but of her actual self as not being there. There are reports from other women who felt as if they were looking down from the ceiling at their bodies during the trauma.

Children who experienced severe trauma are also likely to experience a strong feeling of shame about themselves over the event (Walker, 2009). The child experiences shame because the child cannot understand how a parent or another caregiver, who loves them and is looking out for their well-being, can simultaneously be a harmful, abusive person. This is due to the child's attachment to the parent or caregiver and it makes more sense to the child to think of himself as deserving of the treatment or as a bad person.

The child is also sensitive to shame-development when the abuser calls the child names and says that the child is 'worthless,' or 'pathetic.' The child can internalize the feelings that these statements cause and the child's shame can cause the child to want to forget those feelings, and the child will unconsciously use dissociation as a means to accomplish that. Shame can block access to emotional thoughts and make it difficult for the person to talk about the

experience or gain any new knowledge of the situation because the child's brain disconnects the child from the trauma though dissociation.

Children who experience dissociation also performed more poorly than other children their age, academically (Walker, 2009). The dissociative child lives in an internal world and it makes it hard for him to process what is going on in the external world. Children who suffer from PTSD and express hyperarousal symptoms do similarly poorly in school, because they are so focused on keeping themselves safe and on what is going on in their environment that it makes it hard for them to relax and focus on learning tasks.

When traumatized children grow up to be adults, the consequences of the trauma that they suffered continue to affect their lives. A sad, but firm truth is that traumatized individuals grow up, have kids, and then these individuals can unconsciously impose their suffering onto their children. Individuals who were victims of childhood trauma can develop dissociative symptoms and then when their own children engage in activities (such as crying) that remind the adult of childhood trauma, the adult could dissociate, and this dissociation could lead to child neglect. Adults who were victims of childhood trauma can also unconsciously impose that suffering onto themselves and their children by gravitating toward romantic partners that are a threat to the health and well-being of themselves and their children.

There is a strong correlation between neglect and dissociation (Walker, 2009). It is harder for a parent to be in-tune to his children's emotional needs if the parent was traumatized as a child. An example is offered of a mother who neglected her four children: The mother had a tumultuous childhood—she never knew her father, was rejected by her mother, and was treated very poorly by her aunt when she went to live with her. Whenever the mother's children would cry or would act distraught the mother would dissociate. She would return to her internal world

where the pain and the memories of when she was distraught and hurt as a child couldn't bother her. This retreat into her internal world resulted in neglect of the children's emotional needs.

Individuals who have had a history of sexual abuse and unconsciously used dissociation as a coping mechanism are less capable at assessing whether a romantic partner poses a threat to their children. Dissociation is associated with an avoidant attachment pattern, and that avoidant attachment pattern gets projected onto the romantic partner, and makes it easier for the dissociative individual to deny evidence or suspicions of sexual abuse that their partners could inflict on their children.

Dissociation is linked to repeated behavior patterns, and this is especially true when it comes to choosing a romantic partner. Unconsciously, the traumatized individual is repeating over and over again, with their choice of abusive romantic partners, the abuse that they suffered. Traumatized individuals who cut themselves off from their own suffering through dissociation effectively make themselves blind and unable to properly assess risk in another person.

Deception can be a symptom of dissociation. By cutting off part of their memories, and being avoidant of potentially dangerous behaviors in others, people who dissociate can consciously and unconsciously deceive themselves as well as other people, particularly when confronted with the question of whether they are still in a relationship with their abusive partner. Dissociative identity disorder used to be labeled as multiple personality disorder because it is as if the individual is living two lives: one as the competent, caring mother of her children and the other as the self-destructive type who is avoidant when it comes to traumatic behavior.

Accessing the memories of trauma also makes it hard for an individual to understand oneself. This failure to understand oneself, in turn, makes it more difficult for an individual to identify behaviors in others that are destructive and traumatizing. When one finds an abusive

romantic partner, one can be deceived into thinking that there is nothing wrong with the person by cutting oneself off from the traumatizing memories. This gives the traumatized individual a decreased ability to properly judge others who engage in the same traumatizing behavior, because the brain is suppressing traumatic memories.

When it comes to treating people with dissociation, oftentimes a person will become mute after the trauma, and possibly for several weeks (Walker, 2009). Trauma affects parts of the brain associated with speech and, therefore, purely verbal treatment options would not be effective. Re-traumatisation is another issue. Some people gain relief from talking through their trauma, but for others, recalling their trauma in an attempt to work through it only traumatizes them over again. Less verbally-based treatment options exist that could help individuals who suffer from dissociation and who have experienced severe trauma. These include EMDR, EFT, and TFT.

It also makes it hard to educate traumatized individuals on the nature of victimizers, because it brings up those past memories of abuse, and the individual shuts down and does not take in any information. People who feel shame concerning their trauma need to be treated in a way that takes this into account and should do nothing to further their feelings of shame. Instead treatment should be used focusing on lessening these feelings in order to get the person to be more open about their experiences. The person's denial, rage, and dissociation concerning the traumatizing events will abate if steps are taken to reduce feelings of shame in patients (Walker, 2009).

Work with adult combat veterans helped to develop a new category of PTSD (Wolf, 2013). Specifically, a new subtype of PTSD was formulated and this subtype includes dissociative symptoms like depersonalization and derealization. Dissociation and PTSD have

several connections. More often than not, an individual with a dissociative disorder will also develop PTSD, but the link between the two is not as strong in reverse (individuals with PTSD developing a dissociative disorder). Also, the earlier an adult experienced sexual trauma as a child the greater the chance of the adult developing a dissociative disorder and probably PTSD along with it. Both adults with a dissociative disorder and with PTSD also expressed similar levels and percentages of sufferers who suffered from chronic depression (also called dysthymia).

The results of a latent profile analysis conducted on a group of male and a group of female war veterans showed that 15% of the individuals had dissociative symptoms like depersonalization and derealization that went along with their PTSD diagnosis, but this group was distinct from the other groups. The female dissociative group did not necessarily experience more sexual trauma than the females from the other groups of PTSD sufferers, but the level of their personal trauma was higher, and the dissociative group of females also expressed symptoms of borderline personality disorder as well as avoidant personality disorder (Spiegel, 2012, p. 668).

The DSM-5 does not use the word *subtype* to describe a category of PTSD and its symptoms. Instead, the word is used to label a unique form of PTSD where depersonalization/derealization co-occurs with PTSD. Wolf proposed that the small percentage of individuals with the dissociative subtype of PTSD do not necessarily experience higher levels of PTSD than other groups of PTSD sufferers.

The relevance and generalizability of the dissociative subtype was investigated in a study of 25,000 individuals from sixteen different countries and the study found that about 14% of the individuals could belong to the dissociative group (Wolf, 2013). The group showed elevations in

flashbacks and psychogenic amnesia. Psychogenic amnesia is now called dissociative amnesia, and it is characterized as memory loss concerning traumatizing events. The general profile of this group was as follows: male, having child-onset PTSD, greater levels of trauma exposure, higher levels of functional impairment, suicidality, and anxiety disorders. This study showed more support and evidence for the existence of the dissociative subtype because of the large, culturally and economically diverse sample size.

It is possible that the dissociative subtype has a particular etiology, biology, course, and response to treatment. People could have a genetic predisposition for dissociation and this would have to be accounted for in order to gather statistics, perform statistical analyses, and replicate the results of other studies (Wolf, 2013).

The qualities of dissociation include: amnesia, depersonalization, and absorption. In one study, using taxonometric procedures, 32% of Vietnam veterans with PTSD fit into a dissociative group (Wolf, 2013). Individuals belonging to the dissociative subtype exhibit all of the symptoms of PTSD in addition to derealization, which is defined as "perceiving one's world or environment as not real," and/or depersonalization—"perceiving one's self as not whole, connected, or real."

Depersonalization, derealization, and reduction in awareness are used in latent profile analysis to gauge how severe dissociative symptoms are and found that 12% of veterans with PTSD scored high in dissociation (Wolf, 2013). The veterans belonging to the dissociative subtype of PTSD had higher rates of flashbacks as well as self-reported higher rates of sexual assault as children and adults. Roughly 15% of male and 30% of female veterans with PTSD belong to the dissociative group. Borderline and avoidant personality disorders were more likely to occur together with the female dissociative group (Wolf, 2013).

Symptoms of dissociation include: absorption, gaps in awareness, imaginal involvement, identity alteration, derealization, depersonalization, and amnesia (Waelde, 2005). High levels of both dissociation and PTSD were associated with each other. If a person experienced dissociative symptoms within the first month after the traumatic event then that person was more likely to develop PTSD. PTSD and dissociation shared another connection: individuals who have PTSD, many also scored a clinically significant score on measuring dissociation—not as high as individuals with dissociative disorders, but higher than other groups.

A relationship existed between re-experiencing symptoms and dissociation. Another relationship that existed between dissociation and PTSD is that 80% of one group belonging to a dissociative group was diagnosed with PTSD as opposed to only 18.2% being diagnosed with PTSD who didn't belong to the dissociative group (Waelde, 2005). There was a greater chance of an individual who has dissociative symptoms developing PTSD than there was of an individual with PTSD developing dissociative symptoms.

Adults belonging to the dissociative taxon frequently also experienced dysthymia, and many sufferers of chronic PTSD also reported dysthymia (Waelde, 2005). Since combat trauma was usually repeated many times for an individual, and also because of the severe nature of the trauma, it could explain why combat veterans who have PTSD show higher rates of dissociation than other traumatized groups.

As far as obtaining the most accurate information from the patients in order to treat them properly, a combination of interviews and DES questionnaires should be used instead of just the self-reported information gathered from the DES. Dissociation might be more common in those who have experienced chronic child abuse compared to other stressful events (Waelde, 2005). Research has suggested that anger and dissociation are risk factors for PTSD development, and

that higher levels of PTSD are associated with high levels of anger in people who have survived trauma. Also, a relationship exists between dissociative symptoms and high levels of PTSD. Among veterans, “Anger and dissociation predicted PTSD, hyperarousal, and avoidance/numbing severity.”

The symptoms of PTSD include: re-experiencing traumatic events, numbing of emotions, events of things that trigger distress, exaggerated startle response, and emotional detachment (Kulkarni, 2012). It is estimated that 15% of Vietnam veterans, 2-10% of the veterans of the first Persian Gulf War, and 11-22% of Afghanistan and Iraq active duty soldiers have PTSD. Veterans experiencing anger and dissociation have a greater chance of developing and maintaining PTSD.

Dissociation is defined as “difficulty integrating thoughts, feelings and experiences into consciousness and memory.” Military members who experience dissociative symptoms during and after being exposed to trauma have a higher chance of developing PTSD and the PTSD could be more severe (Kulkarni, 2012). An Individual with PTSD who dissociated at the time of the event was the single greatest predictor of the person developing the dissociative form of PTSD. This outweighed prior trauma history, family history of psychopathology, perceived life threat during the trauma, post-trauma social support and prior psychological adjustment as the chief predictor of dissociative PTSD development. Veterans who had high levels of dissociation during and after the time of the trauma were more likely to have PTSD than not have it.

A sample of female veterans experienced dissociative symptoms and a large portion of them experienced intrusive and avoidance symptoms; intrusive and avoidance symptoms as a result of dissociation development had significant predictive power. Only one group of

Australian Vietnam veterans experienced arousal symptoms related to dissociation (Kulkarni, 2012).

Sexual abuse is thought to potentially be a catalyst for a person developing dissociative symptoms, but physical abuse and assault are thought not to contribute to dissociative potentiality. If a person was sexually abused as a child, then the likelihood of developing dissociative symptoms increases. It was found in a group of Vietnam combat veterans with chronic PTSD that they had high levels of dissociation, and they had higher levels of experience with physical and sexual abuse than Vietnam combat veterans who did not have PTSD.

However, a group of Cambodian refugees who had experienced severe sexual and physical trauma also had high levels of dissociation, and because of this, it was not certain to what extent other factors like the type of trauma, age of the victims, and cultural distinctions could influence the development of dissociative symptoms.

Intrusive thoughts, avoidance, and impaired concentration are part of behavior consistent with dissociation. Dissociation and PTSD are interrelated in that flashbacks and psychogenic amnesia are PTSD symptoms, but are also categorized as extreme dissociative symptoms. And dissociative symptoms like intrusive thoughts, avoidance, and impaired concentration are also symptomatic of PTSD. And those who had PTSD experienced more dissociation, as a group, than non-PTSD sufferers.

One of the main differences between adults and the elderly suffering from PTSD and a dissociation disorder is the impact of passed time on the elderly. Elderly Holocaust survivors were found to have less severe dissociative symptoms, and it could be due to how much time had passed since the trauma (Yehuda, 1996). As with adults, analysis of the elderly Holocaust survivors also showed a correlation between PTSD symptom severity and dissociative symptom

severity. The elderly survivors also experienced fewer instances of particular PTSD symptoms like flashbacks and psychogenic amnesia, despite having high levels of overall PTSD. Dissociative fugue was also analyzed in the elderly by reviewing the actions of a sixty-two-year old Indian woman who fled from her home and had no memory of the flight or of the events that transpired during her dissociative flight (Rajah, 2009).

A study of sixty, elderly holocaust survivors was completed in order to assess the relationships among PTSD, trauma, and dissociation. A control group was part of the study, and consisted of sixteen members. The study showed that the group with PTSD had much higher levels of dissociative symptoms than the other groups, but the level of dissociation was much less than in other groups of people who had experienced trauma and who had PTSD. The possible explanation for this was the age of the holocaust survivors—a lot of time had passed since the trauma, and the lapse in time could have acted as a buffer against the trauma-induced dissociative experiences.

Current stress and other factors that could have skewed the results of the study were accounted for by using the Antonovsky Life Crises Scale and the Elderly Care Research Center Recent Life Events Scale (Yehuda, 1996). However, the group of Holocaust survivors could have had unique characteristics that other people studied for PTSD and dissociation did not share, and therefore the results could not have been representative of the elderly who experience PTSD and dissociation, as a whole. The study also found a positive correlation between PTSD symptom severity and scores on the Dissociative Experiences Scale.

The group of elderly, Holocaust survivors was unique in that they had very high levels of PTSD but very few had symptoms of flashbacks and psychogenic amnesia (3% and 6%, respectively). This group differed from other trauma-exposed groups in that they did not partake

in substance abuse as much as other groups (substance abuse could exacerbate experiences of dissociation). They were unique because the early age at which many of them were exposed to the trauma, and the severity and long-lasting nature of the trauma should, one would think, predict higher prevalence of flashbacks and psychogenic amnesia. Age has been shown to negatively correlate with dissociation. Although the Holocaust survivors scored low, as a whole, on dissociation, other symptoms that can be trauma-induced, like depression and having difficulty expressing, iterating, and feeling emotions (alexithymia), were still very much present.

Some of the Holocaust survivors said that certain PTSD symptoms were more severe in the past, but had abated with time—symptoms such as nightmares, intrusive thoughts, other avoidance symptoms, and physiological hyperarousal. This study showed that dissociation and PTSD were separate phenomena that do not necessarily have to coexist in the experience. An explanation for the low dissociation levels, particularly amnesia, was the cultural effort to not forget what was done to them as a people and were encouraged to speak to others concerning their experiences in the Nazi concentration camps and offer written accounts of their trauma form everyone else to be aware of. This gives more reason to believe that incorporating writing exercises of the trauma into therapy may help those who suffer from PTSD with dissociative symptoms (Yehuda, 1996, p. 937).

"Dissociation is a protective activation of altered states of consciousness in reaction to overwhelming psychological trauma." A case of a sixty two-year-old woman from India, who was diagnosed with dissociative fugue (Rajah, 2009) was documented and investigated. It is estimated that only 0.2% of people experience dissociative fugue, making it a rare dissociative symptom, but it is more common in people who have experienced things like accidents, natural disasters, and wars. Fugue is the name given to the activity of leaving one's environment, maybe

hundreds of miles away, unexpectedly, and not being able to recall recent memories or even memories of the flight from their environment and the activities that took place during the flight. Treatment options for dissociative fugue include hypnosis and/or drug-facilitated interviews.

The sixty two-year-old woman left, unexpectedly from her family and was gone for a few days riding trains to different Indian towns and when the police found her wandering around in one of the towns she told them that she would like to go back home, and she was able to give them the address of where she lived. She got back home and continued her routine as usual except for the fact that she could not remember local people and events that had taken place in the weeks leading up to the episode of fugue.

She was evaluated to determine the cause of the dissociative fugue and was found to have suffered from a fall from a scooter six weeks before the fugue episode. When she went to the hospital for the scooter injury she did not report any loss of consciousness, headache, blurred vision, or vomiting, which could have been indicative of head trauma, which could have helped possibly explain the episode of fugue. She was, however, evaluated for possible post-traumatic sequelae at an in-patient facility. A medical examination found her to have high blood pressure but she was not on any medication. Blood work and a CT scan were normal and she did not show any impairment in her cognitive abilities.

She was described as anxious and tearful when answering questions during an interview and she resisted during the interview. After a session of hypnosis proved ineffectual, a "supportive client-centered approach" was initiated, and she seemed to respond better to that. She reported that she remembered getting into an argument with her husband shortly before she fled. The argument caused her great distress, and she said that it upset her because for years she had dealt with so much stress in her life and that even then he was still being critical of her. She

said that she did not intend to cause her family distress by fleeing and that she only remembered what she was doing after the police questioned her and they brought her home. She did not remember anyone she was in contact with during her episode of fugue. She also had no prior experiences of fugue.

Traumatic experiences can cause people to cope by cutting off memories of the traumatic experience involuntarily. The brain can do this by failing to properly encode memories of the trauma to prevent the strong feelings associated with the trauma like fear, sadness, and anger from manifesting. Dissociation occurs when the brain gives the sufferer the perception that they are separate from their memories of trauma by failing to integrate part or all of the memories associated with the trauma. As far as a biological explanation for dissociation goes, it has been observed in patients who had undergone a dissociative episode that they had a smaller hippocampus and amygdala. Genetics can influence whether someone is prone to dissociative experiences by up to 50%. Increased glutamate release could also account for a person being more likely to experience dissociative phenomena (Rajah, 2009).

Dissociation can affect someone at any time throughout their development. It is possible that biological differences in human beings can predict whether someone is more likely to be a victim of dissociative symptoms. Dissociation is linked to trauma—especially of a sexual nature. There is also evidence to suggest that the younger a person is when they experience sexual trauma the more likely they are to develop a dissociative disorder. Dissociation is also linked to PTSD. A person can have PTSD without necessarily ever experiencing dissociative phenomena, but someone who develops a dissociative disorder is much more likely to develop chronic PTSD than people without dissociative disorders. To further emphasize the predictive power of someone suffering from dissociation being more likely to develop PTSD, if someone dissociates

during or very shortly after a traumatic experience then that turns out to be the chief predictor of future chronic PTSD development.

Children, adults, and elderly individuals, who suffer from a dissociative disorder as well as PTSD, have many things in common. They all share common dissociative symptoms; such as depersonalization and derealization, dissociative amnesia, and retreating to an inner world where they can be cut off from the stimuli of their outside environment. They share common symptoms associated with PTSD, as well; such as flashbacks, hyperarousal, and intrusive thoughts.

A major characteristic of children who have developed a dissociative disorder due to severe trauma is feeling shameful. A small child is entirely dependent on a caregiver and when the child is being traumatized, the child has nowhere to turn but to his internal world as an escape. When the child is in his inner world, the child has thoughts that make it seem as though the abusive behavior is his fault. The child cannot reconcile the idea that his caregiver can both love him and hurt him, so it is easier for the child to rationalize the caregiver's behavior by thinking that he deserves it because he is 'bad.' This causes the child to feel shameful and these feelings of shame can increase if the caregiver describes the child in demeaning ways, such as 'worthless' or 'pathetic.'

Adult sufferers differ from child sufferers in that adults can repeat the cycle of their own abuse by becoming a victim of their dissociative disorder when dealing with their children. An adult who suffers from a dissociative disorder and who has a child can neglect their children during dissociative episodes and put their children in danger by bringing dangerous romantic partners into the home. Consequently, adults who were victims of severe trauma as children have a harder time judging whether someone is dangerous or not.

A marked distinction between the elderly and the other two groups is the way time has impacted the elderly. It is speculated that the reason the elderly, Holocaust survivors showed decreased symptoms of dissociation is because a lot of time had passed between then and the time of the trauma (Yehuda, 1996). The elderly, Holocaust survivors also had low instances of flashbacks and dissociative amnesia even though they had high levels of overall PTSD.

Treatment options exist for people at every stage of their development who suffer from PTSD and dissociative disorders. Some treatment options focus on writing about the trauma and expressing how they feel about the trauma. Other options exist for those who become re-traumatized by talking or writing about trauma. The best thing we can do for individuals who suffer from these disorders is to learn more about their experiences in order to develop the most specific treatment plan for the individual. Continuing to gather data on the causes of dissociation will also affect treatment options. There is evidence to conclude that dissociation can have a genetic link; that sexual abuse as a child is a strong predictor of future dissociative disorders, and that people who suffer high levels of dissociation will probably develop PTSD. Gathering facts like these and exploring personalized treatment plans is the most efficient way to learn more about dissociation and about effective ways to manage and lessen the severity of the disorders.

References

Rajah, A., Kumar, S., Somasundaram, C., & Kumar, A. (2009). Dissociative fugue in the elderly. *Indian Journal of Psychiatry, 51*(4), 305-307. Retrieved October 17, 2014, from Summon.

Spiegel, D. (2012). Divided consciousness: dissociation in DSM-5. *Depression and Anxiety, 29,* 667-670. Retrieved October 17, 2014, from Summon.

Bryant, R. (2007). Does dissociation further our understanding of PTSD? *Journal of Anxiety Disorders, 21*, 183-191. Retrieved October 17, 2014, from Summon.

Kulkarni, M., Porterm K., & Rauch, S. (2012). Anger, dissociation, and PTSD among male veterans entering into PTSD treatment. *Journal of Anxiety Disorders, 26*, 271-278. Retrieved October 17, 2014, from Summon.

Wolf, E. (2013). The dissociative subtype of PTSD: rationale, evidence, and future directions. *PTSD Research Quarterly, 24*(4), 1-8. Retrieved October 17, 2014, from Summon.

Waelde, L., Silvern, L., & Fairbank, J. (2005). A taxonometric investigation of dissociation in Vietnam veterans. *Journal of Traumatic Stress, 18*(4), 359-369. Retrieved October 17, 2014, from Summon.

Yehuda, R., Elkin, A., Binder-Brynes, K. Kahana, B., et al. (1996). Dissociation in aging Holocaust survivors. *The American Journal of Psychiatry, 153*(7), 935-940. Retrieved October 17, 2014, from Summon.

O'Toole, B., Marchall, R., Schureck, R., Dobson, M. (1999). Combat, dissociation, and Posttraumatic Stress Disorder in Australian Vietnam veterans. *Journal of Traumatic Stress, 12*(4), 625-640. Retrieved October 17, 2014, from Summon.

Walker, J. (2009). The Relevance of the Concept of Dissociation in Child Protection. *Journal of Social Work Practice, 23*(1), 109-118. Retrieved November 26, 2014, from Summon.