

WHAT IS DISSOCIATION?

A wide range of definitions for psychological dissociation have been offered by researchers and clinicians. While they might differ in the details, what is common in all definitions is a reference to the lack of usually expected connections between mental content. Dissociative experiences are characterised by a compartmentalisation of consciousness, that is, certain mental events that would ordinarily be expected to be processed together (e.g., thoughts, emotions, motor activity, sensations, memories and sense of identity) are functionally isolated from one another and, in some cases, rendered inaccessible to consciousness and/or voluntary recall (Steinberg, 1994).

The 4th, text revised edition of *The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* (American Psychiatric Association [APA], 2000) defines dissociation as the process whereby the usually integrated functions of consciousness, memory, identity, or perception of the environment are disrupted.

According to Nemiah (1991), dissociation is characterised by “the exclusion from consciousness and the inaccessibility of voluntary recall of mental events, singly or in clusters, of varying degrees of complexity, such as memories, sensations, feelings, fantasies, and attitudes”.

Butler, Duran, Jasiukaitis, Koopman and Spiegel (1996) see the disruption, across a number of domains, of awareness and voluntary control as being central to a definition of dissociation. They describe how dissociation can occur in the domains of perception (e.g., focused attention as in absorption), behaviour (e.g., automatised actions like driving a car), affect (e.g., the numbing of emotional response to overwhelming circumstances) and memory and identity (e.g., amnesia for traumatic events and uncertainty regarding identity during depersonalisation).

Assumptions about the fundamental unity/disunity of the self underlie some definitions of dissociation. Braude (1995) has stated that the self can be considered functionally unitary while Putnam has proposed that the natural state of the self is fragmentary. Erdelyi's (1994) systems theory approach to dissociation incorporates these two viewpoints into a coherent working model of the dissociated self.

Erdelyi (1994) asserts that most individuals, most of the time, have a compelling sense of being unitary, that is, they have a subjective sense of the unity of self. This subjective perception of the self-system as unitary is, according to Erdelyi, central to the concept of dissociation. “Dissociation represents some discrepant manifestation of a system's subsystems; both the system and subsystems are sine qua nons of dissociation” (Erdelyi, 1994, p. 7). Experiences of dissociative phenomena can be alarming to the experiencer as they reveal the subsystem structure of that which they usually perceive as unitary (ie., the self-system). When the self-system is running smoothly, it is subjectively perceived as unitary. When there is disharmony between the subsystems, the smooth running of the self-system breaks down, resulting in experiences of dissociation of subsystems.

Definitions of dissociation also differ according to whether states or traits are being discussed. The notion of a dissociative state implies that dissociation can be an episodic phenomenon. State dissociation is experienced by some people, some of the time, is time limited and presumably, situationally triggered. The dissociative trait refers to dissociation as a common personality feature which, like all personality features, is expressed in greater or lesser degree in each individual.

Dissociation as a defence

According to Cameron (1963), one of the main strivings of the human psychodynamic system is to maintain organisation and avoid disintegration. Defences are those mental and behavioural activities that protect the system from threats to this organisation such as overwhelming, conflicting and intolerable emotions. Simply stated, the purpose of a defence is to protect the individual by helping them avoid or manage these threats (McWilliams, 1994). Popular use of the term ‘defence’ tends to imply pathology or maladaptiveness, however, it should be noted that defences are not inherently pathological; they begin as “global, inevitable, healthy, adaptive ways of experiencing the world” (McWilliams, 1994, p. 96).

In childhood, individuals develop a preference for particular defences which, in adulthood, are relied upon and invoked unconsciously to allow the individual cope with stressful situations. Factors influencing one's preference for a given defence or set of defences include:

- (1) one's constitutional temperament;
- (2) the nature of the stresses that one suffered in early childhood;
- (3) the defenses modeled – and sometimes deliberately taught – by parents and other significant figures; and
- (4) the experienced consequences of using particular defenses

(McWilliams, 1994, p.97).

The status of dissociation as a defence is acknowledged in the psychoanalytic literature (see Cameron, 1963, and Ellenberger, 1970). It is understood as “an attempt to preserve ego integration by reducing ego span, that is by eliminating some ego functions in order to bring emotional tension within manageable limits. . . . The normal person practices dissociation in order to hold off something traumatic, so that he [or she] can prepare [them]self to accept, digest and ultimately assimilate it” (Cameron, 1963, p. 341).

Dissociation is not repression or suppression

It is worth making clear the difference between dissociation, the psychodynamic notion of repression and the conscious act of suppression.

Repression refers to the sequestering of unacceptable, conflicting or intolerable psychic material from conscious awareness. Repressed material is unconscious, that is, it is not directly accessible to consciousness. In fact, repressed psychic material cannot make itself known directly; its existence is inferred through slips of the tongue, dreams and other symbolic phenomena.

Dissociated material can, in comparison, be said to be subconscious. Knowledge of dissociated material can be as direct as knowledge of any other kind of conscious material. That is, it need not be inferred and can be directly observed by the self or others under the right circumstances (for a full discussion, see Braude, 1995).

In describing the differences between repression and dissociation, Braude (1995) and Gruenewald (1985) invoke Hilgard's image of repressed material as existing being below a horizontal barrier, above which lies consciousness and dissociated material as being separated from consciousness by vertical barriers.

Suppression can be distinguished from both repression and dissociation in that it involves a conscious effort to 'not think about' something. The person engaged in suppression does not have amnesia for the suppressed material, the material does not reside sub- or unconsciously and the suppressed material can be accessed readily.

Spiegel and Cardena (1991) make the important observation that “although the concept of dissociation does involve the coexistence of psychological processes that have been compartmentalized and separated from each other, the concept does not require that these processes be completely independent of each other. . . . [O]ngoing psychological processes of which a person [reports] no introspective awareness can affect the execution of ongoing behavior and cognition” (p. 367).

Core dissociative phenomena

Five core dissociative phenomena have been identified: *amnesia*, *depersonalisation*, *derealisation*, *identity confusion* and *identity alteration* (Bernstein & Putnam, 1986; Kirmayer, 1994; Steinberg, 1994). These phenomena may be subjectively experienced or observed by others and are only considered dissociative when not due to the direct physiological effects of a substance (e.g., drugs, alcohol, or medication) or a medical condition (APA, 2000).

Amnesia

Dissociative amnesia is “the absence from memory of a specific and significant period of time” (Steinberg, 1994, p. 61). Dissociative amnesia is viewed as a functional amnesia as it occurs in the absence of any known organic aetiology (Steinberg, 1994) and is distinguished from other forms of amnesia such as childhood amnesia in that it does not reflect normal psychological development. For example, most individuals do not have memory for events before the age of two or three whereas most do have memories, even if scant, for the years following. Individuals experiencing dissociative amnesia typically retain the ability to learn and recall new information; memory loss is restricted to a circumscribed period of time or category of events within the individual's life, usually of a traumatic or stressful nature (APA, 2000). As opposed to the memory disturbance due to degenerative brain disease, injury and other severe organic causes, dissociative memory loss is reversible and may be recovered via hypnosis or on the individual's removal from the stressful situation.

Depersonalisation

Depersonalisation describes the sensation that one is in some way detached from one's self. The depersonalised individual may feel as though they are living in dream or a movie, that they are not real or even that they are dead. This feeling of personal unreality may also include the sensation that one is detached from all or parts of one's body, as if one were not in control of one's actions or as if one were an automaton (Steinberg, 1994). The depersonalised individual typically describes symptoms of detachment in 'as if' terms, that is, the individual maintains intact reality testing and does not believe that the symptoms represent a real detachment from self or body as may be the case for an individual suffering a psychotic disorder such as schizophrenia. In clinical populations, chronic depersonalisation is the third most often reported symptom after depression and anxiety (Gershuny & Thayer, 1999).

Derealisation

While depersonalisation concerns feelings of unreality regarding one's self, derealisation refers to the sensation that

one's surroundings are unreal. An individual experiencing derealisation may feel as though they have lost contact with external reality; that their home, workplace, friends or relatives are unfamiliar or strange. The experience of derealisation often involves a failure to recognise familiar objects and people, for example, one's car or best friend. Depersonalised individuals may also report distortions in their perceptions of space and time (Charbonneau & O'Connor, 1999; Steinberg, 1994).

Transient states of depersonalisation and derealisation are common and spontaneous, "especially under conditions of fatigue, anxiety and danger" (Butler et al, 1996). Cameron (1963) also points out the relationship between derealisation and travel. Individuals may experience feelings of strangeness and unreality during the days following arrival at a holiday destination and again on arriving home.

Identity confusion and identity alteration

Identity confusion refers to subjective feelings of uncertainty regarding one's personal identity. The individual experiencing identity confusion may report an inner battle between themselves and 'another person inside of them' who is struggling to take control of behaviour. Identity alteration on the other hand, is characterised by "objective behaviour indicating the assumption of different personalities" (Steinberg, 1994, p.63). Such behaviours include the objectively reported use of different names and third-person references to oneself. Individuals usually become aware of periods of identity confusion or alteration on the discovery of items among their belongings that they do not recall purchasing or receiving and the unexplained acquisition of new skills and abilities.

Dimension or category?

Pierre Janet's original conceptualisation of dissociation centres around a series of dichotomies regarding the nature of mental activities, psychopathology and psychological constitution.

In regard to the nature of mental activities, Janet conceived of two types: those activities that "preserve and reproduce the past and activities which are directed toward synthesis" (van der Hart & Friedman, 1989, p. 5). Normal mental functioning comprises a combination of the two activities where material from the past is synthesised and integrated. Where there is a focus on the preservation and reproduction of material from the past and a failure to synthesise and, ultimately, integrate this material, pathological dissociation results.

According to Braude (1995), Janet saw mental states as having particular patterns of associative links between them and that when these links are broken, certain mental states become dissociated from the rest. Furthermore, Janet believed that such pathological dissociations only happened in individuals suffering from particular kinds of mental illness (ie., hysteria).

In terms of constitution, Janet held the firm view that people who experienced pathological dissociative phenomena are a special group of individuals, different from 'normal' individuals with regard to their physical constitution, emotionality and suggestibility (Putnam, 1997). As noted earlier, Janet conceived of pathological dissociators as 'loosely put together' while normal folk were 'well put together'.

Implicit in Janet's conceptualisation is the view that dissociation is a categorical construct in that: 1) people who dissociate differ in important ways from people who do not dissociate; and 2) normal dissociation differs in important ways from pathological dissociation.

However, contemporaries of Janet such as Morton Prince and James, argued that dissociation represents a continuous construct, and is experienced to a lesser or greater extent by all people. This view took hold and led to the dimensional reconceptualisation. According to this view, dissociative phenomena rest upon a continuum reflecting their severity in terms of frequency of occurrence and disruption to functioning. At the 'normal' end of the continuum are commonly reported, transient and non-disruptive dissociative experiences such as becoming absorbed in an activity, day-dreaming and performing well-learned actions without conscience awareness. At the pathological end of the continuum are rarer but more pervasive and life disrupting experiences such as chronic depersonalisation and identity alteration. The continuum model survived the lull in dissociation research in the middle of the twentieth century and continued through the 1980s and early 1990s as the prevailing conceptualisation of dissociation. It is possible that Janet came around to this dimensional way of thinking later in his career as suggested by his statement that "pathological phenomena are only exaggerations of normal phenomena" (Janet, 1925, cited in Putnam, 1989, p. 415).

Putnam (1997) noted that although the dimensional conceptualisation of dissociation is not ideal, it has allowed for the development of psychometric measures of dissociative phenomena and for the scientific investigation of their correlates in both clinical and non-clinical populations. As the co-author of one of the most popular continuum-based measures of dissociation (Dissociative Experiences Scale; Bernstein & Putnam, 1986; Carlson & Putnam, 1993), Putnam was also cognisant of the fact that the frequency and type of dissociative experiences reported by members of certain diagnostic groups suggested "the existence of two or more discrete dissociative types" (Putnam, 1997, p. 66). This finding was investigated and confirmed by Waller (1995) in his psychometric review of Carlson and Putnam's scale leading to the description in the literature of the dissociation taxon (Waller, Putnam & Carlson, 1996).

The dissociation taxon

Waller et al (1996), in an investigation of the dissociative experiences in clinical and non-clinical populations, discerned two types of dissociative phenomena - pathological and non-pathological - and two groups of dissociators - again, pathological and non-pathological. The pathological type, or taxon, of dissociative phenomena includes those proposed by Nemiah (1980) as reflecting pathology, namely, amnesia and identity alteration with the addition of depersonalisation and derealisation. Individuals experiencing phenomena of this type belong to the pathological group of dissociators. According to Irwin (1999), the frequency and severity of dissociative taxon experiences are not normally distributed suggesting that the dissociation taxon represents a category rather than a dimension of its own (Irwin, 1999).

Dissociative phenomena of the non-pathological type include absorption and imaginative involvement. Waller et al. (1996) suggest that these non-pathological phenomena are manifestations of a dissociative *trait*, qualitatively different from the pathological type of dissociation experienced by those individuals in the pathological group. Although the frequency and severity of non-pathological dissociative phenomena are not normally distributed (typically, they are positively skewed), non-pathological dissociation clearly represents a trait or dimension (Irwin, 1999).

The identification of the dissociation taxon marks a return to Janet's original conceptualisation of dissociation as a discontinuity of awareness experienced only by the mentally unwell (Putnam, 1995; Waller et al., 1996). According to this categorical conceptualisation of dissociative phenomena, the distinction between normal and pathological dissociation represents not only a difference in degree but also a difference in type (Waller et al., 1996). Support for the dissociative taxon can be found in the literature examining dissociation in non-clinical populations which shows that "individuals who report high levels of dissociative experiences are not necessarily dissociative disordered" (Ruiz, Pincus & Ray, 1999, p. 240).

Not all researcher currently working in the field of dissociation agree with the new trait-taxon conceptualisation (Waller et al., 1996) and the view that dissociation exists on a continuum for both non-clinical and clinical populations has endured in the research literature. A hybrid of the two conceptualisations may prove to be more accurate for while much of the current research is based upon the premise that dissociation is a continuous variable across both clinical and non-clinical groups, the findings of Waller et al. (Waller et al., 1996) suggest that differences between pathological and non-pathological dissociation may reflect a qualitative shift at some point along the continuum. In this way, both the dimensional and categorical conceptualisations can be accepted.

The dissociative disorders

Janet conceived of dissociation as a not uncommon phenomenon that was experienced by mentally ill individuals due to a weakness in their capacity to integrate psychic phenomena, a weakness in 'binding energy' (confirm this label) According to Janet, dissociation is "experienced only by people with certain psychiatric disorders, primarily hysteria, and [is] absent in normal individuals" (Putnam, 1989, p.414).

Early in the current wave of research interest in dissociation (ie., in the 1970s and 1980s), there was a tendency for the terms 'dissociation' and 'Multiple Personality Disorder' to be used interchangeably. In some areas of the literature, this practice has persisted into the 1990s. For example, Brodsky, Cloitre and Dulit (1995) defined dissociation as a "pathological failure to integrate thoughts, feelings, and memories into a coherent, unified sense of consciousness" (p. 1789; see also McWilliams,1994). Waller et al. (1996) made the following comment regarding this tendency in literature:

We have found that drawing firm conclusions from this literature is difficult because many investigators use the word dissociation loosely to denote both pathological and nonpathological altered ego states (original italics, p. 302).

In his 1997 volume, Putnam distinguishes between normal and pathological dissociation as follows: " 'normal dissociation' . . . [is] not associated with maladaptive responses, and 'pathological dissociation' . . . contributes to maladaptation" (p. 8). This is a useful distinction in that values are not placed on individual behaviours, rather, the impact of the behaviour on a person's functioning and well-being is what is of issue. For example, emotional and physical numbing may be very adaptive in the period immediately after a car crash as it may allow you to help yourself and others to get free of the wreckage. However, daydreaming while operating a chain saw is probably quite hazardous to one's safety and well-being.

The *DSM-IV-TR* (APA, 2000) states that dissociation is not in and of itself, pathological but may become so where dissociative symptoms cause a significant disruption to social, occupational and other important areas of function (2000). Five dissociative disorders are described in the *DSM-IV-TR*: Dissociative Identity Disorder, Dissociative Amnesia, Dissociative Fugue, Depersonalisation Disorder and Dissociative Disorder Not Otherwise Specified. Janet grouped a range of disorders under the general classification of hysteria because they presumably shared the same underlying dissociative mechanism. In contrast nosological considerations, that is, description rather than aetiology, are behind the current classificatory division of these disorders (Butler et al, 1996).

Dissociative Identity Disorder

The most severe and well known of the dissociative disorders is Dissociative Identity Disorder (DID, formally known as Multiple Personality Disorder). DID is characterised by the presence of two or more distinct personality states, or

alters, that recurrently take control of the individual's behaviour (APA, 2000). Although psychologically normal individuals may exhibit pronounced 'personality' changes in terms of behaviour, affect and attitude across different social situations and roles, memory for these episodes remains intact as does one's sense of personal and temporal continuity. For the DID sufferer, there are frequent gaps in personal history that are not adequately explained by ordinary forgetfulness and may span in duration from minutes to years as alters take control of behaviour.

The nature of DID - its aetiology, course and resolution - was introduced to the lay population by popular books such as *The Three Faces of Eve* (Thigpen & Cleckley, 1957), *Sybil* (Schreiber, 1973) and *The Minds of Billy Milligan* (Keyes, 1981). The development of the disorder has been reliably linked to early traumatic experiences, memories for which have been isolated from conscious life. During the course of DID, memory for trauma is assumed by one or more alters who act as the 'caretakers' of the memory and associated emotions. Putnam (1988) captures the essence of dissociative alters by comparing them to states that comprise the basic units of 'normal' consciousness (ie., sleep, wakefulness, etc.):

DID can be thought of as a disorder in which the individual's consciousness is organized into a series of discrete dissociative states (alter personalities) centered around specific affects, body images, modes of cognition and perception, state-dependent memories and behaviors. By and large, the transitions between these rarefied states are abrupt and discontinuous compared to the smoother transitions between normal states of consciousness (p.26).

Alters often report being of a different age and gender to the sufferer and may display behavioural characteristics, knowledge and skills not possessed by the primary personality. Until recently, it was thought that switches between alters occurred only during periods of psychosocial stress at which time, the personality most capable of handling the situation assumes control (Bliss, 1984). However, Beere (1996) in a phenomenological study of switching in DID sufferers, found that a number of factors are implicated in the triggering of switches.

Beere (1996) found that although switching may, and often does, occur in the context of negative experiences, this is not always the case. Switching also occurs in response to innocuous events and in anticipation of unfolding situations which are of importance to the emerging alter.

Dissociative Amnesia

Dissociative Amnesia (formerly Psychogenic Amnesia) is characterised by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness (APA, 1994). These gaps in recall usually correlate with particularly stressful or traumatic periods in the individual's life, for example, childhood abuse, violent combat experiences or a car crash in which family or friends were killed. The *DSM-IV-TR* describes five kinds of dissociative amnesia: *localised*, *selective*, *continuous*, *generalised* and *systematised* amnesia. Localised amnesia refers to a total loss of memory for events that occurred during a circumscribed period of time, for example, the victim of a violent crime may have no recall for the week following the incident. Selective amnesia is characterised by the loss of recall for some, but not all, events occurring within a specified period of time. For example, the victim of childhood abuse may recall selected details from the period of abuse. Individuals identified as suffering from systematised, generalised and continuous amnesia experience a more pervasive loss of recall than those suffering from localised or selective amnesia. Systematised amnesia refers to the loss of memory for certain categories of personal information such as information concerning one's family, school years or certain people. The individual experiencing continuous amnesia reports an inability to recall any events following a specific time, up to and including the present while individuals experiencing generalised amnesia experience total memory loss spanning their entire life.

Individuals experiencing dissociative amnesias often report 'blacking out' or a sense that time is discontinuous or distorted. In clinical interviews, individuals experiencing chronic amnesia will often confabulate replies to fill in the gaps in memory (Steinberg, 1994). The various forms of dissociative amnesia are distinguished from non-pathological amnesias in that they do not reflect developmentally appropriate amnesia (ie., childhood amnesia) or an organic aetiology.

Dissociative Fugue

Dissociative Fugue (formerly Psychogenic Fugue) is characterised by sudden, unexpected travel from one's usual place of residence or daily activities coupled with an inability to recall some or all details of one's personal history (APA, 2000). The period of flight may be brief, lasting a few hours or days, or may extend over several weeks or months during which time the individual may establish a new social identity, place of residence and social ties. During a fugue, the individual may appear to be free of any psychopathology, however, they usually come to clinical attention because of their amnesia for recent general and personal events and their uncertainty regarding their personal identity. Once they have returned to their pre-fugue state, the individual may have amnesia for events that occurred during the fugue period. Dissociative Fugue can be distinguished from DID and Dissociative Amnesia in that identity confusion and amnesia are experienced only during, or in relation to, the period of flight.

Depersonalisation Disorder

Depersonalisation Disorder is characterised by persistent or recurrent feelings of detachment from one's self or

body. The individual typically reports feelings of unreality, as if they were living in a dream, and a sense of disconnectedness from their self, as though they were an outside observer of their own mental processes or body. Presentation often includes derealisation, a flat affect and subjective reports that the individual's mental processes and physical actions are somehow not in their control. The individual, however, maintains intact reality testing, that is, they recognise that their feelings of disconnectedness and estrangement are just feelings and do not reflect a real division of, or separation from, one's self.

Depersonalisation is a major feature of a variety of mental disorders such as Schizophrenia, Panic Disorder, Acute Stress Disorder, Post-traumatic Stress Disorder, Borderline Personality Disorder, Eating Disorders and other dissociative disorders. After anxiety and depression, depersonalisation is the third most common symptom reported by psychiatric patients (APA, 2000; Bernstein & Putnam, 1986; Steinberg, 1994); thirty percent of individuals exposed to life-threatening danger and forty percent of patients hospitalised for mental disorders report experiencing transient feelings of depersonalisation. For this reason, Depersonalisation Disorder should only be diagnosed where depersonalisation does not occur exclusively during the course of another mental disorder.

Dissociative Disorder Not Otherwise Specified

The *DSM-IV-TR* recognises a further category of dissociative disorder, Dissociative Disorder Not Otherwise Specified (DDNOS). This category encompasses disorders where the predominant features are dissociative in nature but the criteria for a specific dissociative disorder have not been met. For example, DDNOS would be the appropriate diagnosis in cases where persistent derealisation is experienced in the absence of depersonalisation or for individuals whose dissociative symptoms result from subjection to prolonged thought reform or brainwashing (APA, 2000).

Misdiagnosis

Individuals suffering from dissociative disorders rarely present with the symptoms that define the various disorders. Often the individual will seek medical help for somatic complaints including headaches, visual disturbances and gastrointestinal problems or for other psychiatric conditions such as depression and anxiety. The failure of pharmacologic efforts to reduce these symptoms usually leads to misdiagnoses for yet further somatic and psychiatric disorders. Dissociative symptoms may overlap with schizophrenia symptoms especially Schneiderian First Rank Symptoms. If these cognitive disturbances are focused upon by the diagnostician, which is often the case, the dissociative nature of the disorder may be overlooked. The research shows that sufferers of dissociative disorders are likely to receive four or more misdiagnoses before their condition is correctly identified (Kluft, 1985; Putnam, 1989; Putnam, 1994).

ASD & PTSD

In addition to the five dissociative disorders, dissociation represents a major diagnostic feature of Acute Stress Disorder (ASD) and Post Traumatic Stress Disorder (PTSD; APA, 2000; Carlson, 1994; Putnam, 1994). ASD results from an individual's exposure to a traumatic event in which the individual was confronted with the threat or actuality of death or serious injury to themselves or to others (APA, 2000). ASD was included in DSM-IV (APA, 1994) to allow for the diagnosis of clinically significant post-traumatic symptomatology occurring within the first four weeks post-trauma. Previously, the DSM offered no diagnosis covering this period as PTSD could not be diagnosed until after the fourth week post-trauma.

The ASD diagnostic criteria, more so than the PTSD diagnostic criteria, reflect the prevalence and importance of dissociative phenomena in the post-trauma period. The key diagnostic feature (apart from duration of symptoms) that distinguishes ASD from PTSD is the presence of three or more dissociative symptoms during or after the precipitating trauma. The dissociative symptoms associated with ASD are amnesia, depersonalisation, derealisation, a reduction in awareness of one's surroundings and the numbing of emotional responsiveness. Where dissociative symptoms do not resolve within the four weeks of onset, a diagnosis for PTSD may be appropriate. It is estimated that 75% of individuals who meet the criteria for ASD will meet the criteria for PTSD at two years post-trauma (Bryant, 1999).

PTSD is characterised by the presence, at least four weeks after the precipitating trauma, of symptoms in the domains of: re-experiencing; avoidance; and hyper-arousal. Bryant notes that while most people display PTSD symptomatology in the weeks following a severe trauma, most of these cases will remit without treatment within three months (1999).

Although less emphasis is placed upon it diagnostically, dissociation represents an important component of PTSD, and PTSD populations tend to report higher levels of dissociation than do non-clinical populations (Carrier, Lamberts, Fouwels & Gersons, 1996). However, pathological dissociation and PTSD do not always co-occur (Putnam, 1997). Putnam reports a bi-modal distribution of levels of dissociation in a population of PTSD sufferers with about half scoring in the high-normal range and the other half scoring in the clearly high range. This finding suggests that there are two kinds of PTSD with regard to dissociative symptomatology and provides support for the categorical conceptualisation of dissociation.

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