Case Report

Dissociative Self-mutilation: A Case Report of Dissociative Amnesia

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Objective: To report a case of a patient with self-mutilation during episodes of dissociative amnesia. Case Report: A 22-year-old woman patient with borderline personality disorder started to have episodes of dissociative self-mutilation by cutting her wrist after being rejected by her boyfriend and best friend. She had similar episodes recur after her father’s criticism. After treatment with a lorazepam-assisted interview, psychotherapy and pharmacotherapy, her symptoms improved. Conclusion: This case study suggests that dissociative self-mutilation may be related to child abuse, parents with high expressed emotion, psychiatric comorbidity and interpersonal conflicts perceived as betrayal.

Key words: dissociative amnesia, self-mutilation, high expressed emotion, borderline personality disorder


Introduction

Self-mutilation during episodes of dissociative amnesia is not commonly seen in clinical settings or reported in the literature. We present a case in an attempt to explain the possible mechanism for the expression of this psychopathology.

Case Report

Ms. A is a 22-year-old woman patient who grew up with parents of high expressed emotion (EE). Her father was physically violent toward her mother, and they were divorced when Ms. A was seven years old. She felt abandoned by her mother and also hated her father’s violence. After the divorce, she lived with her father and her elder brother. She was occasionally physically abused by her brother, but her father failed to intervene. She tended to suppress her negative emotions to avoid their criticism. When she was 16 years old, her father left for China for business. She lived with her aunt and was often criticized by her. Again, she felt abandoned by her father. She then began to display unstable mood, temper tantrums, feelings of emptiness and conflicted interpersonal relationships. Fortunately, her best friend and her boyfriend supported her.
After her entering college at age of 18 years, Ms. A broke up with her boyfriend. She also learned that her mother was divorced due to her having had an extramarital affair rather than due to her father’s domestic violence. She felt betrayed by her mother and guilty about misunderstanding her father. She had a severe depressive episode and attempted suicide by cutting her wrist. She then quit school and worked part-time. However, she changed jobs frequently because of conflicts with other employees.

At age 20 years, the patient fell in love with a divorced man and planned to marry him out of pity for his five-year-old daughter. But her father had returned and opposed their marriage and criticized her as promiscuous and troublesome. Unexpectedly, her boyfriend chose to break up with her when she was 21 years old. She was angry at his betrayal and felt humiliated. Two days later, her best friend came to her and blamed her for seducing her boyfriend. As a result, she suddenly lost any sense of what she was doing. When she regained awareness, she found that she was standing on a bridge holding a knife with slashes on her wrist. She had no memory of how she came to be on the bridge or cut her wrist. She was quite afraid, and came to our clinic for help. The results of complete medical check up showed no abnormality except the slashes on her wrist. She was diagnosed as having dissociative amnesia, major depressive disorder, and borderline personality disorder. She said that although she was depressed, she did not intend to die. During follow up, she reported further self-destructive dissociative episodes, either in the forms of wrist-cuttings or drug overdoses. Those episodes occurred 2-4 times per week and lasted 5-30 minutes. They often occurred right after her father criticized her, or blamed her symptoms on malingering. Being frightened, she would go to the emergency department for help. She also reported a false memory in which she believed to have a pregnancy with her first boyfriend but was aborted artificially. His family cared for her very much. Despite treatment with venlafaxine 225 mg per day for two months, the symptoms still persisted.

Ms. A was finally admitted to our psychiatric ward due to her worsen symptoms. The patient’s scores of the Hamilton Rating Scale for Depression (HAM-D$_{17}$) and Dissociative Experiences Scale-Taxon (DES-T) were 22 and 42, respectively. During her first four days of admission, she had two episodes of dissociative self-mutilation after quarreling with her father. On the fifth day, we conducted a lorazepam-assisted interview. During the interview, she expressed both love and anger toward her father. She wondered why her father had hurt her verbally while saying that he cared for her. She wanted to be a good daughter but felt guilty for disappointing her father. She recalled the details of her self-mutilation, by which she hoped to provide proof of her father’s love for her. She could feel real if she mutilated herself but she also feared being abandoned if she kept expressing negative feelings. She reported that the memories of being pregnant were not true, but she was eager to become part of a new family.

After the interview, we arranged a family session to facilitate her expression of ambivalent feelings toward patient’s father at a conscious level. We provided him with psychoeducation about parenting. Following this intervention, she had no more dissociative episodes, and her depression was gradually improved. On the 28th day of hospitalization, she had a severe quarrel with her father and relapsed with an episode of dissociative self-mutilation. We conducted a second lorazepam-assisted interview in which she expressed fear about discharge and living with her father. Her condition was improved after she rehearsed
coping strategies to use after her returning home. She had taken venlafaxine 225 mg per day for major depressive disorder during the admission and was discharged on the 45th day, with a HAM-D$_{17}$ score of 13 and a DES-T score of 29.

After discharge, Ms A received insight-oriented psychotherapy sessions once per week for 12 weeks. We tried to establish a secure attachment and pointed out that her self-mutilation was a way to use her body to speak of her deep psychic pain. We attempted to improve her alexithymia to make connections between affects, thoughts and behaviors. She reported that her mind frequently went blank during sessions, which we interpreted as transference. We suggested that she feared that if she expressed negative feelings, she would be abandoned by her therapist or father. By the end of the sessions, her dissociative and depressive symptoms had all been improved, and her HAM-D$_{17}$ score was 9 and her DES-T 23.

**Discussion**

Dissociative amnesia is defined as an inability to recall important personal information, usually of a traumatic or stressful nature [1]. The prevalence rate ranges from 0.2% to 7.3% in the general population [2, 3]. It is under-diagnosed because patients become aware of the disorder only when it causes socio-occupational disruption. It occurs when vulnerable subjects experience intolerable emotions such as shame, guilt, despair, or rage and is associated with episodes of self-mutilation, attempted suicide, violent outbursts, or disavowed sexual or criminal behavior [4]. The amnesia is reversible, which implies a memory retrieval deficit rather than a failure of memory encoding [5].

Dissociative amnesia is commonly associated with childhood trauma [4] and *betrayal trauma theory* is proposed to explain this phenomenon [6]. Children who are abused by their caretakers are prone to developing amnesia for their abuse because awareness of abuse would imperil the survival of victims by disrupting their attachment to caretakers on whom they depend for food, shelter, and clothing. This theory remains controversial [6]. Dissociative amnesia is also frequently comorbid with depression and personality disorders, especially borderline personality disorder [4]. It may be related with conflictual family environment [7], but its association with high EE parents is not clear.

To our knowledge, there is no literature explaining the mechanism of self-mutilation during a dissociative amnesic episode, but there has been discussion about the relationship between dissociation and self-mutilation. There are three models: First, self-mutilation might constitute an attempt to ameliorate uncomfortable experiences of numbness and depersonalization that accompany dissociation. Second, self-mutilation, accompanied by pain, dysphoria or shame, may be blocked by the dissociative mechanism which increases the pain threshold. Third, self-mutilation and dissociation may co-occur as ways of dealing with intolerably negative self/object internalizations [8, 9].

We have tried to formulate Ms. A’s dissociative self-mutilation based on this literature review. She had insecure attachments because of the high EE of her parents, parental discord, mother’s separation, brother’s abuse, and father’s failure to intervene. She internalized a punitive parental image and developed borderline personality features. She tended to avoid the threat of abandonment by suppressing negative feelings, but felt betrayed and abandoned in ensuing negative life events, including learning the true cause about her mother’s divorce, her new boyfriend’s breaking up with her, her best friend’s accusing her, and her father’s criticizing her. She even thought to escape by get-
ting married and to have the false memory of pregnancy and an idealized family, but all in vain. Thus, she experienced highly conflicting emotions including anger, guilt and love. Self-mutilation is served: (A) to regulate her overwhelming affect and to improve the uncomfortable dissociative numbness, (B) to punish herself for disappointing her father and to prompt him to pay attention to her, (C) to protect her father from her anger towards him, and (D) to enact her wish to cut the tie between them. However, she feared that she would be abandoned by her father if she mutilated herself. The wish to merge with and separate from her father created a more difficult dilemma, from which she escaped by dissociative amnesia. She repressed unacceptable memories of self-mutilation to an unconscious level and behaved as her father’s “good daughter” at the conscious level. Her father’s continuing criticism of her symptoms also perpetuated the dissociation.

During the therapeutic process, we tried to provide a supportive environment. The repressed materials uncovered in the pharmacologically facilitated interview were processed at the conscious level. The use of psychotherapeutic techniques, such as strengthening the ego, verbalizing negative emotions, and interpreting the transference, should preclude the adoption of further maladaptive defenses such as dissociation and amnesia. The comorbid depressive disorder and borderline personality disorder were also treated.

Dissociative self-mutilation may be related to child abuse, high EE parents, psychiatric comorbidity and interpersonal conflicts that have been perceived as betrayal. Although uncommon, its consequences are highly unpredictable and dangerous. Dissociative disorders are often neglected as part of an assessment of suicidality, but they are the strongest predictor of multiple suicide attempts [10]. We present this case report in hope of arousing psychiatrists’ awareness of these complex associations.

References