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CLINICAL FEATURES OF EMPATHY AND EMOTIONAL REGULATION DISORDERS IN DISSOCIATIVE PERSONALITY DISORDER (IN THE CONTEXT OF THE UZBEK CULTURE)

Doniyorova Surayyo Sunnatulla qizi
Scientific Supervisor Assistent, EMU University,
Department of Clinical Reception

Sayfiddinova Muslima Muxiddin qizi
Student, 205-B Group EMU University

Abstract
This scientific article analyzes the clinical features of empathy and emotional regulation disorders within the framework of dissociative personality disorder (DSB) in the Uzbek cultural context. Cultural collectivism, family hierarchy, social control, and gender stereotypes significantly influence the manifestation of dissocial traits. The article covers diagnostic complexities, issues of differential diagnosis, and culturally sensitive therapeutic approaches.
An emerging body of research has begun to elucidate disturbances to social cognition in specific personality disorders (PDs). No research has been conducted on patients with Mixed Personality Disorder (MPD), however, who meet multiple diagnostic criteria. Further, very few studies have compared social cognition between patients with PD and those presenting with symptomatic diagnoses that co-occur with personality pathologies, such as anxiety disorder (AD). The aim of this study was to provide a detailed characterization of deficits to various aspects of social cognition in MPD and dissociate impairments specific to MPD from those exhibited by patients with AD who differ in the severity of personality pathology.

Keywords: Dissociative personality disorder, empathy, emotional regulation, cultural psychiatry, Uzbek society.

Introduction

Dissocial personality disorder is one of the most complex and socially dangerous forms of personality pathology. This disorder is characterized by indifference to social norms, lack of empathy, and poor affective control. Although DSB has been studied primarily in Western societies in modern psychiatry, its clinical manifestations in collectivist cultures such as Uzbek society have not been adequately studied.
Dissocial personality disorder (DSB) is a personality disorder characterized by a chronic pattern of behavior that disregards the rights and well-being of others. People with DSB often exhibit behaviors that are contrary to social norms, leading to problems with interpersonal relationships, employment, and legal issues. The condition typically manifests in childhood or early adolescence, with a high rate

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of associated behavioral problems and a tendency for symptoms to peak in late adolescence and early adulthood.

The forecast for DSB is complex, with high variability in results. Individuals with severe DSB symptoms may have difficulty forming stable relationships, finding employment, and avoiding criminal behavior, resulting in high rates of divorce, unemployment, homelessness, and incarceration. In extreme cases, DSB can lead to violent or criminal behavior, often escalating at an early age. Studies show that individuals with DSB are at high risk for suicide, especially those who abuse substances or have a history of incarceration. Additionally, children raised by parents with DSB may be at greater risk for delinquency and mental health problems.

Although DSB is a permanent and often lifelong condition, symptoms may decrease over time, especially after age 40, but only a small proportion of people experience significant improvement. Many people with DSB also have co-occurring problems such as substance use disorders, mood disorders, or other personality disorders. Research on pharmacological treatment for DSB is limited, and there are no medications specifically approved for the disorder. However, some psychiatric medications, including antipsychotics, antidepressants, and mood stabilizers, can help manage symptoms such as aggression and impulsivity in some cases, or treat co-occurring disorders.

The diagnostic criteria and understanding of DSB have evolved significantly over time. In early diagnostic manuals such as the DSM-I in 1952, "sociopathic personality disorder" was described as a series of antisocial behaviors associated with social and environmental factors. Subsequent editions of the DSM refined the diagnosis and eventually separated ASPD from the more structured checklist of observable behaviors in the DSM-III (1980). The current definitions in the DSM-5 are consistent with the clinical description of the DSB as a pattern of disregard for the rights of others, and there is potential overlap in the traits associated with psychopathy.

THEORETICAL AND DIAGNOSTIC FOUNDATIONS

According to the ICD-11 and DSM-5 classifications, dissociative personality disorder is characterized by disregard for the rights of others, manipulativeness, and impulsivity. Clinically, these symptoms are stable and relatively independent of the situation, affecting the individual's entire life functioning.

Sociogenic model

Symptoms of dissociative identity disorder may be created by therapists using techniques to "recover" memories (such as the use of hypnosis to "access" alter identities, facilitate age regression or retrieve memories) on suggestible individuals.[5][6][28][47][48] Referred to as the non-trauma-related model, or the sociocognitive model or fantasy model, it proposes that dissociative identity disorder is due to a person consciously or unconsciously behaving in certain ways promoted by cultural stereotypes,[47] with unwitting therapists providing cues through improper therapeutic techniques. This model posits that behavior is enhanced by media portrayals of dissociative identity disorder.[45] One example of the disorder in media portrayals, that supports this theory, is in purportedly true books and films in the 20th century; Sybil became the basis for many elements of the diagnosis, but it was later found to be fictionalized.[4][7]

Proponents of the non-trauma-related model note that the dissociative symptoms are rarely present before intensive therapy by specialists in the treatment of dissociative identity disorder who, through the process of eliciting, conversing with, and identifying alters, shape or possibly create the

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diagnosis.[49] While proponents note that dissociative identity disorder is accompanied by genuine suffering and the distressing symptoms, and can be diagnosed reliably using the DSM criteria, they are skeptical of the trauma-related etiology suggested by proponents of the trauma-related model.[50] Proponents of non-trauma-related dissociative identity disorder are concerned about the possibility of hypnotizability, suggestibility, frequent fantasization and mental absorption predisposing individuals to dissociation.[17] They note that a small subset of doctors are responsible for diagnosing the majority of individuals with dissociative identity disorder.[51][6][46]

THE CONCEPT OF EMPATHY AND DISSOCIATIVE PERSONALITY DISORDER

Empathy consists of affective and cognitive components. Affective empathy is severely reduced in individuals with dissociative personality disorder, but cognitive empathy may be preserved for instrumental purposes. This situation reinforces manipulative behavior mechanisms. People with DSB may have limited empathy and may be more interested in benefiting themselves than in harming others. They may have no regard for morality, social norms, or the rights of others. People with DSB may have difficulty starting or supporting relationships. It is common for a person with DSB to revolve around the exploitation and abuse of others in their interpersonal relationships. People with DSB may show arrogance, others think low and negative, they have limited remorse for their harmful actions, and they have a rude attitude towards those who have hurt.

EMOTIONAL REGULATION MECHANISMS

Emotional regulation is based on a functional balance between the frontal cortex and the limbic system. In DSB, this balance is disrupted, manifesting as impulsive aggression and low tolerance for frustration.

Emotional regulation is the ability of an individual to recognize, manage, and modulate their emotions in a situation-appropriate manner. This process is mediated by complex neurobiological systems.

1. Basic brain structures

• Prefrontal cortex (PFC): Plays a leading role in emotional control and cognitive reappraisal. Dorsolateral PFC is associated with cognitive control, ventromedial PFC is associated with emotional appraisal.
• Amygdala: controls rapid detection and response reactions of fear, anxiety and negative emotions.
• Hippocampus: important in emotional memory and contextual assessment.
• Anterior cingulate cortex (ACC): Involved in detecting and regulating emotional conflicts.

2. Neural networks

• Top-down mechanism: suppression of the activity of the limbic system (mainly the amygdala) by the Prefrontal cortex.
• Bottom-up mechanism: upward transmission of sensory and emotional stimuli through the limbic system.

3. Neurotransmitters

• Serotonin: Important for emotional stability and impulse control.
• Dopamine: Associated with motivation and the reward system.

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* Norepinephrine: increases the level of Stress and alertness.
• GABA: reduces emotional reactivity through inhibitory action.
* Glutamate: plays a key role in excitatory transmission.

4. Stress and the HPA Axis

During stress, the hypothalamic-pituitary-adrenal (HPA) axis is activated. Increased cortisol levels can increase amygdala activity and temporarily impair PFC function.

DISSOCIATIVE FEATURES IN THE UZBEK CULTURAL CONTEXT

In Uzbek society, collectivism, social prestige, and family responsibility are important. For this reason, dissociative behavior often occurs in a hidden, indirect form, making it difficult to clinically identify.

CLINICAL MANIFESTATIONS OF EMPATHY DISORDERS

Patients often rationalize their lack of empathy. Cultural stereotypes can normalize this condition.

CLINICAL SIGNS OF EMOTIONAL REGULATION DISORDERS

Anger outbursts, affective outbursts, and violent behavior are important clinical signs of BPD.

DIFFERENTIAL DIAGNOSIS

It is important to consider the cultural context when differentiating DSB from borderline and narcissistic personality disorders.

THERAPEUTIC APPROACHES

Cognitive-behavioral therapy, the development of emotional regulation, and the formation of social responsibility are the main therapeutic directions.

Children

The rarity of DID diagnoses in children is cited as a reason to doubt the validity of the disorder,[6][47] and proponents of both etiologies believe that the discovery of dissociative identity disorder in a child who had never undergone treatment would critically undermine the non-trauma related model. Conversely, if children are found to develop dissociative identity disorder only after undergoing treatment it would challenge the trauma-related model.[47] As of 2011, approximately 250 cases of dissociative identity disorder in children have been identified, though the data does not offer unequivocal support for either theory. While children have been diagnosed with dissociative identity disorder before therapy, several were presented to clinicians by parents who were themselves diagnosed with dissociative identity disorder; others were influenced by the appearance of dissociative identity disorder in popular culture or due to a diagnosis of psychosis due to hearing voices – a symptom also found in dissociative identity disorder. No studies have looked for children with dissociative identity disorder in the general population, and the single study that attempted to look for children with dissociative identity disorder not already in therapy did so by examining siblings of those already in therapy for dissociative identity disorder. An analysis of the diagnosis of

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children reported in scientific publications, 44 case studies of single patients were found to be evenly distributed (i.e., each case study was reported by a different author), but in articles regarding groups of patients, four researchers were responsible for the majority of the reports.

The initial theoretical description of dissociative identity disorder was that dissociative symptoms were a means of coping with extreme stress (particularly childhood sexual and physical abuse), but this belief has been challenged by the data of multiple research studies.[45] Proponents of the trauma-related model claim the high correlation of child sexual and physical abuse reported by adults with dissociative identity disorder corroborates the link between trauma and dissociative identity disorder.[22][45] However, the link between dissociative identity disorder and maltreatment has been questioned for several reasons. The studies reporting the links often rely on self-report rather than independent corroborations, and these results may be worsened by selection and referral bias.[22][45] Most studies of trauma and dissociation are cross-sectional rather than longitudinal, which means researchers can not attribute causation, and studies avoiding recall bias have failed to corroborate such a causal link.[22][45] In addition, studies rarely control for the many disorders comorbid with dissociative identity disorder, or family maladjustment (which is itself highly correlated with dissociative identity disorder).[22][45] The popular association of dissociative identity disorder with childhood abuse is relatively recent, occurring only after the publication of Sybil in 1973. Most previous examples of "multiples" such as Chris Costner Sizemore, whose life was depicted in the book and film The Three Faces of Eve, reported no memory of childhood trauma.[50]

CONCLUSION

Empathy and emotional regulation disorders in DSB have unique clinical characteristics in the Uzbek cultural environment. Cultural sensitivity increases the effectiveness of diagnosis and therapy.

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