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DIAGNOSIS AND DIFFERENTIAL DIAGNOSIS IN DISSOCIATIVE DISORDER: CASE REPORT

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Abstract

Trauma and dissociation are two concepts that go hand in hand. Dissociation manifests as fragmentation and instability in memory, emotion, identity, consciousness, and behavior. Childhood traumas cause many psychiatric problems. Trauma can encounter Dissociative Identity Disorder (DID), the most challenging group among dissociative disorders. It is characterized by frequent anger problems, suicide attempts, concentration problems, amnesia, self-harm, and feelings of uncertainty about identity. Dissociative identity disorder causes serious problems in interpersonal relationships, social life, and identity integrity. Dissociative cases also exhibit visual and auditory hallucinations. As a result, it is critical to correctly identify the differential diagnosis in order to distinguish it from psychotic disorders. People often perceive dissociative identity disorder as a rare pathology, which leads to a lack of knowledge and experience in diagnosing and treating it. In this study, we introduce an 18-year-old patient who experienced sexual abuse and physical and emotional neglect during early childhood, leading to the development of dissociative identity disorder. We believe that childhood traumas and symptoms of dissociative identity disorder in this case will influence the diagnosis and treatment process.

Keywords: *dissociation, dissociative disorder, trauma, childhood traumas*

INTRODUCTION

Dissociation is an individual's experience of dissociation and discontinuity in memory, emotion, thought, and identity, which functions as a defense mechanism of the ego. Dissociation functions as a primitive defense mechanism by distancing the individual from trauma and compulsion (Öztürk & Şar, 2005). Dissociative identity disorder is characterized by frequent use of this defense mechanism and recurrent trauma. Dissociative identity disorder is the most comprehensive disorder among dissociative disorders, and it has a negative impact on many areas of the individual's life. When talking about dissociation, it is also possible to talk about attachment (Şar, 2007). Because attachment disorders also play an important role in the formation of dissociative

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disorders, In addition to sexual, physical, and emotional abuse, neglect can also lead to attachment trauma and cause relational trauma (Witt, 2018). People exposed to neglect and abuse in childhood often try to protect their mental integrity by resorting to dissociative defenses to avoid painful experiences (Schimmenti, 2016). Therefore, although we talk about dissociation, the individual is actually trying to maintain his or her psychological integrity.

In the DSM-V (APA, 2013), dissociative disorders are characterized by the following headings:

1. Dissociative Identity Disorder: The presence of two or more identities, culturally referred to as possession. Gaps in memory that cannot be explained by normal everyday forgetfulness.
2. Dissociative amnesia It is difficult to recall one's life history without the influence of organic or other substances.
3. Depersonalization and Derealization: The detachment of the person from his or her environment and experiencing unreality towards his or her environment is defined as derealization, and the detachment from himself or herself in relation to his or her thoughts, emotions, body, and sensations and watching himself or herself as if he or she were an outside observer is defined as depersonalization.
4. Other Defined Dissociative Disorders: There are four headings: syndromes with mixed symptoms that do not fully meet the criteria; syndromes with mixed symptoms, persuaded by pressure torture due to acute situations lasting several hours; and dissociative trance.
5. Unspecified Dissociative Disorder: It is considered in cases where dissociative features are observed but do not fully meet the symptom criteria.

In studies, the prevalence of dissociative disorders is 8.6%–18.3%. The prevalence of dissociative identity disorder varies between 1.1% and 3.1% (Ross, 1991; Johson et al., 2006; Şar et al., 2007). There are also studies indicating that 5% of patients hospitalized in psychiatric services have dissociative identity disorder (Tutkun et al., 1998). Although dissociative identity disorder is more common in females, the gender ratio is closer to one in adolescents (Şar, 2010). When we look at the studies conducted in Turkey, the first study was established in 1993 with the diagnosis of an inpatient patient (Şar & Öztürk, 2018). Studies show that the overall prevalence of dissociative disorders is 0–20% in clinical and non-clinical populations (Şar, 2011; Öztürk & Şar, 2016).

Dissociative identity disorder is positively associated with childhood traumas, yet only 3% of patients under the age of 12 and 8% between the ages of 12 and 19 during adolescence receive a diagnosis. Making the correct diagnosis at an early age is important in terms of easier treatment in childhood and protecting the child from trauma (Zoroğlu et al., 2001). Early intervention in diagnosis and treatment is also preventive for self-harm behaviors (Zoroglu et al., 2003).

Although dissociative identity disorder is a psychiatric disorder that has been known for a long time, it has been neglected in the historical process and is considered a by-product of other disorders. Although the relationship between psychological trauma and dissociative disorders is known, the lack of attention has had negative consequences (van der Kolk et al., 1996). Dissociative identity disorder is not a rare phenomenon but a common disorder. Despite its prevalence, we cannot diagnose it. According to Schuengel et al. (1996), DID is a more common disorder than it is believed to be, and it is at least as common as schizophrenia.

This case presents the clinical follow-up process of a client who suffered from childhood neglect and abuse and developed dissociative identity disorder, with the aim of highlighting the diagnosis process of dissociative identity disorder.

CASE

The client, who was 18 years old and in her first year of university, presented with auditory hallucinations that increased in severity in the last 3 years, identity confusion, and suicidal thoughts. The client stated that she had bisexual tendencies, but she was not sure. The client mentioned that she had a depressive and dark side, and that she had the potential to act in ways that were contrary to her identity if she made a sudden decision, leading to internal conflict. Despite not experiencing complete amnesia, she admitted to experiencing moments of memory gaps. She mentioned a few conversations in which there were gaps in her memory, and she stated that she did not recognize a few people who claimed to know her. She stated that she left the dormitory with an intense urge, went out and consumed alcohol in a way contrary to her identity, and that she could be in dangerous environments in the middle of the night without feeling any fear. She stated that the client's alcohol and substance use had increased recently, and that she had difficulties with identity transitions when she transitioned from the periods when she did not stay in the dormitory to family life. The client described her experiences of depersonalization and derealization as "I feel as if my body does not belong to me" and "I feel as if the environment and people I am in are foreign; I feel as if I am looking at myself from the outside". She added that, especially in the recent period, her sleep patterns had been disturbed, she had difficulty focusing, she was constantly drifting, she heard voices in her mind, it was very tiring, and she felt like she was someone else. In the initial family-accompanied interview, her parents reported that she exhibited incompatible behaviors and decisions. At one point, she embraced a rebellious masculine identity, changing her gaze, tone of voice, and even her name. On another occasion, when she presented herself to them in a pious manner, her childlike identity surfaced and she requested toys. The case was referred for psychiatric consultation due to the presence of psychotic symptoms. The necessary examinations were performed, a diagnosis of dissociative identity disorder was made, and the psychotherapy process was started.

Curriculum Vitae and Family History

She was born as the first child of a family of two. It was an intended pregnancy, and there were no complications during or after the delivery process. Her childhood growth and development periods were appropriate for her age.

The mother is a 40-year-old housewife, and the father is a 42-year-old tradesman. She described the relationship between her parents as conflicted, especially during childhood. She stated that her mother was cold and distant; she met her self-care needs, but did not see her emotional needs. She said of her mother that "while she feels sorry for a tragedy she watches on the screen, she can act as if there is no such problem when I have a problem." She stated that she had a better relationship with her father in her childhood, but she thought that he manipulated her later. She described her father

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as generally calm but prone to sudden outbursts of anger. She expressed her childhood fear of his departure, as she had a habit of disappearing when she became angry. Additionally, she expressed her intense fear of her calling her name aloud.

The client's stressful experiences and type 1 trauma history frequently highlighted conflicts between her parents during her childhood, as revealed in the interviews. She stated that she was a popular and successful student in primary and secondary school, but she was uncomfortable with the boarding school and the system in high school, and she had a lot of difficulties. At the age of 5, she was sexually harassed by a neighbor in the neighborhood; at the age of 7–8, she was sexually harassed by a family relative who was an adolescent; and again, at this age, she was sexually harassed by her father's employee. She remembers that in the first childhood harassment, she came to her family and told them about it. At that moment, family relatives at home were going to call and inform the police, but her mother got worried and prevented her from doing so by saying, "Don't let her father hear it; he will be very angry." She also stated that when she saw her father sitting her on his lap during the harassment by an employee at work, she called the employee out, talked to him, but did not know what he said. But they continued to work together; they still kept in touch, and she was very angry with her family because of all these reactions. In primary school, a group of her peers cornered her in the restroom and threatened to harm her, prompting her to flee.

Mental State Examination

We observed the client's general appearance to be attentive and age-appropriate. Her mood was depressive and anxious, and her affect was consistent with her thoughts. Her speech and affect were compatible with her age, and her motor behavior was also compatible with her age. The thought flow was goal-oriented. She did not describe any deterioration in the thought content. We observed normal attention and perceptual memory. However, the client stated that she heard inner voices and was very disturbed by them. When someone is psychotic, their inner voices only went in one direction. But when someone is dissociative, they can talk and interact with their voices, they have different identities, and they can still see reality clearly. This suggests that they may not be experiencing psychosis. The client was referred for a psychiatric examination due to self-harm, suicidal thoughts, and psychotic symptoms. The client showed an open attitude towards cooperation.

"Alter Identities"

- She is a very brave person who does not need food or sleep. She drinks alcohol and has a strong person (when this alter is active, he can write literary works). She doesn't want to be boring and ordinary like other people. At the age of 13, she remembers being bullied and exposed by her friends. After this incident, her mother referred to her as a dirty girl. She says she is here to challenge the system.

- She's an admirable woman in her 30s. She has a tough nature; she commands. She is also a very beautiful woman. She expresses a memory of being left with her grandmother, being tricked by her parents in the village, and running away at the age of 6.

- She doesn't find angry people trustworthy. In fact, she is calm as long as they don't make him angry, but she gets angry when they enter his space. She is very intelligent and strong. She remembers her childhood abuse and believes that children are not safe in this world. She is especially active when she is frustrated.

- She is 7 years old, active at home and sometimes in the dormitory. She is a child who wants to play and have fun. She was active in a session once, and her speech changed during that time. She is a child who has experienced neglect, abuse, and deception. She exhibits signs of neglect, weakness, and disorganization, expressing a need for attention.

- She's 35; she wants to use drugs. She thinks she has been wronged. She has memories of not wanting to go to Quranic courses.

Clinical Monitoring and Treatment Process

The client continued to cooperate in the process of psychiatric examination and subsequent medication use, and attended monthly check-ups with the psychiatrist. She continues to use sertraline and risperidone, active substance medications. During the therapy process, the client underwent an alter change, encountered one of her identities, experienced complete amnesia in one of the sessions, and couldn't recall how he got there.

In the initial phase, we structured sessions as two per week. We adjusted them to once a week as the symptoms and complaints eased. We continue psychiatric examinations once a month to monitor medication. The sessions involved a review of all processes in the case. We categorized emotions and behaviors, family relationships, academic life, social life, and current problems, and identified coping skills. She utilized both internal and external resources in her life during this process.

The initial goal was to intervene in the case of self-harm and self-destructive behavior. We questioned the client, who was also undergoing psychiatric treatment, about suicidal ideation, and conducted stabilization studies on self-harm. Initially, we questioned the reasons and discussed these topics. When the urge arose, we tried alternative behavioral methods such as taking a cold shower, going out, changing the environment, identifying the triggers, and intervening at those moments. Regulating behaviors and triggers in the home environment helped the client overcome crisis moments without any issues. The family discussed attitudes and moments that triggered the client, raising awareness. The client did not attempt suicide during the process. However, self-harm behaviors continued for a while and disappeared over time.

After establishing the therapeutic alliance with the client, we provided psychoeducation to help the client understand and make sense of the process. We discussed and clarified the process, its difficulties, and any exaggerated thoughts the client may have had. One of the important steps in the therapy process was to address the factors that make the process difficult in daily life. Especially, the lack of family support is one of the factors that complicates the patient's process. With the client's permission, we included family interviews at We informed the family as much as the client permitted, requested their cooperation, and provided a brief psychoeducation. was given. The family showed a tendency to ignore the disease from time to time and an approach that took it into consideration from time to time. We observed a decrease in aggression towards the family and the formation of an alliance in the following sessions. One of the factors that facilitated the

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process was the patient's awareness, social support, intelligence, and motivation.

Another phase in the therapy process was to identify identities and transitions between identities. We made sure to comprehend the formation of each identity, when it occurred, and the purposes behind it. During this phase of the therapy, we established communication with all identities and ensured group cooperation by maintaining an equal distance from each one. During this phase, the focus was on confronting the past, taking ownership, and addressing challenging life experiences. This process also entails trauma-focused work. We ensured the client mastered the story and filled the gaps in memory by addressing the entire traumatic story. We worked on trauma using the "Eye movement desensitization and reprocessing" (EMDR) method.

Studying the client's traumas uncovered aggression. This was revealed to be caused by an angry alter identity. In addition to the stabilization and integration work with this identity, we conducted breathing exercises and guided the client towards a sport that demands strength and aggression. The process placed emphasis on both internal and external resources. We used resources like painting, meetings with favorite friends, and family gatherings. There were also moments when the client experienced regression. The scans revealed the child's identity, prompting the initiation of integration studies. The child's identity, trapped in the trauma's time, found its way into the present.

Therapists frequently encountered resistance and defenses during the therapy process. In dissociative identity disorder, ensuring identity integration, making sense, and normalizing is an important stage. Once we integrated the client's memories, we focused on interpreting the events. Working with the distorted thoughts she blamed herself for ensured the correct interpretation of the trauma.

The client's self-harming behavior disappeared, the inner voices she heard decreased, and she became better able to cope with the problems she experienced in social and family communication. We emphasized stabilization studies in the first 5–6 sessions. In the following sessions, the alter systems were tried to be understood, and the transition to the integration phase was ensured according to the readiness of the alter identities. In the 10th session and ongoing processes, the traumatic memory EMDR method was studied. In the following process, the client's negative automatic thoughts and cognitive distortions were worked with in the cognitive behavioral therapy (CBT) method. A total of 30 sessions were conducted, and the client's coping and problem-solving skills increased with new stress events.

DISCUSSION

As a defense mechanism, dissociation is an intensive integration effort of the divided consciousness system (Öztürk, 2017). Dissociation allows the pain to go away and enables the person to cope with this compulsion. Implicit memory stores everything associated with the trauma. However, when the repeatedly traumatized mind uses dissociation frequently, dissociative disorders occur (Lewis, 1994). Several times in childhood, our case experienced abuse and neglect. The abuse she experienced and the belief that her family did not protect her caused the client to not perceive the world as a safe place. In addition, the client's transition to adolescence, when all her social life was cut off and she went to a boarding school, caused her to withdraw even more. As a result, it seems that the client experienced dissociation as a primitive defense mechanism against cumulative traumas: childhood abuse, dysfunctional family structure, dissociation as a primitive defense mechanism, and over time, the client developed dissociative identity disorder.

Due to the similarities in symptoms between dissociative identity disorder and many psychopathologies prevalent in this age range, diagnosing dissociative identity disorder in children and adolescents can be challenging (Putnam, 1996). Clients with dissociative identity disorder often present with complaints such as depression, personality disorders, delusions in psychosis, and suicide attempts. There may be comorbidity, as well as symptoms originating from the altered system. Therefore, it is very important to make the correct diagnosis and differential diagnosis. Studies have shown that the later the diagnosis is made, the higher the number of misdiagnoses (Zoroğlu et al., 2001). One of the most common misdiagnoses is epilepsy. Psychiatry referred our patient for an electroencephalography (EEG) evaluation for temporal lobe epilepsy, but found no findings. Schizophrenia is also one of the most common diagnoses. If other symptoms of schizophrenia are absent, if the progression of the disease has been the same for a long time, if it has a systematic course, and if all the symptoms of psychosis are absent, dissociative disorder should be the first diagnosis that comes to mind (Zoroğlu et al., 2000). Our patient had auditory hallucinations, but as seen in psychosis, the sound came from his mind, not from outside. Psychosis typically observes short and repetitive sentences, but in our case, we observed long and reciprocal dialogs. There was also no blunting of affect and no impairment in the perception of reality. A psychiatrist evaluated her complaints of distractibility and inability to focus in the context of attention deficit and hyperactivity disorder. When evaluated within the framework of personality disorders, she meets some diagnostic criteria for dissociative identity disorder. However, transitions between alters can also cause these symptoms, which mayFor instance, despite the presence of self-harming behavior in borderline personality disorder, we determined that the presence of a persecutor alter in our case triggered this behavior, which subsequently disappeared during the therapy process. sappeared during the therapy process. We ruled out depression in our case because depressive themes were not present in all alters. However, the psychiatrist prescribed antidepressants as supportive treatment.

CONCLUSIONS AND RECOMMENDATIONS

Although there are many studies on the prevalence of dissociative identity disorder, it is evident that clinicians' approaches to diagnosis and treatment are limited. One of the reasons is that we are waiting for this disease to take its most severe course. A lack of accurate diagnosis interrupts the disease treatment process and increases symptoms. Psychotherapy treats dissociative identity disorder. We use medication as a supportive treatment. The psychotherapy process should be based on a treatment method specific to DID. Experts believe that mastering the diagnosis and treatment processes associated with this pathology is crucial for clinicians.

By detailing the differential diagnosis process, this case emphasizes that dissociative identity disorder, which has a high prevalence rate, may be present in non-severe cases without dissociative fugue or amnesia. The fact that the case developed dissociative identity disorder as a result of childhood abuse and family conflicts emphasizes the important consequences of neglect

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and abuse experienced during childhood. By focusing on awareness-raising activities, families should become more aware of the effects and consequences of trauma on human life. Dissociative identity disorder is a severely destructive disorder that carries the traces of neglect and abuse in childhood, and it is of great importance that clinicians increase their knowledge and experience in diagnosis and treatment and master the process.

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