CASE CONFERENCE

Dissociative Identity Disorder- Diagnostic Issues

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Abstract : *Dissociative Identity Disorder is a very rare and challenging phenomenon in clinical practice. The clinical picture of Dissociative Identity Disorder may closely resemble certain other disorders like schizophrenia, complex partial seizures, factitious disorders, and trance and possession disorder. A case of Dissociative Identity Disorder is reported, and the issues of diagnosis are discussed in the light of available research and classificatory systems.*

Key words: *Dissociative Identity Disorder, Multiple Personality Disorder*

INTRODUCTION

Dissociative Identity Disorder (hereafter abbreviated as DID) is a very rare and challenging phenomenon in clinical practice. Interest in Dissociative identity disorder (previously called multiple personality disorder; still called so, in ICD-10) has increased in recent years. It involves the "presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about environment and self)" that exchange executive control of the individual's behavior.[1, 2] In addition, almost all such patients report dissociative amnesia, which is inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness[2]. Often different relationship styles (dependent versus assertive/ aggressive) and mood states (depressed versus hostile) segregate with different identities. This fragmentation of personality often occurs in response to trauma in childhood, and is perceived, unconsciously, by the patient as protective, which allows the child to tolerate or evade chronic abuse.

DID is a rare disorder and its prevalence is approximately 1% of psychiatric inpatients.[3, 4] Greater research in area of childhood sexual/ physical abuse and its sequelae has led to greater detection of cases.[5] These patients are also very suggestible. The disorder is more frequent during childhood but typically emerges in adolescence.[1] Untreated, it is a chronic and recurrent disorder. Moreover, it rarely remits spontaneously, but the symptoms may not be evident all the time.[6] Major comorbid psychiatric illnesses are depressive disorders, substance abuse disorders, and borderline personality disorder. DID needs to be differentiated from other dissociative disorders (dissociative amnesia, fugue, trance & possession states), schizophrenia/other psychotic disorders, factitious disorder, complex partial seizures and posttraumatic stress disorder.[1] Individuals with DID commonly report somatic or conversion symptoms[7] and other psychosomatic symptoms such as migraine headaches[8]. World literature is still at the level of case reports.

Indian literature, too, has some case reports[9-12] highlighting various issues, some common with developed world and others unique to developing countries.

A case of Dissociative Identity Disorder as a component of Mixed Dissociative Disorder is reported, and the issues of diagnosis are discussed in the light of available data and classificatory systems.

THE CASE

A 12-year-old girl, student of class 7 from an urban

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nuclear family of middle socioeconomic status was admitted to the hospital following a sudden change in her identity. She had been maintaining well till about 1 ½ years back, when she started having a continuous type of moderate grade fever associated with diarrhea and headache. Headache was bifrontal, continuous, throbbing in nature and varying in severity. The patient would often cry and complain about the pain. There were no precipitating or aggravating factors but the headache was relieved by distraction. No associated photophobia/phonophobia, vomiting, focal neural deficit, etc. were reported. Fever and diarrhea subsided with antibiotics but headache continued with lesser severity. Meanwhile, patient was promoted to next class on compassionate grounds. She remained stable with headache of only mild grade for the next 3-4 months. She again had recurrence of fever (102-104°F) with associated vomiting followed by an episode of unresponsiveness for 15-20 minutes. There were no associated tonic-clonic movements, rigidity, urinary or fecal incontinence, up rolling of eye balls, frothing or tongue bite. She was admitted in a hospital where all her biochemical parameters, EEG, CSF analysis, CECT and MRI head were found to be normal. She improved in all symptoms except headache.

One month later [in Sept-Oct., 2005], she claimed that she had seen a black lady with red eyes and a ball of fire coming out of her mouth, who was trying to scare her with a big knife. She saw this in full consciousness, along with the other objects in the room while others were unable to see the same. She appeared fearful and refused to enter the house. She voiced that the same lady was following her and wanted to harm her; started remaining fearful and anxious, would not remain alone at home. Headache worsened and vomiting restarted. She would often cry, pressing her forehead. She stopped going to school. Sleep was decreased to 2-3 hours only. In addition to these, she started having episodes of unresponsiveness, which were not associated with tonic-clonic movement, rigidity, incontinence, up rolling of eye balls, frothing or tongue bite. These were terminated by pressing her nose hard and she had no memory of events during the episode. These episodes of unresponsiveness increased in frequency to 4-5/ day.

She was first seen in our outpatient services about 5 months earlier and was diagnosed as a case of dissociative disorder with undifferentiated somatoform disorder with one episode of Acute Transient Psychosis. By virtue of detailed evaluation by the pediatricians, organic causes of unresponsiveness had been ruled out. She continued to have headache till about 2 months back when while doing her homework, she complained of severe pain for a few minutes, which was followed by inability to use her right arm. This persisted for 3 days and recovered with repeated massage and reassurances by the family members. Parents were psycho-educated and advised to cut down the secondary gains.

About 1 month back, she had worsening of headache, excessive crying due to headache and decreased appetite and sleep. However she managed to attend school despite above problems. T. Clonazepam 0.5-1 mg HS was given but all the above problems persisted. After a few days, while in school and without any apparent reason, she started crying and voicing "my grandma will come back". During the following days, she started appearing sad and would talk about her grandmother. At times, she was also observed to talk while facing the wall. On being asked, she would reply that she was talking to her grandmother. But on further enquiry, she would become quiet.

On 10th February, 2006, while she was lying down in her room, her mother heard sounds of objects being thrown and the patient shouting while facing the wall, "You have ruined our house.

My father started drinking because of you. My grandma died because of you. Will you take my life also? You have taken away everything; what else do you want now?" On being asked as to whom she was talking to, she asked for the family album. She indicated the photograph of her father's aunt but gave no further explanation; appeared anxious and tried to run away from home; therefore, she had to be physically restrained.

Next day, similar behavior was repeated and then she became unresponsive for 4-5 minutes. On regaining responsiveness she voiced, "How can you people sit at the same level as the master [i.e. she herself]?" On being asked, she further said "My name is Shri Hariyamaan Koshi Guruji and I have my aashram in Gurgaon. On being asked about Ms A [her own name], she replied "I do not know anyone with this name."

Her parents made futile attempts to remind her of Ms A by discussing about her relationships, hobbies, school and bad health.

She started switching between these two states [one, her primary personality and second, this master] without any provocation. She would remain in one state for 3 hours to a couple of days and would, at that time, deny any knowledge of the other state. This transition was sometimes spontaneous and at other times was preceded by a brief period of unresponsiveness. She had been in the altered state for a couple of days when she was brought to Psychiatry OPD. She said to the doctors, "Where have you hidden Ms A? I have come on the request of Mrs. & Mr. Gupta [hinting at her parents] to cure their daughter Ms A with my *tantric vidya* [magico-religious power] and to take her back home".

During this period she was observed to be irritable, stubborn and demanding. Her sleep remained disturbed despite 2-4 mg Lorazepam/ day. She was admitted to Psychiatry ward on 16th February for diagnostic clarification and further management.

No h/s/o sudden and unexpected travel away from home which she could not recall; recurrent experiences of feeling detached from her mental processes or body; feeling or recalling to be possessed by somebody.

No h/s/o syndromal depression, phobias, panic disorder, obsessive compulsive symptoms, Schneider's First Rank Symptoms, mania. No h/s/o head injury, thyroid dysfunction.

Past history: no significant psychiatric illness

Personal History revealed significant information as follows: Patient's father had had a premarital affair with his childhood friend. But due to caste barrier, that marriage had not materialized. He had an arranged marriage in 1993. Father had poor frustration tolerance and critical attitude towards wife which often led to altercations between parents. The patient had been born of full term vaginal delivery (forceps) with no perinatal complications. Developmental milestones had been age appropriate. Since the beginning, the household was dominated by the grandmother. The patient was more attached to her father and grandmother. She would receive either excessive affection or harsh punishment from her father. Her mother, being a submissive and meek person, could not intervene. She started schooling at 4-5 year of age and was weak in studies since the beginning. Parents were worried and used to scold her frequently. In November 2002, father again came in contact with his previous beloved. He started spending time away from home; started ignoring his family responsibilities and stopped devoting time to the patient. Patient's mother became suspicious of his ways and came to know about her husband's extra-marital relationship after ~1 year. Following this, there were more frequent altercations between parents, most of which happened inadvertently in front of the patient. Within next 6 months, the father started contemplating divorce from patient's mother and even talked of marrying

his friend and of taking patient along with him. Patient's mother agreed for the divorce but refused to part with the children. Patient's father started abusing alcohol which further tensed up the atmosphere. Finally, families of all the 3 sides intervened and the extramarital relationship ended in January, 2005, after which there was a further increase in the alcohol intake (reaching dependent pattern) by patient's father who stopped devoting time to family members and appeared "tense and sad" for most of the time. It was in the background of all these circumstances that the patient had development and evolution of the history of present illness.

Temperamental characteristics: The patient has been described as less active, rhythmic, withdrawing from the new situation, adaptable, neither sad nor cheerful, submissive, with low intensity of reaction, average threshold of responsiveness, average attention span, persistent, and not distractible.

Physical examination: was within normal limits.

MSE (on admission): Claimed herself to be "the Guru" who had supernatural powers to heal others; did not know about her previous self (Ms A); behaviorally- aggressive & demanding.

Course in ward- When asked to elaborate, she repeated the earlier assertion that she was Shri Hariyamaan Koshi Guruji said, "I was born 19 years ago in Ooty. Both my parents were Guruji. I had two brothers: one 20 years old and the other 15. When I was 5 years old, my parents died in an accident. After that, my elder brother left me in Panchkula and himself went to Hoshiarpur. I do not know the whereabouts of my younger brother." On enquiry about Ms A [her real name], she said, "I don't know Ms. A; nor have I seen her. However, I have heard about her from Mrs. & Mr. Gupta [referring to her parents] who met me in Delhi while I was on my visit there to see my disciples. Both of them expressed their wish to adopt me to which, I acceded under compassion. Thereafter, I changed my name to Harry Gupta."

On 21st February, 2006, the patient went on parole with her parents during which her father fulfilled all her demands (bought many articles). On the way back to hospital, she again became unresponsive for ~30 seconds (no evidence of true seizure). After this, she had a change in behavior and voiced, "Where am I? Who brought me here and how?" She could not remember anything about past week; also could not recognize the therapist and other people whom she had met during the last week in hospital. She became calm, quiet, non-demanding and had no anger outbursts- had switched back to her previous self [primary personality].

Notably, she complained of having forgotten some pieces of important personal information like the death of her grandmother (she still believed that her grand mother was alive), name of her teachers, friends and close family members; subjects taught in school except Maths and English. Psychological testing had been unremarkable.

TREATMENT

Non-pharmacological treatment of the patient included- exploration, supportive psycho-therapy & pentothal abreaction. In the exploratory sessions, various personal details of the two different personalities were noted and the discrepancies in the patient's version were challenged. The patient revealed marked distress about family atmosphere at home due to father's extramarital affair and the resultant altercation between the parents. Also, she shared her concerns regarding her scholastic difficulties and her having had to repeat a class. In supportive psychotherapy sessions, ventilation and catharsis were achieved along with orientation to problem solving perspective in handling difficult times in life. In pentothal sessions, abreaction and

therapeutic suggestion were accomplished [Towards later part of her therapy, she had started entertaining the possibility initially that the second personality [Guruji] might be her twin and later that he/ she might be a part of herself]. Non-pharmacological treatment included separate sessions with the family members and the marital conflict of the parents was explained as one important stressor for the patient. The parents resolved to work on it and also gave commitments to the patient.

The patient had to be given pharmacological treatment in the form of 1-2 mg of risperidone during the times she was in secondary personality as she would become very demanding, adamant, domineering and thus, unmanageable.

Short-term outcome- Over the period of about 3 weeks, the patient started showing improvement: there was reduction in the periods of secondary personality; the identity change started showing partial dissociation in which she retained some of the characteristics of primary personality e.g. her name. Long-term follow-up is needed to see the maximum extent of improvement and the time taken for that.

DISCUSSION

Discussion of Diagnostic exercise:

Diagnoses of Mixed Dissociative Disorder, Somatoform pain disorder and an episode of Acute Transient Psychotic Disorder were considered. For the presenting complaint of change of personality, possibility of Dissociative Identity Disorder [Multiple Personality Disorder] rather than Trance and Possession Disorder was considered [as one of the components within larger category of Mixed Dissociative Disorder]. The points in favour & against these considerations are as under:

1. *Mixed dissociative disorder:* in view of the various dissociative syndromes viz. dissociative identity disorder/ multiple personality disorder, dissociative stupor/ seizures, dissociative motor disorder
   - Points in favour of dissociative identity disorder [multiple personality disorder]

1. Presence of two distinct identities or personality states with only one of them being evident at a time
2. Two identities were unaware of existence of each other
3. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness
   - Points in favour of dissociative stupor/ seizures

1. Episodes of loss of responsiveness to external stimuli
2. Absence of physical disorder that might explain stupor (normal EEG and MRI)
   - Points in favour of dissociative motor disorder

1. Loss of ability to move the limb
2. No anatomical and physiological correlates
3. Improvement with suggestions

2. *Persistent somatoform pain disorder*
   - Points in favour:

1. Chronic, persistent, severe and distressing headache
2. No physical or investigatory evidence of continued physical illness
3. Pain decreased with distraction
4. Temporal correlation with a stressor
   - Points against:

1. Evidence of intermittent physical illness
2. Intermittent association with vomiting
3. Acute transient psychosis [Possibility for the episode in Sept-Oct, 2005]
   - Points in favour:

1. Intense transient emotional turmoil
2. Talking to self
3. Persecutory ideas