

**DISSOCIATIVE IDENTITY DISORDER:
DIAGNOSIS, COMORBIDITY, DIFFERENTIAL DIAGNOSIS,
AND TREATMENT**

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Abstract

Dissociative Identity Disorder: Diagnosis, Comorbidity, Differential Diagnosis, and Treatment

The cardinal feature of dissociative disorders is disruption which can affect almost every mental function. Dissociative amnesia, depersonalization, derealization, identity confusion, and identity alterations are core dimensions of dissociative psychopathology. While dissociative identity disorder is the most pervasive condition among them, partial representations of this spectrum of psychopathology may be diagnosed as dissociative amnesia, depersonalization disorder, or dissociative disorder not elsewhere classified (DDNEC). Dissociative disorders report the highest frequency of childhood abuse and/or neglect among all psychiatric disorders. Beside constituting a disorder on its own, dissociation may accompany almost every psychiatric disorder and operates as a confounding factor on research in the entire psychiatry. Although they do not have a specific drug treatment, dissociative disorders may be cured by psychotherapy.

Key words: Dissociation, diagnosis, childhood trauma, psychotherapy

Introduction.

The cardinal feature of dissociation is disruption. Dissociation may affect thinking, emotions, behavior, memory, identity, consciousness, perception, and/or sensorimotor functioning. The main clinical components of dissociative psychopathology can be identified in five dimensions: Amnesia, depersonalisation, derealisation, identity confusion, and identity alteration. Secondary symptoms of dissociation enrich the overall phenomenology which are positive (e.g. hallucinations, Schneiderian experiences) or negative (e.g. somatosensory deficits) in content.

All dissociative disorders are either complete or partial representations of a single psychopathological dimension; i.e. dissociation. Among them, DID is the most pervasive form covering all spectrum of dissociative symptoms including personality states and mental intrusions with their own sense of self and agency. Partial conditions are dissociative amnesia (may or may not be accompanied by fugue) ,depersonalisation disorder, and DDNEC. Dissociation and dissociative disorders may accompany almost every psychiatric disorder and may influence their phenomenology and response to treatment (Sar and Ross 2006).

Epidemiology.

Among women, the prevalence of DSM-IV dissociative disorder in New York (one year prevalence) and in Sivas-City/Turkey (lifetime diagnosis) was between 8.6-18.3% (Sar, 2007; Johnson et al,2006). The most frequent type was DDNEC (4.3-8.3%). Dissociative amnesia was between 2.6-7.3%. Depersonalisation disorder (0.9-1.4%) and DID (1.1-1.4%) were the smallest groups. Although the prevalence of dissociative fugue was only 0.2 %, this was not due to its rarity as a phenomenon. When happens, the dissociative fugue usually is a symptom of a more pervasive dissociative disorder such as DID or DDNEC.

The prevalence of dissociative disorders in psychiatric settings are between 10-12% (Şar,2011) with the highest prevalence in emergency psychiatric ward: 34.9% (Şar et al., 2007). The main difference from community studies is that, in clinical settings, DID is as frequent as DDNEC (Şar, 2011b; Tutkun et al.,1998) and women constitute the majority of the patients. In a Turkish study on both genders in the community, Dissociative Experience Scale (DES) scores did not differ between genders, however, there were twice as much as men among high scorers (Akyüz et al.,1999). In the New York study, there were no significant difference in gender distribution of dissociative disorders (Johnson et al.,2006). There is a general belief based on clinical observations that,in clinical populatiopns, male patients more readily hide their symptoms and trauma histories. In contrast of clinical populations, in a Turkish study on highly functioning college students, men reported more childhood trauma than female students (Şar et al., 2006).

Aetiology.

There is a close relationship between PTSD and DID, because alter personalities may be considered as an elaborated version of trauma-related mental intrusions. PTSD is related to single traumatic experience of adulthood whereas DID is related to chronic developmental traumatization. In DID, traumatic memories are decontextualized (Brewin, 2001) and processed to keep the internal and external balance (Şar and Öztürk, 2005) leading to formation of alter personalities with sense self and agency (Spiegel et al., 2011), personal history, ciphers, and a mission (Öztürk 2009b). This fragmentation disrupts overall identity of the person. Ninety percent of all patients with DID report at least one type of childhood abuse and/or neglect (incest and other types of sexual abuse, physical and emotional abuse, physical and emotional neglect) (Şar et al.,1996; Spiegel et al.,2011). A subgroup of patients have amnesia to a period of childhood which may lead to rather underreporting. There are also “apparently normal” families with covert dysfunctionality (e.g. pseudomutuality, double-bind, marital schism, insecure attachment, high expressed emotion) (Öztürk and Şar, 2005).Functional brain imaging studies revealed bilateral hypoperfusion in orbitofrontal regions (Şar et al., 2001,2007) which supports an orbitofrontal hypothesis of DID (Forrest, 2001).

A structural investigation yielded smaller hippocampi and amigdala (Vermetten et al.,2006). The latter structural changes seem to be secondary to developmental stress.

Pathways Leading to Diagnosis of DID.

Most of the patients with a dissociative disorder express only a subgroup of his/her symptoms which predominate the current status. However, they are usually able to describe the entire syndrom in a complete psychiatric examination. Awareness about possible types of application in clinical settings may assist the clinician in catching the possible diagnosis. However, partial expression of the syndrom would lead the clinician easily to an alternative diagnosis depending on the prevailing symptom group.

Double depression: Most of the patients with DID or DDNEC report chronic depression usually fitting the course of double depression; i.e. dysthymic disorder as baseline with repetitive major depressive episodes superposed. The latter mark periods of crisis throughout the life course of the patient triggered by internal or external stressors. Many patients report the onset of their depressive mood early in childhood; i.e. “from the beginning on” continuing “almost uninterruptedly”. In contrast of the primary depressive disorder, this condition usually does not respond to antidepressant pharmacotherapy and is labeled as “treatment resistant”. However, upon integration in psychotherapy, the depressive syndrome disappears instantly. This condition may be considered better as a “dissociative depression” (Şar 2011c) in differentiation from a primary depressive disorder which seems to have a different pathogenesis, course, and treatment response.

Conversion disorder: In the general community, 26.5% of the women who report having experienced at least one conversion symptom in their life, have a dissociative disorder (Şar et al., 2009). This figure is between 30.1-50.0% among psychiatric inpatients of both gender (Şar et al., 2004; Tezcan et al., 2003). When accompanied by a dissociative disorder, patients with a conversion symptom have more psychiatric comorbidity, childhood trauma history, suicide attempts, and self-mutilation (Şar et al., 2004).

Functional somatic symptoms distinguish dissociative disorders from other psychiatric disorders (Şar et al., 2000; Şar, 2010). A recent study in Turkey yielded a very high lifetime prevalence of conversion symptoms among women 48.7% (Şar et al., 2009). Notwithstanding the cultural factors, this may be an indicator of a high prevalence of dissociative disorders as well. Conversion symptoms usually mark an acute crisis period superposed on the chronic course of dissociative disorder in these subjects. The predominance of somatic symptoms such as pseudoseizure constitutes a medical emergency and may hide the broader spectrum of dissociative symptomatology.

“Borderline personality” features: Among subjects who fit the DSM-IV borderline personality disorder criteria, 64.0-72.5% have a DSM-IV dissociative disorder as a first axis diagnosis (Şar et al., 2003; 2006). The validity of these criteria for a personality disorder seem to be low (Hudziak et al., 1996). In fact, they describe interpersonal aspects of dissociation and catch subjects who have dissociative disorder.

Acute dissociative psychosis: This condition may resemble a delirium mania or schizophrenic psychosis (Şar and Öztürk, 2008; 2009). It ceases in a few weeks latest, and is characterized by dissociative symptoms based on a “revolving door” or “co-consciousness” crisis. Flashback experiences, conversion symptoms, fugue states, catatonia, hallucinations, suicidality, violence, and delusions may be part of the condition. The patient may remain amnesic to the entire episode. Short term hospitalization, supportive psychotherapy and especially separation from a distressing family environment have been the most useful measures for the management of the disorder. Besides being a discernable diagnosis, dissociative psychosis may happen in patients with DID as a result of decompensation after an acute stressful life event. This may manifest itself as a struggle for control and influence between alter identities carrying frightening, fearful, aggressive or delusional features, some of whom may have had been dormant for a long time (Tutkun et al., 1996). Consequently, the former “hysterical psychosis”, which is considered “dissociative psychosis” now, has been the diagnostic starting point which led to the recognition of DID in Turkey.

Bipolar (II) mood disorder: Trauma-related affect dysregulation and/or switching between alter personalities with distinct mood states may resemble cyclothymia or bipolar (II) mood disorder (Van der Kolk et al., 1996). These alterations do not respond to mood stabilizers but recover in integrative psychotherapy.

Substance dependency: Dissociative disorders were seen 17.2 % of a large inpatient group seeking treatment for substance abuse (Karadag et al., 2005). Patients with a dissociative disorder utilize more substances in number of types, they drop out from treatment more frequently, have shorter remission duration, and they are younger. In majority of them (64.9%), dissociative symptoms started before substance use; i.e. usually in adolescence. Suicide attempts, childhood emotional abuse, and female gender predict dissociative disorder among substance users. The prevalence of dissociative disorders increased to 26.0% when probands with only alcohol dependency were excluded (Tamar-Gürol et al.,2008). These findings are alarming, because they demonstrate the importance of the recognition of dissociative disorders for prevention and successful treatment of substance dependency among adolescents and young adults.

Sexual dysfunction: Childhood sexual abuse is reported by patients with sexual dysfunction frequently. Among patients with DID, personality switching (e.g. to child or opposit-gender personalities) or flashback experiences may occur during a sexual relationship; e.g. , such a condition may mimic vaginismus (Kuşkonmaz ve ark., 2000).

Repetitive suicide attempts: The majority of the patients with DID has suicidal ideas, and suicide attempts are not rare. The prevalence of completed suicide is around 1-2 % (Kluft 1995). Some of the patients call for help just before or after an attempt, because some of the alter personalities (e.g. child alter) may resist against such an action.

Self-mutilation: Many patients with DID inflict self-injuries, mostly during a dissociative crisis. The patient may suffer from depersonalization during or remain amnesic to the crisis episode.

Dissociative fugue: Most of the cases with a dissociative fugue have an underlying chronic dissociative disorder such as DID. Thus, a solitary diagnosis of dissociative fugue is relatively rare.

Possession: Paranormal (extrasensory or supranatural) experiences are common among patients with dissociative disorders. In contrast of the alter personalities, the origin of possession is experienced in the external world. The relationship between possession and dissociative disorders is universal (Ross, 2011). There is also a significant relationship between childhood psychological trauma and paranormal experiences in the community (Ross and Joshi, 1992).

Non-psychotic dissociative crisis: Most of the patients with a chronic dissociative disorder have also acute dissociative states superposed to the underlying disorder. There is also a transient type of acute dissociative condition without an underlying chronic dissociative disorder which is proposed to be listed as an example of dissociative disorder not elsewhere classified in DSM-5 (Spiegel et al., 2011). In Latin culture, the latter is known as “ataque de nervios”, however it is not a culture-bound phenomenon (Lewis-Fernandez et al., 2007; Martinez-Taboas et al., 2010). Palpitations, fainting shaking, and depersonalization are common during these episodes which may also be associated with a conversion symptom such as pseudoseizure. Dissociative crises of the patients with chronic dissociative disorder consist of trauma-related flashback experiences, self-mutilation, “revolving door crisis” of the alter personalities competing for taking control, and/or amnesia (Şar and Öztürk, 2008; 2009). Hence, emergency psychiatric wards have the highest prevalence of dissociative disorders (Şar et al., 2007). These acute crises may serve as a “diagnostic window” for patients who have a chronic dissociative disorder such as DID but may only have subtle symptoms between these acute decompensation periods.

Alter personalities: Several types of alter personalities have been described. Here are a few types listed which may have strategic importance for therapeutic interventions (Öztürk, 2009b).

“Host”: The host personality is usually depressed, may suffer from PTSD and acute dissociative crises which one may remain amnesic of. Fusions should always be conducted in the presence of and toward the host personality because the direction of the fusion may lead to different results. Conducting fusion between alter personalities is not recommended.

“Persecutor”: The persecutory personality is hostile against the “host” and may lead to suicide attempts, and self-mutilation. However, the “persecutor” determines success of the intervention and should be gained for cooperation. The “persecutor” should be fused to the “host” before other alter personalities. Not doing so may undermine the “balance” between alter personalities (Öztürk, 2009b). The “persecutor” resembles a child feeling anger and guilt due to the traumatic experience.

“Prostitute”: Observed both among men and women. This is a strong character which is prone to assist the treatment, because it has the mastery to persuade other alter personalities in entering cooperation, e.g. the persecutory personality. This personality should be kept as a helper and should not be fused during early stages of treatment. The “prostitute” may also cause difficult scenes in daily life when becomes socialized.

“Child”: Creating rarely problems during the early stages of treatment, the child personality may be neglected erroneously. This is hazardous, because it turns to a secondary persecutory personality afterwards. Otherwise, the “child” assists the treatment as a guide.

“Gay/Lesbian” : This is a cheerful character with some “antidepressive” quality, is prone to be cooperative, nurtures life energy. The gay/lesbian personality does not have any significance about post-integrative sexual orientation of the patient.

Comorbidity and Differential Diagnosis.

Schizophrenia: Hallucinations, Schneiderian symptoms, and acute crises superposed to the underlying chronic dissociative disorder which lead to grossly disorganized behavior may resemble the schizophrenic disorder. Lack of negative symptoms of schizophrenia in patients with dissociative disorders may assist differential diagnosis. However, comorbidity between schizophrenia and dissociative disorders is possible which may be considered as dissociative subtype of schizophrenia or schizodissociative disorder depending on the predominance of the symptoms.

Borderline Personality Disorder: Many patients with a chronic dissociative disorder resemble a borderline personality disorder at the surface. Hence, the DSM-IV criteria should not be considered as sufficient to make a personality disorder diagnosis. The overall level of functionality (may be lower in borderline personality disorder) is a cue for differential diagnosis whereas comorbidity is possible.

PTSD: Many patients with PTSD have dissociative flashbacks and many patients with dissociative disorder develop PTSD. Comorbidity is possible.

Migrain: Beside non-specific forms of headache usually triggered by personality switchings. Many patients with dissociative disorder suffer from genuine migrain.

Attention Deficit Hyperactivity Disorder : Both child and adult form may resemble a dissociative disorder whereas comorbidity is possible. Among adolescents in particular, motor uneasiness and affect dysregulation due to dissociative disorder may also resemble ADHD.

Obsessive Compulsive Disorder: Some of the dissociative patients have comorbid obsessive compulsive disorder. According to one study, 15.8% of patients with obsessive compulsive disorder (OCD) had DES scores of 30.0 or above 49.

Significant positive correlations were found between DES scores and emotional, sexual, physical abuse and physical neglect scores. Among children, instructions of a persecutory alter personality may resemble an OCD at the surface unless the patient is able to report the connection to dissociative symptoms.

Bipolar Mood Disorder: Although comorbidity with dissociative disorder is not very common, bipolar mood disorder is an important item in differential diagnosis, because many patients with dissociative disorders are erroneously diagnosed as having bipolar mood disorder or cyclothymic disorder due to the mood fluctuations related to post-traumatic affect dysregulation.

Epilepsy and other organic mental disorders: Any episodic behavioral syndrome requires an evaluation in terms of organic aetiology. Temporal lobe epilepsy may cause dissociative symptoms (depersonalisation, fugue) and, although controversial, some subclinical epileptic phenomena (“kindling”) are proposed to cause chronic, episodic, psychosis-like syndromes.

Factitious disorder and malingering: In consideration of its self-destructive aspects, factitious disorder with psychological (Münchhausen’s syndrome) or somatic symptoms may be based on a dissociative disorder. Malingering can be differentiated from dissociative disorder by the complexity of the latter which is difficult to imitate.

Pathognomonic symptoms and standardized evaluation: Making a dissociative disorder diagnosis means to identify the pathognomonic symptoms of the disorder. Internal dialogues, feeling some one or another personality inside oneself, made feelings, behavior, and thoughts; memory gaps about daily life and the past leads to diagnosis of a dissociative disorder. An average score above 30 in the Dissociative Experiences Scale is a cue for a dissociative disorder (primary or comorbid) whereas this figure is around 50 for DID (Bernstein and Putnam 1986). SCID-D (Steinberg 1994) and DDIS (Ross et al., 1989) are helpful for making a diagnosis. Rorschach test may assist the elimination of schizophrenia.

Natural Course.

In contrast of many psychiatric disorders, dissociative disorders may be cured. However, given the current controversies in psychotherapy field overall, successful treatment of dissociative disorder depends on personal talent, knowledge, and qualities of the therapist. Many patients try to self-repair themselves before effective treatment, however, this usually leads to further complexity. Untreated cases do not integrate spontaneously, however, an outcome such as living under control of a single alter personality has been reported (Kluft 2007). This means a constricted life. Dissociative disorders make the subject open to being abused. Even, many patients abused by therapists sexually have a dissociative disorder which leave them un-protected. This situation of revictimization has been called “sitting duck syndrome” (Kluft, 1989).

Treatment.

There is no specific drug treatment for dissociative disorders. However, comorbidity and painful symptoms are usually tried to be alleviated by pharmacotherapy. This aspect of drug treatment should be explained to the patient early in treatment. However, dissociative disorders may be cured by psychotherapy. The classical approach, phase-oriented trauma therapy is described in the most recently updated version of the ISSTD Treatment Guidelines (Chu et al.,2011). Basically, this approach consists of three phases: stabilization, trauma-work, and integration.

In an earlier paper on the theory of “functional dissociation of the self”, we introduced the concept of the “sociological self” as an interface between society and the individual (Sar & Ozturk, 2007). Healthy interpersonal relationships are based on a harmonious development and coupling of the sociological and psychological selves. Developmental traumatization leads to detachment between the two selves. In fact, as an individual mental agent, it is more than an interface. The sociological self represents (as does the psychological self) a supraordinate pattern of thinking, experiencing, and behavior which can utilize and interact with every mental content and capacity (e.g., emotions, alter personalities, the trauma-self) in its own way.

The properties of the sociological self are universal (Table 1). Its specific task is to save the psychological self from the destructive influences of others and to buffer psychological trauma. Subsequent enlargement and fragmentation of the sociological self restricts the further development of the psychological self and keeps it frozen.

We explore three coexisting self-systems to understand consequences of psychological trauma in clinical conditions and in everyday life. These are the trauma (symptomatic) self, the sociological (preserving) self, and the psychological (preserved) self. The trauma self, with its resistances, seeking for help, and complaining attitude, is in the front-line clinically. It needs to be dealt with during early stages of treatment. A deep intervention on alternate identities before establishment of a relationship with the trauma self may be premature. The moderator is a distinct intrapsychic system, responsible for cognitive coherence, affect regulation, and maintenance of interpersonal distances. Its temporary collapse due to overwhelming pressure by the impaired tripartite self-system should not be mistaken as a primary disorder. Our treatment approach pursues establishment of the balance between sociological and psychological selves. This entails a shift from self-preservation to self-regulation (Ford, 2009). This can be achieved through the four domains of treatment: 1) Resolving the resistances of trauma self (depressive phenomena, trauma-related obsessions, and disruption of interpersonal mutuality), 2) Deciphering the functions of alter personalities. 3) Facilitating internal migration from sociological to psychological self. 4) Working on denial, guilt, and shame. We actively utilize specifically shaped questions as tools to facilitate processing in each domain.

In treatment of DID and related conditions, working with alter personalities is common in various stages of treatment, however, in our view, this is not sufficient to cover the patient's entire subjectivity. Based on our theory of the "functional dissociation of the self", we propose that working on the resistances of the trauma-self and achieving an internal migration from sociological to psychological self are two additional components of psychotherapy (Şar and Öztürk, 2007; Öztürk 2009b).

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Table 1: Properties of Sociological and Psychological Selves
(Adapted from Sar & Ozturk, 2007)

Sociological Self	Psychological Self
Modeling, imitation, copying	Creativity
Eclecticism	Authenticity
Dogmatism	Possibilities
Polarisation	Synthesis
Negotiation	Choice
Reversibility	Constancy
Competition	Self-expression
Single-focus awareness	Multi-focus awareness
Cruelty	Compassion
Affiliation	Contact
Fusionary attachment	Boundaries
Religion	Spirituality
Metaphers, metonyms, symbols	Signs
Fantasy, utopia, imaginations	Facts
Heroes and heroines	Icons