

## **Dissociative Identity Disorder Presenting with Multiple Suicidal Attempt: A Case Report**

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### **Abstract**

**Introduction:** Dissociative Identity Disorder (DID) is diagnosed if a person has at least two different identities that alternately control a person's actions with no memory of the incident. Suicide is one of the most observed symptoms in DID and suicide rates were reported as 70 - 72% in DID. We describe the case of a 23-year-old patient who presented with DID and discuss the issues raised about the psychiatric manifestation, and the treatment implications for her illness.

**Methods and Results:** Findings on psychiatric evaluation encompassing detailed history, mental state examination and baseline laboratory examination suggested Dissociative identity disorder /non-possession form/, known type I DM on treatment.

**Conclusions:** Dissociative identity disorder is known as a rare disorder due to its being misdiagnosed. Suicide attempt is one of the presenting symptoms in DID. Taking into account this case, the cases of suicide in DID's should be evaluated with caution. In our case, she responds for hypnosis therapy. Most importantly DID warrants close monitoring for suicidal behavior after discharge of all cases of DID.

**Keywords:** *Dissociative Identity Disorder; Suicide; Multiple Personality Disorder; Malingering*

### **Abbreviations**

BPD: Borderline Personality Disorder; DID: Dissociative Identity Disorder; DM: Diabetes Mellitus; DSM-5: Diagnostic and Statistical Manual of Mental Disorder-5; OPD: Out-Patient Department; PTSD: Post-Traumatic Stress Disorder; LFT: Liver Function Test; RFT: Renal Function Test

### **Introduction**

Dissociative Identity Disorder (DID) is diagnosed if the person has at least two different identities that alternately control a person's actions [1]. Thus, it is also addressed as multiple personality disorder [2,3]. According to DSM-5, DID has disruption of the usually integrated functions of: "consciousness (e.g. trance states, non-epileptic seizures, pseudo-delirium); memory (e.g. impairment of autobiographical memory, that is, dissociative amnesia); awareness of body and/or self (depersonalization; e.g. feeling numb, watching oneself from a distance as if in a movie); environment (derealization; e.g. world appears far away or "foggy"; familiar places/people seem unfamiliar or strange; tunnel vision); and identity (e.g. confusion about one's identity; experiencing discrete and discordant senses of self-referred to as "identities", which we refer to here as "dissociated self-states" [2,4-6].

The estimated of DID prevalence worldwide is about 5% among the inpatient psychiatric population, 2% - 3% among outpatients, and 1% in the general population [2,7]. Dissociative identity disorder (DID) has a total prevalence of .4 - 14% of both psychiatric inpatient

and outpatients [5]. Dissociative identity disorder is known as a rare disorder due to its being underdiagnosed and misdiagnosed [1]. One of the strongest risk factors of dissociation is antecedent trauma, particularly early childhood trauma, as well as difficulties with attachment and parental unavailability [1,5,8]. Dissociation is a process that provides protective psychological containment, detachment from, and even physical analgesia for overwhelming experiences, usually of a traumatic or stressful nature. Dissociation is conceptualized as defensive reaction freezing to escape distressful traumatic event [5].

There are several conditions which linked with this disorder; including depression, self-harm, post-traumatic stress disorder (PTSD), substance use disorder, borderline personality disorder or anxiety [1] and conversion disorder [1,9]. Suicide attempt is one of the presenting symptom in DID [1,10]. Borderline personality disorder (BPD) and DID have often been reported to occur together [5,11,12]. BPD diagnosed in 30% to 70% of DID patients [5,11].

Suicide has been reported as a complicating condition of DID in psychiatric practices. Even though, the suicide rates decrease after treatment of depression but rarely Suicide emerges related to antidepressant treatment in patients with depression that it is generally seen in adolescent's age group [1,10]. Administration of Adjunctive antidepressants accepted as a treatment option for DID in clinical practice [1]. Despite extensive use of antidepressants in clinical practice, the unfavorable effects of antidepressant on dissociative identity has not been determined.

In this case study, we describe the case of a 23-year-old patient who presented with DID and discuss about the psychiatric manifestation, and the treatment implications of her illness.

### Case Report

This is a case of 23-year-old female client who is a first year Nursing student. She came to our hospital with her brothers, her mother, her dorm mates and her boyfriend. The data was collected from herself and her relatives stated above.

The patient is known type 1 diabetic since the age of 7 on treatment and follow-up. As her mother reported her first behavioral disturbances started in 2005G.C one year after her diagnosis of type 1 diabetes mellitus.

According to the client the behavioral change starts after she sustained sexual assault at age 8 by someone working for her family where she felt ashamed and terrified after the trauma. later she also sustained at age 11 while she is grade 6 student by neighbor who is 5 year older than her without her consent and the last attempt was at age 15 while she was unconscious due to her diabetes when she wake up she found a stranger trying to rape her. However, since 6 years ago in (2014 G.C) after she changed her living place to other city in hope of improvement her behavioral disturbance becomes more frequent and severe. Because of the severe extent of the stress, she discontinued her education at 11<sup>th</sup> grade due to her illness. After taking a break for a while and she again went to study at another city and finished her 12<sup>th</sup> grade education. She joined University in physics department in 2018G.C. After scoring good grade in first year she shifted her department to nursing. Because, she want to understand her health issues more. According to her family and friends report, she is industrious, religious, calm, sociable and funny girl except during her illness periods.

### Current Presentation

Currently the client presented with repeated attempt of suicide, i.e. 3 times within 2 weeks period. 2 weeks back she tried to hang herself impulsively with a rope. This occurred at mid-day when her dorm mates left the dorm. She reported that she had no plan to harm or kill herself, but she remember that immediately before the attempt she has intuition that something is going to happen to her. Afterwards, she visited the university student clinic. She was given fluoxetine and diazepam. She reported she was adherents to her medications.

In addition to this self-harming behavior, she has also attempted episodic choking of her dorm mates while she was interacting peacefully with them. She claims that she had no recollection of the incident or memory of the incident. Her dorm mates also confirmed that she does not do it deliberately and has few or no memory after the incident. The patient added that it has no specific triggers.

Her second suicidal attempt was on second week of January/2019 G.C that is one week before her admission to psychiatry ward at which time she ingested overdose of her prescribed psychiatric drugs at once. She denied of any organized plan to end her life, but she said she was largely unaware about it and even if she had slight idea about these events she couldn't prevent them from happening. For this reason, she went to medical emergency department and managed. After stabilizing for 24 hours, consultation made to Psychiatry emergency department staff for thorough evaluation and to assess the risk of suicide. During this time patient evaluated and considered as having dissociative identity disorder with possible strong differential diagnosis of borderline personality disorder. After psychiatrist evaluation, she was discharged with oral diazepam, Psycho-education, short appointment and advice on danger signs.

Her third suicidal attempt occurred immediately the following day at which time she stabbed her lower abdomen with knife and presented again to surgical emergency OPD. After this presentation the patient was re-evaluated at Psychiatry emergency and admitted to female Psychiatry ward with earlier mentioned diagnosis.

In our emergency OPD, the patient was claiming that she having two different personalities which occurred alternatively in a varying duration and frequency. She labeled the two personalities as 'A' and 'M'. During her stay in the hospital the patient has sustained frequent switches between the two identities. We had a prospect of witnessing and communicating with both personalities. Generally, 'A' is a good, disciplined, sociable polite person with respect of norms and values. However, 'M' is violent, aggressive, impulsive and suicidal with no accountability for her action. The detailed description of the peculiar manifestation of the two personalities has been listed in the table 1 below.

Roll no	Different aspects of personalities	Personality 'A', host personality/state	Personality 'M', alter personality/state
1	Identification	23 yr, Female, 'A'	14 Yr, Female, 'M'
2	Sexuality	Dormant, plans to have sex after marriage	Wants to have multiple sexual partners, prostitution
3	Substance use	Totally against any use of psychoactive substances	Wants to chew chat, smoke cigarette, drink alcohol etc.
4	Generalized behavior	Calm, playful, joker, sociable, rarely irritable	Aggressive, male like, antisocial, cruel, crude,
5	Spiritual inclination	Strives to be spiritual, tries to obey religious rules	Completely against religious rules and to be Christian
6	Appetite	Feeds well, no selection	No appetite
7	Language	Amharic predominantly	Completely prefers English
8	Insight	Knows she is diabetic and takes medications regularly	Total denies any medical or mental illness, resists drugs
9	Academic view	Outstanding student, reads always, top scorer	Completely hates reading, learning or any job.
10	View of 1 to another	My enemy but rarely helps	My enemy I want to kill her
11	Social life	Numerous friends in early childhood through current life...stable relations	Isolated, grandiose, no need of other human beings for existence.

**Table 1:** Description of the peculiar manifestation of the two personalities.

The patient claimed that her early childhood was full of trauma and incidents. She experience three sexual assault. The attempts occurred at the age of 8, 11 and 15 years.

During her altered state she reported that she was not happy with her parents. She characterized her father as verbally aggressive towards her, she feared him excessively, and blamed him not preventing those sexual abuse attempts especially the first one. Even she stated that she doesn't recognize her mother as her real mother but assumes her as grandmother explaining that she was brought up by her elder sister.

Routine laboratory tests including CBC, LFT, RFT, RBS and thyroid-stimulating hormone were within normal range.

Mental state evaluation at admission at psychiatric ward at first she was cooperative for interview, later the client become irritable and arrogant within the interview room and her language automatically changed from Amharic to English. She has psychomotor agitation. Speech was normal range of volume, tone, speed and amount. She expresses her Mood "I feel slightly low because of my unpredictable behavior and hope you will help Me". Her affect was labile. When her personality switches, she became angry, irritable, and rude. She had suicidal ideation at her altered state with self-harm behavior. She is alert and oriented to place, person and time. Fund of knowledge and abstract knowledge was intact. She has Level 4 insight i.e. (she knows that she has illness but didn't know what caused it).

With the working diagnosis of Dissociative identity disorder/non-possession form/, known type I DM on treatment and follow-up admitted to our ward. Psychotherapy with 3 sessions of eye movement desensitization and reprocessing (EMDR) therapy and hypnosis given during her hospital stay focusing on her past traumatic event and the way she can overcome it. In addition, the patient got psychiatric medications (fluoxetine and diazepam) to control her anxiety symptoms and aggressive symptoms. During her hospital stay she comes in terms with her two personalities that they show up as defense mechanism to deal with her childhood sexual trauma memories. She also said she will not be blamed because now she is an adult and safe. She also reached in agreement and reconcile with her real mother and she has less shifting of personality. After 3 weeks of stay, the patient's condition got better and discharged. Currently the patient is on close follow-up and continues the treatment to date.

### Discussion

Childhood traumas, abuse and neglect implicated as a risk factor for dissociation. Initially, Dissociation is a process that provides protective psychological containment, detachment from, and even physical analgesia for overwhelming experiences, usually of a traumatic or stressful nature. Dissociation acts as and allows the child to move away from a situation that she cannot control. However, it becomes pathological when it causes social and functional impairment [5,13]. In our case, she has repeated sexual assaults starting from early childhood which make prone for DID.

During psychiatric examination of the patient revealed that she had altered identity, and the act of suicide ideation wasn't recalled. She had no recollection of the suicidal attempt or acts she did during the altered personality. Evidences show that patients diagnosed with DID often report chronic suicidal feelings with some attempts [1,10].

Suicide is one of the most observed symptoms in DID and suicide rates reported as 70 - 72% in DID and presence of a dissociative disorder was the strongest predictor of a suicidal behavior [1,10]. DID is highly associated with consequent risk of recurrent suicidal behavior. It warrants close monitoring and follow-up after discharge of all cases of DID.

In the differential diagnosis, several questions come to mind with regards to the case due to her repeated Self harm, labile emotion, impulsivity which suggests the diagnosis of comorbid borderline personality disorder. Evidences show that Borderline personality disorder (BPD) and DD have often been reported to occur comorbidly [5,11,12]. BPD diagnosed in 30% to 70% of DID patients [5,11]. In our patient comorbid occurrence might be possible because she fulfill criteria of the BPD. However, presence of stable friends and difficulty arises only during alter state suggest DID.

Malingering can occur in many other psychiatric disorders [14] and DID is no exception. In this case, she is a nursing student and had ample opportunity to read many popular books and view a number of movies on the subject of DID. It is always good to have a wide aspect of differentials when seeing psychiatric patient. Coons and Milstein suggested that clinician must look, rather, for the signs characteristic of factitious disorder or malingering in DID [14,15]. These include chronic severe disability since late adolescence, lack of a consistent work history, dramatic and exaggerated presentation of symptoms, pseudologia-fantastica, demanding and depreciating attitudes towards health care providers, refusal of collateral examinations, selective amnesia, and hospital seeking behaviors [14,15]. In our case all the symptoms and behavior suggestive for malingering and factitious were negative. As Coons and Milstein suggest doing hypnosis as a diagnostic maneuver to avoid a false positive diagnosis of DID [14]. In this case, during hypnosis she was easily suggestible and the procedure has relieved the stressing personality state and she has no secondary benefit and she doesn't seek long duration of unnecessary hospital stay which is highly suggestive to diagnosis of DID.

### Conclusion

Dissociative identity disorder is known as a rare disorder due to its being under diagnosed and misdiagnosed. It is always good to have a wide aspect of differentials when seeing psychiatric patient. Dissociative Identity Disorder (DID) is diagnosed if the person has at least two different identities that alternately control a person's actions with no memory of the incident. One of the strongest risk factors of dissociation is antecedent trauma, particularly early childhood trauma, as well as difficulties with attachment and parental unavailability. There are several conditions which link with this disorder, including depression; self-harm, post-traumatic stress disorder (PTSD), substance use disorder, borderline personality disorder or anxiety, and conversion. Suicide attempt is one of the presenting symptoms in DID. Taking into account this case, the cases of suicide in DID's should be evaluated with caution. It is highly associated with consequent risk of recurrent suicidal behavior. It warrants close monitoring and follow-up after discharge of all cases of DID. Finally, using hypnosis is effective in diagnosis and treatment.

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