CASE REPORT

Dissociative Identity Disorder with Depression in A Man with Traumatic Childhood: A Case Report

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Abstract

Dissociative identity disorder (DID) previously known as multiple personality disorder is associated with depression and traumatic childhood which can be either physically or sexually abuse. It is hard to establish diagnosis of DID because of the complexity and controversies that surrounding it. We report a case of a young man who has DID and Major Depressive Disorder in the background of traumatic childhood experience who was recently admitted to our inpatient psychiatric unit and demonstrated transitions to other distinct personality state.

Keyword: Dissociative Identity Disorder, Major Depressive Disorder, Traumatic Childhood

Introduction

Dissociative identity disorder (DID) formerly known as multiple personality disorder presented with two or more distinct personality states [6]. It has been described as difficult to understand, difficult to diagnose, difficult to treat and difficult to discuss objectively because of controversies that surrounding it [2]. Patients with suggestive symptoms are often misdiagnosed as malingering or even having schizophrenia due to lack of experience and knowledge of clinicians resulting in small number of patient with this diagnosis [7].

DID is also connected with traumatic childhood, usually abuse [1]. The diagnostic process should include an effort to assess the patient’s trauma history. Because of their dissociative amnesia, DID patients often provide incoherent history early in treatment; a more complete personal history typically emerges over time [8]. This case report present DID in a depressed young gentleman with history of traumatic childhood.

Case Report

Mr. C is an 18 years old Chinese gentleman who works as salesman. His parent was divorced at the age of 1 year old. He had history of being abused physically and emotionally by his step mother during his childhood. He had multiple episodes being beaten by his step mother to the extent of putting hot clothes iron onto his body. Every day he was locked in a store room and was only given small amount of food. His step
mother (who was baby-sitting other neighbor’s baby) also abused other child. He also witnessing his step mother putting his neighbor’s baby in the fridge to make them quiet. His father knew what had happen but just ignored it. He managed to run away from his house at the age of nine years old and found his biological mother. Afterward, he stayed with his mother. However, his mother was also verbally abusive toward him.

He also had history of being bullied at school and was stopped schooling at the age of 14 years old. He had no close relationship to any of his family members and others except for one of his female friend.

At the age of 16 years old he had history of being sodomized by a stranger. This occurred when he tried to protect his female friend from being raped. Subsequently his friend committed suicide because of the incident. Since then he always had sad mood, feeling guilt and had multiple episodes of deliberate self-harm.

At the age of 18 years old, he was first admitted to psychiatric ward due to attempted suicide by cutting his wrist after quarrelling with his sister. He was treated as major depressive disorder with differential diagnosis of Borderline Personality Disorder. In ward, it was revealed that he also had gender dysphoria and wanted to be a female. Later, he was discharged with tablet Fluvoxamine 50 mg ON.

After one week, he was admitted again due to attempted suicide by cutting his wrist after quarrelling with his mother because of his plan to change his gender to female.

During interviewing session with patient on day two of admission, he dissociated into a personality known as Mrs. C. Mental state examination revealed marked shift in affect and mannerism in which he displayed famine gesture. His alter personality claimed that he was the one who work as salesman and admitted that he was the one who responsible to stopped him from pursuing her intention to commit suicide. He had multiple episodes of dissociated into Mrs. C during interview session usually after being asked regarding his childhood. His affect quickly turned from depressed mood to happy. He had no recollection of this episode.

He was prescribed with Tablet Fluvoxamine up to 150 mg ON. Then his depressive symptom together with his dissociative states improving.

He was also given supportive psychotherapy in ward. Upon discharge, he had no more suicidal idea and able to take care of himself and return to his family.

Discussion

DID is one of a collection of psychiatric conditions called dissociative disorders. Dissociative identity disorder (DID) patients function as two or more identities or dissociative identity states (DIS), categorized as ‘neutral identity states’ (NIS) and ‘traumatic identity states’ (TIS). NIS inhibit entrance to traumatic memories thus allowing daily life functioning. TIS have access and responses to these memories [4]. Clinical syndromes are characterized by a core of depressive and dissociative symptoms and a childhood history of significant trauma, primarily child abuse [3].

Study shows that dissociative disorders, including dissociative identity disorder, are common in inpatient settings [5]. Although it is common in psychiatric in-patient settings, it is rarely diagnosed due to the
lack of understanding of this phenomenon and the inclinations to adhere to the rigid common practice of using internationally diagnostic criteria [7].

In this case it is difficult for physician to established diagnosis of DID due to patient factors including patient guarded and not forthcoming during interview. Other includes doctors factor due to lack of experience in handling DID.

Treatment for DID should follow basic principles of psychotherapy and psychiatric medical management, and therapists should use specialized techniques only as needed to address specific dissociative symptomatology [8]. In this patient, the medication use to treat depression shows improvement toward patient’s dissociative state.

There is three stages phase-oriented treatment approach:

1. Forming safety, stabilization, and symptom reduction
2. Confronting, working through, and integrating traumatic memories
3. Identity integration and rehabilitation [8].

In view of acute in-patient psychiatric hospitalization, we are focusing on phase one treatment for this patient in establish safety before discharge and the reduction of depressive symptoms.

In summary, this case report illustrates a common co-morbid DID, depression and traumatic childhood. There is need to have suspicious when dealing with patient who had history of traumatic childhood as it might associated with other psychiatric illness including DID.

References


(Lippincott Williams & Wilkins, 2014).


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