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Research Article

Dissociative Identity Disorder with Five Alters: A Case Report

Gangguan Identitas Dissosiatif dengan Lima Alter: Sebuah Laporan Kasus

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Abstract

Dissociative Identity Disorder (DID) is a complex disorder that stems from repeated trauma during childhood. Although not particularly rare, DID is surrounded by myths and stigma that prevent it from being diagnosed and managed as an authentic mental condition. The purpose of this case report is to present a typical case of DID to raise awareness of and decrease the stigma on DID and to reaffirm that this disorder requires proper treatment. The patient is a 25-year-old male diagnosed with DID and had five alters consisting of: two protectors, a prosecutor, a suicidal alter, a child alter, and one debatable female alter. He was given psychoeducation without any oral treatment as the second alter was not open to any treatment that could make the female – either a hallucination or an alter – disappear. In contrast to media portrayals and myths about DID, the patient did not in fact have any supernatural powers nor commit any crimes. He also had distinctive manifestations of DID that were in accordance with the diagnostic criteria of DID. The conclusion of the case report is that DID in the patient is a true diagnosis, and the treatment should be done regardless of any myths and stigma in society.

Keywords*: dissociative; identity disorder; multiple*

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Abstrak

Dissociative Identity Disorder (DID) adalah gangguan kompleks yang berasal dari trauma berulang selama masa kanak-kanak. Meskipun tidak terlalu jarang terjadi, mitos dan stigma mengenai DID menghambat diagnosis dan pengelolaan DID sebagai penyakit mental yang autentik. Tujuan laporan kasus ini adalah untuk menyajikan sebuah kasus DID tipikal untuk meningkatkan pengetahuan, mengurangi stigma mengenai DID dan menegaskan bahwa gangguan ini perlu pengobatan. Seorang laki-laki berusia 25 tahun didiagnosis dengan DID dengan lima alter yang terdiri dari dua orang *protector*, satu *prosecutor*, satu alter yang ingin bunuh diri, satu alter anak, dan satu sosok wanita yang masih diperdebatkan keberadaannya sebagai alter. Ia diberikan psikoedukasi tanpa obat per oral karena alter kedua tidak terbuka terhadap pengobatan apapun yang dapat membuat sosok wanita – baik halusinasi ataupun alter – menghilang. Berbeda dengan proyeksi media dan mitos tentang DID, pasien sebenarnya tidak memiliki kekuatan supranatural maupun melakukan kejahatan apapun. Pasien juga memiliki manifestasi khas DID yang sesuai dengan kriteria diagnostik DID. Simpulan laporan kasus ini yaitu DID adalah diagnosis yang aktual, dan terapi harus diberikan tanpa memedulikan mitos dan stigma dalam masyarakat.

Kata kunci: disosiatif; gangguan identitas disosiatif; multipel

Introduction

Dissociative Identity Disorder (DID) is a trauma-associated mental condition with a diagnosed prevalence of 1.5% worldwide.[1] It comes from repeated trauma in childhood and manifests as a disunification of personalities, creating split or alternate personalities known as “alters” with their view of themselves and the world.[1 2] However, myths about DID lead to it being considered a fad, an over-diagnosed disorder, the same as a borderline personality disorder, or even an iatrogenic disorder and that its treatment is harmful to the DID patients.[3 4] This prevents the people who have DID from seeking treatment and receiving acceptance which has an impact on both their prognosis and quality of life and the health care professionals from providing the treatment itself.[5] The media had also portrayed this illness as something horrific and something that might give rise to supernatural powers.[6] On the contrary, research has shown DID as a legitimate disorder and not particularly rare.[7] Even so, DID is still stigmatized and often overlooked as another mental illnesses.[4 8] This case report is made to increase awareness and reduce stigmatization of DID by discussing the clinical manifestations of DID in a patient that fulfils the diagnostic criteria.

History

The first known documentation of DID was of Jeanne Fery who recorded symptoms of identity fragmentation and a history of childhood trauma in the year 1584. She had an alter (protector) called Mary Magdalene, the devil Garga, Cornau, and other devil alters. They were sometimes heard arguing inside her head. She also suffered from symptoms of episodic loss of memory, knowledge, and skills, disruption of sleep, and intense chronic pain. Jeanne was described as having a "doubling of the personality" and this term was then used for naming of the disorder – Multiple Personality Disorder, and then DID.[9] These symptoms were repeatedly reported in documentations of DID, with Louis Auguste Vivet being the first person to be officially diagnosed with DID.[10]

Louis Auguste's case of DID was documented during the 1880s by his attending physicians. Louis was abused during childhood, became a thief when he was eight and sentenced to a rehabilitation centre. Louis was bitten by a viper at the age of 17 and experienced leg paralysis, then he was transferred to an asylum to study tailoring. At age 18, he was released from the asylum, went to visit his mother, and continued his agricultural work. Unfortunately, he was admitted back into an asylum as he suffered from a conflicting range of symptoms such as total paralysis to completely no symptoms. This hemiplegia was however noted as odd as the patient could walk while under hypnosis by the attending physician. During his hemiplegic and antagonistic state, Louis was noted to not have any recollection of his stay in the asylum when he was 17, but had total recollection when he reverted back to his calm state. There were also records of him inexplicably losing and finding objects he had no memory of, alternating personalities shown through complementary actions of thievery and of diligent agricultural work, and differing somatic symptoms.[10] [11] Louis manifested symptoms of DID which include a disruption of identity and episodic memory loss not caused by substance.[12]

Several other DID cases were described throughout the years, with the markedly famous case being of Elena, described by the Italian psychiatrist Giovanni Enrico Morselli in 1930. Elena was sexually abused during childhood by her father. She then developed alternate personalities fluent in different languages – Italian and French. However, had no knowledge of the different states of the other's existence and had differing memories and characters.[13] DID was officially recognized as a mental illness in 1980 by the American Psychiatric Association.

Case Description

The patient, a 25-year-old male, came to the psychiatrist with urging from his friend. His friend saw that he was behaving abnormally, and would even sometimes hurt himself, and thus had him go see a psychiatrist.

He was able to remember the events of his trauma and was even unable to forget its occurrence, which signified that he himself did not have amnesia related to the trauma. He said that when he was 5 years old, his parents signed him into a boarding class. The students were then told to memorize certain scripts. However, he was unable to do so even if he tried hard. Afterwards, the teacher threatened to hang him if he could not memorize the scripts, and even

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showcased the instruments available to do so. This became his trauma, and from then on, a voice inside his head kept on jeering him on and on about the hanging. This was the first alter to be formed, and after enduring about 5 days, he left the place and continued his daily activities.

During high school, the jeering voice was still present, and he realized there was a ‘person’ aside from him who resided inside him. He confessed that he was bullied, and in this experience, he met a woman who was very gentle and kind to him. This woman comforted him and gave him warmth. However, this woman was believed to be a hallucination rather than an “alter”, as when he went to a psychiatrist who gave him Risperidone, the woman disappeared. This was a crucial problem as it turned out that a second alter had appeared to protect the woman and that the second alter considered what the psychiatrist did as a threat to the woman. The second personality was also noted to have homicidal and violent tendencies in regard to his duty of protecting the woman.

It was during college that he worked part-time as a bartender. His friend urged him to go to another psychiatrist and the data of this case report was collected from this psychiatrist. At this point in time, the patient confessed to having 5 alters. The first alter was a child who grew up along with him. This alter was the one who used to jeer at him whenever his emotions wavered, but after they grew up, the alter did not jeer at him anymore and even helped prevent the second and fourth alters from fronting. The second alter was the alter with a more aggressive personality who threatened the psychiatrist with harm if the psychiatrist were to remove the woman with anti-hallucinogenic medicine. The third alter, like the first alter, helped prevent the second and fourth alters from fronting. Different from the first alter, however, the third alter was mentioned to be more emotionless. The fourth alter was described to be detrimental to the shared body. He would punch walls, glass, and do self-harm. This alter fronted whenever the supposed ‘host’ (the reason why ‘host’ is given quotation marks will be discussed below) experienced trouble with his parents. However, no other alters had any recollection of what occurred when the fourth alter fronted and could only deal with the aftermath, which is a sign of inter-identity amnesia. The fifth alter was described as a child who never grew up. He still jeered at the ‘host’ and could not express his emotions properly – as a child would. The first to fourth alters were noted to be the same age as the ‘host’. As time passed, the patient mentioned that all the alters would try to front and sometimes argued with each other. Even so, the first and third alters would keep the second alter from fronting as much as possible.

When asked if the ‘host’ was the ‘host’, he denied it and declared that the alters were him, and that he was the alters. The psychiatrist considered this to be the ‘host’ hiding behind the alters as a form of defence and would be detrimental to treatment as the patient himself was unable to separate himself from the alters.

Mental examinations showed that the patient had proper conduct and rapport. The patient's thoughts were unrealistic and preoccupied with alters, although the flow was coherent. The patient had a dysphoric mood and a normal range of expressions. An aggressive and threatening change in gait and gaze were noted when the patient talked about the psychiatrist that made the woman disappear. Physical findings were insignificant, except for a glass wound on his hand because of the fourth alter's fronting. Laboratorial tests were not conducted. The DID progression timeline of the approximate discovery of the first alter until the fifth alter can be seen in the following figure (figure 1).

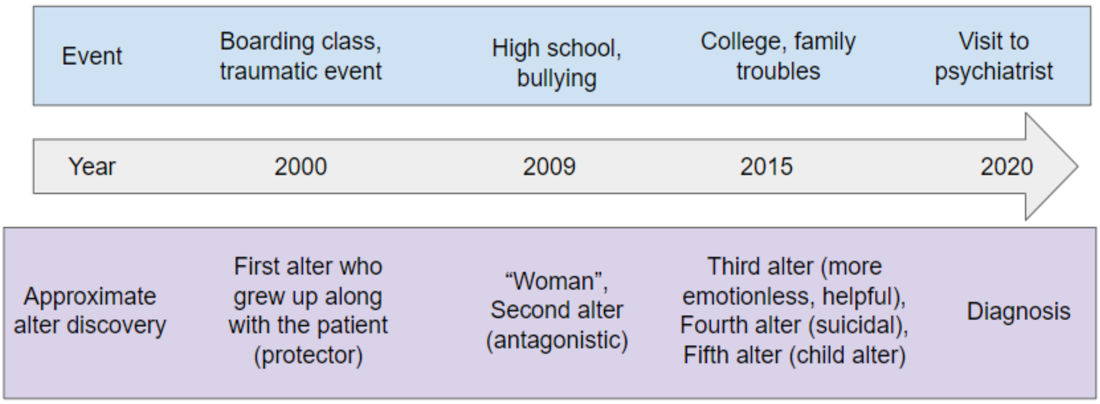

Figure 1 Timeline of DID Case Progression

The last treatment for this patient was around a year before this case report was constructed as the patient did not come by the psychiatrist again. The patient was given psychoeducation about DID, hallucinatory and personality disorders, and environmental changes that occur with DID. Oral medicine was not provided as the second alter had threatened the psychiatrist with bodily harm if he were to trifle with the existence of the woman, thus the temporary goal of the treatment was to increase the patient's quality of life holistically. As further rapport was needed, psychotherapy was yet to be done.

Discussion

General Manifestations

DID is associated with repeated childhood trauma in which case the recipients feel as if they were about to die or needed something or someone greater than themselves to deal with what was happening. A certain degree of dissociative inclination is also required as not all children experiencing trauma will develop DID.[14 15] Stress is found to magnify symptoms and make them more evident.[12] This is apparent in this patient as various stressors originating from interpersonal problems become triggers to the fronting of other alters. According to DSM-5, DID is diagnosed as follows in table 1.

Distinctive general manifestations of DID are described in the diagnostic criteria. The patient in this case report fulfils the diagnostic criteria of DID as he was described to have multiple alters and had impairment in everyday life. Inter-identity amnesia was present as some alters cannot remember what occurred during the fronting of other alters. The symptoms of this patient were also not attributed with cultural or religious practices, nor were they results of substance abuse or other medical conditions. Unlike how it is presented in media, the patient did not have any supernatural powers nor did he commit crimes.

In comparison with several historical cases, this patient has exhibited similar symptoms of unpredicted and swift mood swings and differing sets of personalities as with the 19th century case of Louis. This patient at times displayed aggressive behaviour and preoccupation with 'the woman', but returned to being soft-spoken afterwards. There were also lapses in memory which occurred in all of the historical cases and also in this case. However, unlike the cases of Louis and Elena, the host, first, and third alters were aware of each other's existence. Similar to Jeanne Fery, this patient also had an alter that re-enacted the traumatic scenes from childhood, and an alter that was suicidal and harmed the body. All the cases of DID mentioned stems from childhood trauma – this shows its significance in the formation of DID in a person.

Table 1 Diagnostic Criteria of DID from DSM-5[12]

	Diagnostic criteria
A	"*Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behaviour, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.*
B	*Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.*
C	*The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.*
D	*The disturbance is not a normal part of a broadly accepted cultural or religious practice. Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play.*
E	*The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behaviour during alcohol intoxication) or another medical condition (e.g., complex partial seizures).*"[9]

Alter Formation

The trauma from repeated death threats during his stay at the boarding school may have been the main source of his DID. As a five-year-old, his personality had not fully integrated yet, and repeated risks to his life while defenceless may have caused him to believe that he was not going to survive. He might have dissociated as a defence mechanism and needed someone else to experience the event for him – this may have taken form in fronting of the first alter.[12] The second alter may have manifested around the same time as the woman with the needed protection of the woman as cause. The existence of 'the woman' as a simple hallucination or an alter is still debatable, as alters can manifest as the opposite gender.[16 17] Further observations of the patient need to be made in order to determine this issue. The timing of the third and fourth alters' appearance were not clear, although the fifth alter was said to be formed because of pressure from being given more responsibilities in his workplace and perhaps mirrored his subconscious wish to have less burden.

Alter roles

During the interview, the host was observed to have been hard on himself and a perfectionist. This view may be further exacerbated as the second alter perceived the host as weak. This showed that the second alter may have filled a more persecutory role in the system as he was antagonistic to the host.[16] Contrary to this role, the first and third alters may have taken on a more protective role in the system as they prevented the second and fourth alters from fronting and causing the body potential harm. Several other systems also have this kind of structure; the host that spends the most time in the body, the protectors that regulate the system, the prosecutors that may be confrontational because of trauma and a misguided sense of protection but can react better to external threats, and the suicidal and child alters. However, many other roles may be present in other systems, as the specific manifestation of DID is unique to each system.[16 18]

Triggers

Triggers may vary from individual to individual and strong triggers may be related to the source of the trauma as exemplified by a 43-year-old female that had been abused sexually, physically, and emotionally during childhood whom had been triggered when she received a message from her abuser.[19] However, no specific triggers were mentioned during the interview of this case and mostly occurred when the host experienced stress.

Effects

DID is a complex disorder affecting different aspects of a person's life. Although DID originates from a defence mechanism and may be viewed as a way to survive, negative impacts of this disorder on the patient himself cannot be denied. Physically, living with DID in this case had increased injuries for the body – as evidenced by the injured hand during physical examination. Potential life-threatening incidents was also present as the fourth alter was partial to self-harm. On the social aspect, the behaviours (change of personality, habits, body gait, actions) caused by switching may be perceived as odd to the surrounding people and may impair socialization. Having to live with constant jeering may have also affected the patient mentally and, in addition with his own personality, may hinder the patient's ability to accept himself without shielding behind the alters.[12]

Treatment

The previous psychiatrist's antipsychotic treatment was significant in differing this patient's symptoms from psychotic disorder as it was known that 'the woman' disappeared after the oral treatment. However, the antipsychotic did not make the other alters disappear. Thus, there is strong suggestion that 'the woman' is part of a hallucination, while the other 5 alters are neither hallucinations nor delusions.

The recommended standard treatment for DID is a phase-oriented treatment. According to the third revision of Guidelines for Treating Dissociative Identity Disorder in Adults, the three stages of treatment of DID include: "*1. Establishing safety, stabilization, and symptom reduction; 2. Confronting, working through, and integrating traumatic memories; and 3. Identity integration and rehabilitation.*".[20] Integration or resolution – the alters being able to integrate into a single personality, or the alters being able to cooperate steadily and respond adequately to both themselves and the world around them – is a desired outcome of treatment. In spite of that, a more definitive treatment in this case becomes contradictory because the patient himself resists the outcomes and would thus have to be delicately handled until a desire for resolution is achieved. This type of patient may belong to the third subgroup of patients which was described as people with DID who were less open to working towards integration and were more prone to self-harm. In this case, supportive therapy may be needed for long periods of time. Although convalescence may be minimal in this subgroup, and some cases treatment may remain as simply supportive, a small number of cases can be privy to more definitive treatment.[15 21]

Conclusion

This case of DID has distinctive predisposition and symptoms in accordance with theory. Although the general manifestations of this disorder in the diagnostic criteria are quite distinctive, diagnosis and treatment of this disorder are impaired as lack of education and myths still surround this disorder. Thus, proper awareness of DID as a not uncommon, real, disorder, and its manifestations are crucial to decreasing stigmatization and managing this disorder.

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