ISSN 2515-8260 Volume 09, Issue 06, 2022

Beyond the veil: a case series on the spectra of dissociative identity disorders

Dr. Priyash Jain[1] , Dr. Varchasvi Mudgal[2] , Dr. Vijay Niranjan[3] ,

***Dr Rashmi Dhakad[4]**

1 Junior Resident, Department of Psychiatry, M.G.M Medical College, Email: Dr.priyashjain@gmail.com

2 Asst Professor, Department of Psychiatry, M.G.M Medical College, Email: varchasvimudgal04@gmail.com

3 Asst Professor, Department of Psychiatry, M.G.M Medical College, Email: dr.vijayniranjan@gmail.com

4 Junior Resident, Department of Psychiatry, M.G.M Medical College, Indore, India Email: rashmidhakad1@gmail.com

Abstract

Background - Patients with Dissociative Identity Disorder (DID) have high rates of comorbid psychiatric disorders. Although distinguishable from other psychiatric disorders, with some effort and skills, it can have an entire gamut of clinical presentations which can lead to misdiagnosis and can change the line of management. We aim to study a variety of clinical presentations about Dissociative Identity Disorder.

Case presentation

Patient's detail	**Clinical presentation**	**Comorbid psychiatric illness**	**Treatment**	**Outcome**
30 years/female	Symptoms of Dissociation	Depression	Escitalopram 20 mg	Remission
19 years/ male	Symptoms of Dissociation	Obsessive-compulsive disorder	Fluoxetine 60 mg	Remission
27 years/female	Symptoms of Dissociation	Schizophrenia	Clozapine 450 mg	Remission
30 years/male	Symptoms of Dissociation	Schizophrenia	Olanzapine 15 mg plus escitalopram 10 mg	Remission
30 years/male	Symptoms of Dissociation	Alcohol dependence with	Naltrexone 50 mg plus low	Remission

ISSN 2515-8260 Volume 09, Issue 06, 2022

		borderline personality	dose lithium and escitalopram with DBT	
36 years/male	Symptoms of Dissociation	Epilepsy	Escitalopram 10 mg	Remission

Conclusions - DID could also be seen in the context of comorbid OCD, depression, anxiety, and even psychosis; these comorbid disorders can sometimes be the cause of dissociation. Though in clinical situations major psychiatric diagnoses like schizophrenia, depression, OCD, and substance use disorder are often heeded more yet in many situations, DID is equally hampering for the patient and family members. Thus, there is a need for the psychiatrists to stay vigilant while assessing such cases and tailor their management as per the distress associated with the particular clinical presentation while keeping a keen eye on all the symptoms causing distress to the patient.

List of Abbreviations

DID	Dissociative Identity Disorder
OCD	Obsessive-compulsive disorder
DES	Dissociative experiences scale
YBOCS	Yale brown obsessive compulsive scale
OPD	Out patients department
ICD	International classification of diseases

Case series

Background

The prevalence of dissociative disorders is reported to be 9-18% in general population studies worldwide while that of dissociative identity disorder is 1-1.5% in the general population. [1] Due to the rarity of its incidences, it is generally postulated that DID is a culture-bound syndrome primarily found within Euro-American cultures. The prevalence of DID ranges from 1 to 5% in North America, and Europe, and a meager <0.5% in countries like India and China. [3,4]

Dissociation identity disorder is characterized by a complicated picture of symptoms and severe functional impairment; Patients with DID have high rates of comorbid post-traumatic stress

ISSN 2515-8260 Volume 09, Issue 06, 2022

disorder (PTSD), major depressive disorder, somatic symptom disorder, and substance use disorders as well as high rates of non-suicidal self-injury (NSSI) and suicide attempt. [5,6,7]

DID is a disorder that presents with amnesia, identity confusion, and coexistence of dissociative identities. Characteristic features include a complex array of co-existing symptoms associated with psychosis, mood, anxiety, affect regulation, and personality functioning. It can have two forms of presentation possession state and non-possession state, when in the former state the patient experiences a sense of being taken over by an external agency, while in the latter state the patient simply shifts to another different personality. Although distinguishable from other psychiatric disorders it can have an array of clinical presentations which can lead to misdiagnosis and change in line of treatment. DID could also be seen in the context of comorbid OCD, depression, anxiety, and even psychosis; these comorbid disorders can sometimes be the cause of dissociation. [8]

Here we present a few case reports which represent the dissociative spectrum ranging from classical dissociation to psychiatric disorders presenting covertly with dissociation to conspicuous co-existence of dissociation with psychiatric disorders.

Case presentation

Case report 1

Mrs. A, 30 years female, reported to the Department of Psychiatry along with her husband. For the last 1 year, her family members noticed that her behavior and action became altered. She used to talk in a strange manner resembling a child which they had never witnessed earlier. She went outside home without informing them, her choice of clothes also deviated from usual and, as per her husband, her desire for having sexual relations had increased drastically. This erratic behavior was episodic and her family members described it was as if she had become someone else during these episodes. She identified herself as three personalities; Miss L, Miss B, and Miss P.

During her dissociative state Miss L, she used to have increased sexual desire. She used to dress and talk seductively, and at times even sent inappropriate photos to family members. During her altered state as Miss B and Miss P, she used to behave like a teenage girl. Later she identified herself as Miss P multiple times, and this change of personality Miss P was sudden and she revealed that she is a 16-year-old unmarried girl. She described several details of her family and her house based in a random unknown village. Her speech and behavior were quite different from her usual personality. She became more confident, and spoke sometimes in some unknown language instead of her mother tongue Hindi. The transition back to her original personality was also sudden and it occurred with the patient going unconscious for a short duration. After returning to her original self, she would not remember anything that happened during this altered state. The occurrence of the personality change was not preceded by any major life events or immediate stressors.

ISSN 2515-8260 Volume 09, Issue 06, 2022

For the past 8-10 months she developed sadness of mood and became concerned about her state of affairs, she felt a lack of interest in doing anything, developed suicidal wishes, disturbed sleep, and a pessimistic view about the future. All of her complaints were being perpetuated by her husband's uncooperative and callous attitude towards her who thought her wife was feigning all the symptoms to get rid of her household chores.

In subsequent interviews patient told that during her childhood her parents gave her scarce attention, they used to scold her excessively. Her parents were always busy with some work and did not care much for her needs. A few years back she met a man who lived nearby and considered her a sister and had taken care of her at various difficult times. But the patient reported that she developed sexual feelings towards him which she never revealed to anyone due to fear of social sanctions.

No other significant history was elicited, and the patient did not report sexual or physical abuse in past. All routine investigations were normal including complete blood counts, liver and renal functions, and electrolytes. On admission, organic causes were ruled with a thorough neurological examination and imaging.

A provisional diagnosis of dissociative identity disorder with secondary depression any was made after a serial mental status examination using the DSM V. Dissociative experiences scale (DES) was used for quantification with an initial score of 42 out of 100, indicating a high level of dissociation.

The management plan was formulated by targeting presenting symptoms using escitalopram 10 mg titrated later to 20 mg and clonazepam 0.5 mg. This was assisted by supported psychotherapy. Within the next 3 weeks, there was a symptomatic improvement with a decrease in DES score.

Case report 2

A 19-year-old male educated up to 11th standard living in a semi-urban area with his parents was brought to the mental hospital OPD with complaints of episodic alteration of behavior involving a change in effect and personality. At times he used to start behaving as if he is some djinn (spirit), his voice would become heavy, his eyes would get uprolled and he would start breathing heavily. He would jump around and say that he is a djinn and that he has possessed Mr. G to liberate him from his sins. The episode would last for 5-10 minutes following which he would become unconscious for a few seconds but would regain consciousness when water was sprinkled over his face. He would have no memory of the episode and would appear confused. In some other instances, he would start behaving as if he was some lady who had possessed him. During this, he would shout and would say that she loved Mr. G and wanted to have sexual relations with him. He would do so for a few minutes after which he would become his normal self. These episodes were occurring with varying frequency over the past 1 month and he had experienced 5-7 such episodes before he visited the OPD. The patient was then admitted to the

ISSN 2515-8260 Volume 09, Issue 06, 2022

hospital and a detailed assessment was done. It was revealed that he was apparently alright 6 months back when he started having reduced social interaction along with repetitive thoughts and activities. He started spending more and more time washing hands, bathing, and grooming activities. He would keep washing his hands for a prolonged interval during which he would repeatedly wash hands. This kind of repeated hand washing was accompanied by repeated arranging and rearranging of things. He started arranging his table again and again and would try to keep things parallel to each other and on the edge of the table. On enquiring about these repeated behaviors, he reported that he had these intrusive thoughts which he identified to be his own and were of distressing quality. He would have also a feeling that something untoward might happen to him if he did not act on these thoughts. This went on for around 3 months when he started having blasphemous thoughts. Abusive and denigratory comments about God would intrude his mind as a result of which he engaged in excessive worshipping. He also started asking his mother if he had done something wrong and if he was a terrible person. As a consequence of their problems, his family members took him to various faith healers with no results. Finally, after suffering for 6 months they came in contact with a person who had some kind of mental illness who suggested they to visit us.

The patient was started on Fluoxetine 20 mg which had to be titrated up to 60mg, Clonazepam 0.25mg was used initially to target associated anxiety. The patient was discharged and followed up regularly. He showed a good response with a decrease in YBOCS score from an initial value of 22 to 8 at an 8-week interval. The dissociative symptoms also showed response as the patient and family members reported to have had no dissociative episode for the last 4 weeks.

Case report 3

A 27-year-old unmarried female reported to the mental hospital during emergency hours with the complaint of irritable aggressive behavior. The patient was a follow-up case of schizophrenia and upon inquiry, it was discovered that she had been off medication for the past 2.5 months due to the lockdown imposed during the Covid-19 pandemic. Given disruptive symptoms, she was subsequently admitted to the hospital and was put on injectables for management of aggression. The total duration of her illness had been 8 years and her illness started with complaints of hearing voices of people not around, undue suspiciousness over her relatives, irritable aggressive behavior, and disruption of biological functions. During her last admission, she was started on clozapine 350mg after the failure of an adequate dosage of Olanzapine, Risperidone, and Haloperidol for an adequate duration.

During her stay, she again complained of hearing the voices of her uncle and a friend. The voices used to threaten her to marry the friend lest she wanted to face dire consequences. As a response used to shout back or just mutter to herself. Sometimes she used to beg to be left alone. She used to suspect that it was all her teacher’s plan who was doing some black magic to control her and destroy her life because she wrote an incorrect answer during her school exams. She would say that her school teacher, her uncle, and her friend were all involved, and sometimes she would

ISSN 2515-8260 Volume 09, Issue 06, 2022

even allege that her family members had connivance in their plan. Given the past history of response on clozapine, she was restarted on the same drug. During her hospital stay, it was observed that at times she used to have an episodic change of behavior. She used to start breathing heavily, would uproll her eyes, and would speak in a heavy voice. During these episodes, she would say that she is her friend and that he has come to liberate her from those voices. She would shout "getaway", "Let her be", and similar phrases during these episodes. The episodes used to last for about 5-10 minutes after which she would start behaving like her normal self. She would only have a partial recollection of events that transpired during these episodes. These episodes were frequent and were happening about 5-6 times daily.

But as her treatment progressed and psychotic symptoms subsided the frequency of these episodes also diminished.

Case report 4

A 30-year-old married male reported to the mental hospital during emergency hours with the complaint of episodes of change in behavior and personality over the past year. On evaluation and reviewing prior records it was found the patient was a follow-up case of schizophrenia for 3 years and his illness started with complaints of hearing voices of people not around, undue suspiciousness over her relatives, irritable aggressive behavior, and disruption of biological functions.

For the past one 1 year, the patient reported five episodes of altered behavior and change in personality. During these episodes, he took the identity of half male and half female (ordinary). During the episode, he start moving his head and hands like tremors in a posture like giving a blessing to all, feels warm, had a female like voice, and start predictions about the future. This change was also evident to the people around him, this lasted for around half an hour and during the episode, he had partial awareness of his surroundings and had difficulty recalling the complete event. On further enquiry, he said he has worsening illness and these episodes because he was not attended properly by doctors during the covid pandemic. His routine investigations including blood counts, liver & kidney functions, and electrolytes were unremarkable. His EEG and MRI were within normal limits.

There was history of inadequate response on risperidone and aripiprazole at adequate doses. Pharmacotherapy was initiated in the form of olanzapine titrated up to 15 mg along with escitalopram 10 mg and clonazepam 0.5mg along with supportive psychotherapy periodically. The patient was reviewed after 1 month and had a decrease in symptoms of psychosis but his dissociative symptoms persisted although the frequency had decreased, then escitalopram was hiked to 20 mg and clonazepam to 1mg in divided doses. After a month his symptoms had significantly reduced and the patient remained stable over a follow-up of 3 months.

ISSN 2515-8260 Volume 09, Issue 06, 2022

Case report 5

A 35-year-old alcoholic was brought to the department of psychiatry by his wife with the complaint of altered behavior episodic in nature. During these episodes, his wife claimed, that he used to borrow money from money lenders and later would forget to have borrowed any money. On evaluation, it was found that he was a chronic alcoholic for the last 15 years and consumed alcohol regularly in a dependence pattern. Alcohol intake initially was about ½ - 1 quarter of country liquor which he gradually increased to 2-3 quarters daily as he reported that he had less effect as his consumption increased. Currently, he was consuming 2 quarters of country liquor daily. He reported that he experienced tremors, sweating, nausea, heavy headedness if he skipped alcohol on any day. But he used to stay abstinent for a couple of days during which he used to behave as if he was someone else. These episodes lasted for 2-3 days during which he had a completely different personality. He used to identify himself as a businessman who had come to the city looking for business opportunities. He used to deny any relation with his wife and would treat her as a stranger. During such episodes, he borrowed money from the market and spent it on an assortment of things that he claimed to be for business. Later when the episodes subsided, he would not be able to recollect anything that happened during these episodes. There had been 3-4 such episodes over the past 2-3 years. History was ruled out for any other psychiatric illness as well as any medical illness. Family history was also insignificant for any psychiatric illness. An assessment of their personality revealed that he also had multiple incidences of self-harm behavior, frequent domestic violence, and an inability to control his anger. At times he even used to doubt that his wife had affair with someone. At other times he used to praise his wife for having helped him through thick and thin. He reported having had a persistent sense of loneliness which he tried to cover with substance use.

A diagnosis of mental and behavioral disorder due to alcohol was made along with dissociative identity disorder and borderline personality disorder. After initial detoxification with chlordiazepoxide, he was started on Naltrexone to curb his craving. Multiple sessions of relapse prevention therapy were done. For his borderline personality disorders, he was put on low dose lithium and escitalopram, along with regular sessions of Dialectical behavioral therapy. During subsequent follow-ups, he reported having shown remission in his alcohol dependence apart from a few lapses. He also reported that he was better able to control his emotions and anger compared to earlier. Although his wife reported that he still behaved as if he was someone else once in a while.

Case report 6

A 36 year man presented to the department of psychiatry with the complaints of episodes of altered awareness during which he used to behave as if he is a sage from the past and wants to bring about peace in the lands. During these episodes of altered identity, he used to command his superior officers not to give hectic work to his vessel as he is a spiritual man and that they should follow his orders instead of ordering him. Such episodes used to last for a few minutes and used

ISSN 2515-8260 Volume 09, Issue 06, 2022

to happen frequently after he was given a duty that was undesirable to him. Sometimes these episodes used to terminate with him going unconscious and falling dramatically for a few seconds and regaining consciousness to not remember anything at all. Later his personality change ended with the occurrence of seizure-like episodes. In two such instances, he suffered major injuries resulting in third-degree severe scalding burns as he fell into a pot of boiling oil and in another instance, he suffered injuries due to falling from the staircase. The patient was referred to the department of psychiatry by his superiors. On subsequent evaluation, it was found that the patient was having these episodes for the last 8 years. Initially, the episodes were sparsely spaced but for the last 3-4 months after he was posted for the night shift, he started having these episodes quite frequently, almost every week. During the serial mental status examination, the patient revealed that during childhood his father who practiced very strict parenting and verbally abused him quite often used to take him to attend functions of a sage frequently. His father had an extreme level of trust and faith over the godman and followed the sage blindly even at expense of his household responsibilities, this led to the patient developing a sense of jealousy towards the godman and he wanted to become like the godman one day to gain his father's attention and approval. However, he didn't accept that he ever followed his wish later. The patient's father died about 9 years back and the patient started having such episodes around a year later. The patient was admitted to the ward with differentials of dissociative identity disorder and epilepsy. Routine investigations were done, and neuroimaging and EEG were performed which were all unremarkable. Thus, after ruling out other organic causes and looking at the nature of illness and presentation dissociative identity was diagnosed.

The patient was started on escitalopram 10 mg and clonazepam 0.5 mg, along with supportive psychotherapy and his symptoms improved gradually within the next 4 weeks. SSRI was optimized to 20mg, and clonazepam was tapered, the patient's state improved, and he was able to resume his job. The patient was followed up while sustaining treatment and remained in remission for the next 6 months.

Discussion

As per the current ICD nosology, the heavyweights like schizophrenia, depression, OCD, substance use disorders are given preference in comparison to dissociative disorders, but in clinical practice, such disorders and dissociation are frequently encountered where the latter has led to such a degree of impairment that its presentation cannot be overlooked.

Merely treating the primary psychiatric diagnosis might improve the dissociation in a few instances but it is not always the case. In case 1 Mrs. A, as supported by existing literature, is a typical presentation of dissociative identity disorder with Depression being the core of the disorder. Thus, supportive psychotherapy and hypnotherapy helped in the resolution of the disorder.

ISSN 2515-8260 Volume 09, Issue 06, 2022

In 2nd case of dissociation with OCD, the treatment of psychopathology led to a drastic improvement in dissociation. Thus, here OCD can be considered as the contributory factor in dissociation, if not the whole sole perpetrator. Many reports have highlighted similarities between OCD and DID. Patients of OC often report higher dissociative experiences. The ego-dystonic component of OCD can be understood as an internal conflict with no outlet for resolution which is a lynchpin of DID as well. In our case, the blasphemous nature and the incestuous content of his thoughts were a source of psychological distress which might have precipitated DID. [9, 10]

Progressing toward case 3 and 4 where the patient had schizophrenia, it was observed that the primary symptoms of schizophrenia veiled the underlying dissociative symptoms due to the sheer vitality of psychotic symptoms and dissociative symptoms remained undetected due to an overlap with schizophrenic symptoms. [11, 12] This, in turn, led to a delay in the identification and treatment of DID. Although not the mainstay of dissociative disorders the treatment with antipsychotics resulted in alleviation of dissociative symptoms as well.

Case 5 presents DID in the purview of personality disorder with alcohol use disorder and gave us insight into the need to treat DID as a separate entity as even after response to depressive symptoms and successful abstinence from substances the patient continued to have dissociative episodes. He required additional psychotherapeutic intervention for dissociation with a special focus on his borderline personality traits which led to successful remission of dissociative symptoms. [13-14]

Finally, case number 6, DID in the context of epilepsy can be very troublesome if not evaluated at great lengths. There is a plethora of literature against a connection between dissociative states and epilepsy stating both have separate etiology and presentation. [15,16] In our case the patient had a childhood experience and dissociative state owing to its manifestation rather than a sequalae of any seizure which could have been misidentified and inappropriately managed. The patient was managed with help of psychotherapy and SSRI rather than antiepileptics. So, in totality DID has a multifaceted presentation rather than a unidimensional layout.

Thus, as evidenced from the above reports dissociative disorders are not just the psychological and unconscious conflicts masquerading as a clinical disorder but also an entity having a starkly variable presentation with a background of core psychiatric disorders which might be difficult to elicit and identify. As per existing literature, the symptoms of dissociation overlap with other psychiatric disorders like psychosis, OCD, and depression which on a facile assessment may lead to a diagnostic dilemma. [9, 10, 11, 12] On one hand, if undetected these co-morbidities can lead to greater distress, poor response profile, and adds to the clinician’s frustration. On the other hand, with an evident psychiatric co-morbidity that overshadows the dissociation, the clinician may be inclined to unruly usage of unnecessary pharmacological agents, greater in-patient duration, additional psychometric tests, and altogether the dissociative symptoms may be

ISSN 2515-8260 Volume 09, Issue 06, 2022

worrisome for the patient remaining hidden from the clinician's focus leading to disruption of the therapeutic alliance between the two.

In contrast to case 1, the patient's dissociative symptoms in case 5 did not subside even after remission of depressive episodes on the clinical rating scale and subjective experience and require additional focused psychotherapeutic modalities along with assessment and identification of preexisting stressors.

Thus, we want to emphasize the co-existence of psychiatric co-morbidity and dissociative disorders which need holistic management to decrease distress to the patient and reduction of hospital stay. The approach to the treatment of the core psychiatric illness like schizophrenia, depression, OCD, substance use disorders, and dissociation can vary in a striking manner, with dissociation focusing on internal conflicts and trying to unrevealed the psychological knot.

Conclusion

In the Asian context particularly focusing on India, the low incidence of DID was believed to be due to prevalent polytheistic religious beliefs and greater social and cultural acceptance, especially for the possession form. Another reason for this epidemiological skewing could be highly prevalent faith healing practices and the population's trust over it leading to the disorder being under-reported. Also, the dismal state of liaison psychiatry and lack of awareness about the disorders even amongst clinicians adds to the burden. [17]

Thus, we have presented literature of cases where a variety of pharmacological agents like antidepressants, antipsychotics, mood stabilizers, and psychotherapeutic modalities have led to a variable degree of improvement and a diverse outcome which should be kept under consideration along with a vigilant approach while treating DID as evidenced by other authors as well.[18] However as per a recent meta-analysis the treatment for dissociative disorders is quite variable and lacks sufficient evidence base thus, cannot be generalized to all such cases due to its variable etiology and the treatment needs to be tailored as per patient profile, socio-cultural background and past life experiences should be explored.[19] To keep away from misdiagnoses, clinicians ought to get a more precise understanding of dissociative problems along with childhood experiences, thus making it easier to differentiate the minor nuances between symptoms of different causations and the quality of symptoms, thus enabling them how to report dissociative and non-dissociative patients.[20] Rather than focusing on a general guideline to treat dissociative identity disorder, this article aims to shed some light on the prismatic presentation of the disorder and keep a birds-eye view on the origination and development of the disorder to customize treatment. Psychiatrists with fewer encounters with DID, need to widen their diagnostic skills which would require dedicated training to identify this mischievous disorder with often an array of co-morbidities beyond the veil.

ISSN 2515-8260 Volume 09, Issue 06, 2022

References:

1. Şar, V. (2011). Epidemiology of dissociative disorders: An overview. Epidemiology Research International, 2011, 1–8. 10.1155/2011/404538
2. International Society for the Study of Trauma and Dissociation. Guidelines for treating dissociative identity disorder in adults, third revision. J Trauma Dissociation. 2011;12:115–187.
3. Chaturvedi SK, Desai G, Shaligram D. Dissociative disorders in a psychiatric institute in India--a selected review and patterns over a decade. Int J Soc Psychiatry. 2010 Sep;56(5):533-9. doi: 10.1177/0020764009347335. Epub 2009 Sep 17. PMID: 19762410.
4. Xiao Z, Yan H, Wang Z, Zou Z, Xu Y, Chen J, Zhang H, Ross CA, Keyes BB. Trauma and dissociation in China. Am J Psychiatry. 2006 Aug;163(8):1388-91. doi: 10.1176/ajp.2006.163.8.1388. PMID: 16877651.
5. Spiegel, D. , Loewenstein, R. J. , Lewis-Fernandez, R. , Şar, V. , Simeon, D., Vermetten, E. , … Dell, P. F. (2011). Dissociative disorders in DSM-5. Depression And Anxiety, 28, 824–852. 10.1002/da.20874
6. Foote, B. , Smolin, Y. , Neft, D. I. , & Lipschitz, D. (2008). Dissociative disorders and suicidality in psychiatric outpatients. Journal of Nervous and Mental Disease, 196, 29–36. 10.1097/nmd.0b013e31815fa4e
7. Webermann, A. R. , Myrick, A. C. , Taylor, C. L. , Chasson, G. S. , & Brand, B. L. (2015). Dissociative, depressive, and PTSD severity as correlates of non-suicidal self-injury and suicidality in dissociative disorder patients. Journal of Trauma and Dissociation, 17, 67–80. 10.1080/15299732.2015.1067941
8. McAllister MM. Dissociative identity disorder: a literature review. J Psychiatr Ment Health Nurs. 2000 Jan;7(1):25-33. doi: 10.1046/j.1365-2850.2000.00259.x. PMID: 11022508.
9. Belli H, Ural C, Vardar MK, Yesılyurt S, Oncu F. Dissociative symptoms and dissociative disorder comorbidity in patients with obsessive-compulsive disorder. Compr Psychiatry. 2012 Oct;53(7):975-80. doi: 10.1016/j.comppsych.2012.02.004. Epub 2012 Mar 17. PMID: 22425531.
10. Goff DC, Olin JA, Jenike MA, Baer L, Buttolph ML. Dissociative symptoms in patients with obsessive-compulsive disorder. J Nerv Ment Dis. 1992 May;180(5):332-7. doi: 10.1097/00005053-199205000-00008. PMID: 1583477.
11. Foote B, Park J. Dissociative identity disorder and schizophrenia: differential diagnosis and theoretical issues. Curr Psychiatry Rep. 2008 Jun;10(3):217-22. doi: 10.1007/s11920-008-0036-z. PMID: 18652789.
12. Laferrière-Simard MC, Lecomte T, Ahoundova L. Empirical testing of criteria for dissociative schizophrenia. J Trauma Dissociation. 2014;15(1):91-107. doi: 10.1080/15299732.2013.834860. PMID: 24377975.

ISSN 2515-8260 Volume 09, Issue 06, 2022

13. Ross CA, Ferrell L, Schroeder E. Co-occurrence of dissociative identity disorder and borderline personality disorder. J Trauma Dissociation. 2014;15(1):79-90. doi: 10.1080/15299732.2013.834861. PMID: 24377974.
14. Laddis A, Dell PF, Korzekwa M. Comparing the symptoms and mechanisms of "dissociation" in dissociative identity disorder and borderline personality disorder. J Trauma Dissociation. 2017 Mar-Apr;18(2):139-173. doi: 10.1080/15299732.2016.1194358. Epub 2016 May 31. PMID: 27245196.
15. Devinsky O, Putnam F, Grafman J, Bromfield E, Theodore WH. Dissociative states and epilepsy. Neurology. 1989 Jun;39(6):835-40. doi: 10.1212/wnl.39.6.835. PMID: 2725878.
16. Ross CA, Heber S, Anderson G, Norton GR, Anderson BA, del Campo M, Pillay N. Differentiating multiple personality disorder and complex partial seizures. Gen Hosp Psychiatry. 1989 Jan;11(1):54-8. doi: 10.1016/0163-8343(89)90026-1. PMID: 2912820.
17. Kim, I., Kim, D., & Jung, H. J. (2016). Dissociative Identity Disorders in Korea: Two Recent Cases. Psychiatry investigation, 13(2), 250–252. https://doi.org/10.4306/pi.2016.13.2.250
18. Gentile, J. P., Dillon, K. S., & Gillig, P. M. (2013). Psychotherapy and pharmacotherapy for patients with dissociative identity disorder. Innovations in clinical neuroscience, 10(2), 22–29.
19. Ganslev, C. A., Storebø, O. J., Callesen, H. E., Ruddy, R., & Søgaard, U. (2020). Psychosocial interventions for conversion and dissociative disorders in adults. The Cochrane database of systematic reviews, 7(7), CD005331. https://doi.org/10.1002/14651858.CD005331.pub3
20. Pietkiewicz, I. J., Bańbura-Nowak, A., Tomalski, R., & Boon, S. (2021). Revisiting False-Positive and Imitated Dissociative Identity Disorder. Frontiers in psychology, 12, 637929. https://doi.org/10.3389/fpsyg.2021.637929