35 Psychotic Presentations of Dissociative Identity Disorder

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35.1 DISSOCIATION AND PSYCHOSIS

The *American Psychiatric Glossary* (Stone, 1988) defines psychosis as a major mental disorder of organic or emotional origin in which a person's ability to think, respond emotionally, remember, communicate, interpret reality, and behave appropriately is sufficiently impaired so as to interfere grossly with the capacity to meet the ordinary demands of life. This term is applicable to conditions having a wide range of severity and duration, including schizophrenia, bipolar disorder, depression, and organic mental disorder.

Dissociative identity disorder (DID) and related forms of dissociative disorder not otherwise specified (DDNOS) are thought to be the most severe and complex types of dissociative disorders (American Psychiatric Association, 1994). Many clinicians, however, also accept the existence of a dissociative psychosis (DP) which was formerly called hysterical psychosis (Hollender & Hirsch, 1964; Hirsch & Hollender, 1969; Öztürk & Göğüş, 1973;

Cavenar, Sullivan, & Maltbie, 1979; Spiegel & Fink, 1979; Maleval, 1981; Gift, Strauss, & Young, 1985; Van der Hart, Witztum, & Friedman, 1993). Although never included in the standard nomenclature, the concept of DP lives on without official sanction (Modestin & Bachman, 1992; Libbrecht, 1995).

In fact, the construct of dissociation was not applied only to "hysteria" originally. Bleuler (1911) also linked it with the typical schizophrenic symptoms, such as disruption of thinking and emotions, thought to be the primary psychopathogenic mechanism in schizophrenia. Unfortunately, this approach led to the neglect of major dissociative disorders in mainstream psychiatry for many decades, rather than contributing to better understanding of human suffering due to chronic traumatization. Recently, there has been a renewed interest in the relationship between dissociation and schizophrenia. For example, Ross (1997, 2000) has proposed a dissociative subtype of schizophrenia. Notwithstanding the importance of this new stance, we will focus solely on psychotic presentations of major dissociative disorders (DID and related types of DDNOS). First, however, we will elaborate six domains of clinical psychopathology that will help to elaborate a concept of dissociation that is relevant to this debate.

35.1.1 Psychogenic Psychosis

The concept of a psychogenic psychosis distinct from schizophrenia has persisted throughout the 20th century (Faergeman, 1963; Strömgren, 1974). Psychogenic psychosis is usually considered reactive, in contrast to schizophrenia and manic depressive illness, which have been considered endogenous, that is, conditions with an unknown, but supposedly biological, origin (Strömgren, 1986).

European psychiatry has retained psychogenic psychosis in its tradition. Scandinavian psychiatrists adopted Jasper's distinction between process schizophrenia and reactive psychoses, with a better prognosis for the latter (Gelder, Gath, Mayou, & Cowen, 1996). In Denmark and Norway, the terms *reactive psychosis* or *psychogenic psychosis* are commonly applied to conditions that appear to be precipitated by stress, are to some extent understandable in their symptoms, and have a good prognosis (Strömgren, 1974, 1986). In France, the term *Bouffée délirante polymorphe aigüe* (literally, "acute polymorphous delusional puff") is used for a sudden-onset syndrome of good prognosis (Pichot, 1982, 1984). In Germany, Leonhard (1957/1979) published a classification that distinguishes schizophrenia from the cycloid psychoses, a group of nonaffective psychoses with a good outcome.

In North American psychiatry, many concepts that purported to explain the psychopathogenesis of schizophrenia may be applicable to the etiology of dissociation: for example, double bind (Bateson, Jackson, Haley, & Weakland, 1956), schizophrenogenic parent (Fromm-Reichmann, 1950), marital schism (Lidz, Fleck, & Cornelison, 1965), and pseudomutuality (Wynne, 1958). These models had collapsed in the face of evidence that supported a biogenetic etiology for schizophrenia during the so-called neo-Kraepelinian period. While the models may apply to schizophrenia only to a modest degree, they may, nevertheless, more accurately apply to dissociative disorders, especially to DID (Spiegel, 1986), which tends to arise not only in overtly disturbed families but also in the context of an "apparently normal" but dysfunctional (i.e., dissociative) family type (Öztürk & Şar, 2005). In fact, many famous patients who were previously thought to have had schizophrenia are now considered to have had a dissociative disorder (Greenberg, 1964).

Geographic trajectories are interesting. European psychiatry and the Kraepelinian tradition provided a niche for DP and DID cases in the psychogenic psychosis category. The mainstream of North American psychiatry and the Bleulerian tradition put them at the psychogenic pole of a broad schizophrenic spectrum. Turkish psychiatry has recognized the existence of a DP distinct from schizophrenia or any other "endogenous" psychosis for many decades, though this recognition did not lead to the discovery of DID until the 1990s (Şar, Yargıç, & Tutkun, 1996). Nevertheless, the long-standing recognition of DP has provided a firm basis for the effective introduction of DID as a valid diagnostic category in mainstream Turkish psychiatry.

35.1.2 Reality Testing

The *American Psychiatric Glossary* (Stone, 1988) defines reality testing as the ability to evaluate the external world objectively and to differentiate adequately between it and the internal world. Impaired reality testing is one of the major hallmarks of psychosis. Patients with DID or related types of DDNOS usually have insight into their illness. Their reality testing is intact except during DP episodes.

The dissociative patient's reported claim of containing another person's existence, or of having more than one personality, cannot be considered a delusion. Such claims do not originate from a primary thought disorder, but rather from experience itself—the actual experience of the other as "not me" (Sullivan, 1953). In contrast, the

delusions of a schizophrenic patient are thought to be the result of a primary disturbance of thought content.

Dissociation allows for the existence of several different (subjective) versions of reality within one person's internal world. Thus, Kluft (1993) once called DID "multiple reality disorder" and referred to "alternating reality states" (Kluft, 2003); Chefetz (2003) referred to identity alteration in DID as "isolated subjectivities"; Şar and Öztürk (2003) proposed a dissociation model based on "fragmented sociological and psychological realities." However, among dissociative subjects, external reality and the internal world are confused neither permanently nor pervasively. When it happens, it does so only in a time-limited and circumscribed fashion (i.e., restricted to distinct alter personality states and the limited information accessible to them).

35.1.3 Borderline Personality Disorder

The prodromal manifestations of schizophrenia may mimic obsessive compulsive disorder, an affective disorder, or a dissociative disorder. Some authors labeled prodromal cases or cases suggestive of schizophrenia pseudoneurotic schizophrenia or borderline schizophrenia (Hoch & Polatin, 1949). After a period of debate about its relationship to schizophrenic and affective disorders (Akiskal, 1981; McGlashan, 1983), the borderline syndrome was formally classified as borderline personality disorder, on Axis-II in DSM-III (American Psychiatric Association, 1980). While BPD was formally classified as a personality disorder, BPD cases are still considered psychosis-prone (Volkan, 1987), for instance, as living "on the borderline between psychosis and neurosis."

Research concerning paranoid ideation and depersonalization/derealization among patients with BPD (Zanarini, Gunderson, Frankenburg, & Chauncey, 1990) led to the introduction of the ninth diagnostic criterion of BPD in DSM-IV. This diagnostic criterion states: "during periods of extreme stress, transient paranoid ideation or dissociative symptoms may occur, but these are generally of insufficient severity or duration to warrant an additional diagnosis" (American Psychiatric Association, 1994). This criterion unfortunately confounded dissociative phenomena with the psychosis-proneness that had traditionally been considered a characteristic feature of "borderlines" by clinicians and theoreticians, even the core meaning of the still popular term.

Studies report a high frequency of dissociative symptoms among patients with BPD (Shearer, 1994; Brodsky, Cloitre, & Dulit, 1995; Zanarini, Ruser, Frankenburg, & Hennen, 2000). However, recent research (Şar et al., 2003; Şar et al., 2006) demonstrates that roughly two-thirds of patients with DSM-III-R BPD and three-fourths of patients with DSM-IV BPD have symptoms that are not simply stress-related or transient, and which call for a separate DSM-IV Axis-I diagnosis. Among the most frequently observed dissociative symptoms are chronic or repeated depersonalization, dissociative amnesia and other symptoms of DID. Consequently, the dissociative psychopathology seen in these putative BPD patients extends far beyond the boundaries of BPD's ninth diagnostic criterion.

High rates of childhood abuse and/or neglect have also been reported as central to both BPD (Herman, Perry, & Van der Kolk, 1989; Ogata, Silk, Goodrich, Lohr, Westen, & Hill, 1990) and dissociative disorders (Chu & Dill, 1990; Lewis, Yeager, Swica, Pincus, & Lewis, 1997; Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997; Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden, 1998). Chu and Dill (1990) argued that BPD is a type of posttraumatic syndrome involving the mechanism of dissociation. Although Kernberg's psychoanalytic concept of BPD is not identical to DSM-III BPD (American Psychiatric Association, 1980), it played a major role in the conceptualization of this syndrome as a personality disorder. Kernberg regarded "splitting" (after Melanie Klein) as the main defense mechanism in BPD, whereas some current authors (e.g., Ross, 1997, 2000; Bromberg, 1998) would reinterpret splitting as dissociation. Alternation between dissociated self-states may account for the identity disturbance, affective instability, and idealizing and devaluing relationships that are characteristic of BPD (Blizard, 2003). We hypothesize BPD is a heterogeneous diagnostic category: that trauma-related BPD is a dissociative disorder, while other BPD cases may be prodromal, subsyndromal, or attenuated forms of mood disorders, organic mental disorders, or schizophrenic disorders (Gunderson, 1984).

Such a view allows us to reinterpret those highly communicative and benign crises of BPD sufferers, their so-called transient psychotic reactions and transference psychoses, as episodes of DP.

35.1.4 Crisis and Process

Crisis is a state of psychological disequilibrium (Stone, 1988). Although DID is a chronic condition, its course is largely determined by crises. DID may remain dormant for a long time (Kluft, 1985). Most subjects with DID enter the mental health system during a crisis that they are unable to resolve using their own psychological resources. We define three types of crisis situations in this context.

We define a *primary crisis* as any overt dissociative condition that causes subjective distress or interferes with daily functioning to a certain extent, but does not lead to a collapse of overall adjustment. For example, dissociative symptoms may be recognizable in a psychiatric examination; there may also be some occupational and intimacy problems, difficulties in school, fluctuating suicidal tendencies, or depressive mood.

We define a *secondary crisis* as any grossly inappropriate behavior leading to overt instability. For example, a patient with DID or DDNOS may enter an unstable phase characterized by rapid switching of personality states, severe anxiety and depression, fear due to hallucinations, and the like. Such a condition may lead to hospitalization.

We define a *tertiary crisis* as any transient condition (lasting no longer than a few hours) that interferes with the normal activities of daily living. These episodic behavioral disturbances include acute somatoform dissociative symptoms (e.g., pseudoseizures), flashbacks, self-mutilation, suicide attempts, or micropsychotic episodes.

Any acute dissociative condition (including somatoform dissociation, such as conversion disorder) should raise suspicion about an underlying chronic dissociative condition that may have been present since childhood (Tutkun, Yargıç, & Şar, 1996; Şar, Akyüz, Kundakçı, Kızıltan, & Doğan, 2004). DP would then apply to the most severe forms of crisis.

35.1.5 Culture-Bound ("Exotic") Syndromes

Psychiatry is the medical specialty most influenced by cultural issues. This is due not only to cultural differences in the phenomenology of psychiatric disorders, but also to differences in psychiatrists' attitudes and varying mental health delivery systems of different countries.

The thesis that DID is merely a North American phenomenon has been refuted in the past decade by research reports based on standardized assessment from diverse countries, such as from The Netherlands, Turkey, and Germany (Boon & Draijer, 1993; Şar et al, 1996; Gast, Rodewald, Nickel, & Emrich, 2001). Clinicians and researchers should be careful to avoid categorizing a universal human condition as culture-bound. Far from being culture-sensitive, such a mistake impedes scientific bridge-building among scientists from diverse cultures. Conversely, the identification of universal psychopathological conditions, regardless of cultural differences, would lead to significant clarifications about what is, in fact, cultural. The ongoing story of the "discovery" of DID in various cultures has underscored the importance of this stance.

With regard to dissociative psychosis, what is universal and what is culture-bound have also to be clarified.

Many conditions listed under DSM-IV's DDNOS, example 4, Dissociative Trance Disorder in the DDNOS section of the DSM-IV (with suggested research criteria in Appendix B), were previously categorized as culture-bound or exotic syndromes (Meth, 1974; American Psychiatric Association, 1994): for example, amok (Indonesia), bebainan (Indonesia), latah (Malaysia), pibloktoq (Arctic), ataque de nervios (Latin America), and possession (India). DSM-IV defines dissociative trance disorder as "single or episodic disturbances in the state of consciousness, identity or memory that are indigenous to particular locations and cultures … [but] not a normal part of a broadly accepted collective cultural or religious practice." Langness (1965) considers the *bena bena* syndrome in the New Guinea highlands as a DP.

DP is not limited to certain cultures (Langness, 1967); precipitating factors, however, may differ. From a general clinical perspective, DP is an urgent medico-psychiatric-legal condition. Within general clinical psychiatry, we regard DP as a trauma-related psychopathology ranking with other traditional severe conditions such as schizophrenia, manic depressive illness, and organic mental disorders. We believe that psychotherapy might prevent such severe crises by allowing other ways to express dissociative psychopathology, and consequently that limited availability of psychotherapy ought to predict a high prevalence of DP. Such limited availability might be due to diverse reasons: insufficient mental health delivery, ignorance of dissociative disorders by professionals prompting inappropriate interventions, or the pervasive presence of unbearable and inescapable realities, such as a restrictive cultural environment or outright war.

35.1.6 Hypnosis

Steingard and Frankel (1985) proposed that certain highly hypnotizable persons are prone to experience transient but severe psychotic states. Spiegel and Fink (1979) stated that DP patients are highly hypnotizable and curable with psychotherapy, in contrast to schizophrenics. Hypnotizability has a bearing on the differential diagnosis between schizophrenia and DP (Van der Hart & Spiegel, 1993). Hypnosis can be used productively in psychotherapy with patients with DP (Van der Hart & Spiegel, 1993; Van der Hart & Van der Velden, 1987; Van der Hart et al., 1993).

35.1.7 A Definition of Dissociation

Dissociation is defined in DSM-IV (American Psychiatric Association, 1994) as a disruption in the usually integrated functions of consciousness, memory, identity, or

perception of the environment. We would propose a reexplanation of the term *dissociation*. In our view, the construct *dissociation*, as defined in DSM-IV, is merely a reflection of *depersonalization*. We consider *depersonalization* to be a mental mechanism rather than merely a symptom. Depersonalization is the only concept that covers all dissociative phenomena. While the construct *dissociation* connotes a loss of integrity in at least one of various psychological faculties, *depersonalization* connotes an impairment of a single faculty, which Jaspers (1913) called *personalization*—the experience that all psychological faculties (perception, body perception, memory retrieval, imagination, thought, feeling, etc.) belong to oneself.

All traumatic events (interpersonal or impersonal) have the inherent character of a double bind, creating multiple perceptions of reality (Şar & Öztürk, 2005). These multiple and simultaneous perceptions of reality destroy personalization. To cope with this, the traumatic fact (person, idea, situation, etc.) may be kept at a distance or, alternatively, the subject may remain in an oscillating relationship with the various perceptions. Intact personalization is possible only if there is just one perception of reality concerning a given fact (person, idea, situation, etc.) over a given time period. Metapsychologically, dissociation is based on a chronic developmental detachment of the sociological and psychological selves from each other, leading to overall psychological disharmony and to a hypertrophy of the sociological self (for a more complete treatment of this discussion, see Şar & Öztürk, 2007).

35.2 THE DOMAIN OF DISSOCIATION

Psychotic phenomena observed among patients with DID can be subsumed under two headings: dissociative psychosis (DP) proper and conditions that mimic psychosis. DP fits most psychosis definitions in general psychiatry, whereas the latter merely resemble psychosis, such that a psychotic diagnosis would be considered a misdiagnosis due to ignorance of an underlying dissociative disorder.

35.2.1 Dissociative Psychosis (Formerly Hysterical Psychosis)

While the term *hysterical psychosis* has a long history, we prefer the term *dissociative psychosis* in this study, in keeping with the modern nosology of dissociative disorders, even in referring to earlier works; for instance, we use the terms *DP* and *hysterical psychosis* interchangeably.

Hollender and Hirsch (1964) gave a clinical phenomenological description of DP. Van der Hart et al. (1993), reviewing Hoek, Breukink, and Janet, emphasized the dissociative foundation and traumatic etiology of DP. Hollender and Hirsch's definition requires a brief duration (three weeks or less) and emphasizes amnesia for the episode. Van der Hart et al. (1993) argue against the criterion of brief duration. Integrating both approaches, and agreeing with a traumatic etiology, Tutkun et al. (1996) underscored the link between DP and DID.

35.2.1.1 Four Perspectives

35.2.1.1.1 Descriptive perspective

Hollender and Hirsch (1964) provided a clinical description of DP that has been considered useful by most psychiatrists in the second half of the 20th century. From the descriptive standpoint, DP begins suddenly and dramatically. The onset is temporally related to an event or circumstance that has been profoundly upsetting. The manifestations may take the form of hallucinations, delusions, depersonalization, or grossly unusual behavior. Affectivity is usually not altered. If altered, it is in the direction of volatility rather than flatness. Thought disorders, when they do occur, are generally circumscribed and transient. The acute episode in DP usually lasts 1 to 3 weeks. The process recedes as suddenly and dramatically as it began, leaving practically no residue, and, occasionally, with amnesia for the episode.

35.2.1.1.2 Dissociative nature

Van der Hart and Friedman (1989), on the basis of Janet and Breukink's forgotten works on DP, and on their own experiences, have a different perspective on DP from Hollender and Hirsch. They emphasize the essential role of traumatically induced dissociation in the genesis of reactive psychosis. Based on case reports of DP (in the literature and their own), they conclude that a dissociative foundation is essential to DP, while brief duration is not (Van der Hart & Spiegel, 1993; Van der Hart et al., 1993).

Van der Hart et al. (1993) quote Janet, who said that the criteria for a dissociative psychosis would be: (1) the psychosis is embedded in dissociative phenomena; (2) the psychosis itself is seen as a dissociated state; (3) a splitting or doubling of the mind has occurred; (4) subconscious phenomena are observed; and (5) altered states of consciousness occur.

35.2.1.1.3 Common traumatic ground

Some authors who try to explain the psychodynamics and precipitating environmental stresses accompanying DP suggest intrafamilial relationships and environmental stress (Richman & White, 1970), disturbed marriages (Martin, 1971), an unwelcome or wished-for but not forthcoming sexual advance (Cavenar, Sullivan, & Maltbie,

1979), and complacent overadjustment to a restrictive environment (Öztürk & Göğüş, 1973) as etiological factors. Şar (1983) underscores maternal rejection among female patients in particular. Van der Hart and Spiegel (1993) consider both DP and DID as trauma-induced severe dissociative disorders; however, they do not mention a possible overlap between the two.

35.2.1.1.4 Overlap of DID and DP

Studies on DP and DID have had little overlap in the 20th century. One exception is the study by Tutkun et al. (1996); they evaluated Turkish patients for both conditions over a period of time, demonstrating the link between DP and DID. They conclude that DP might be a manifestation of a more chronic and complex dissociative disorder (DID or DDNOS). The initial clinical presentation of these cases fits most of the criteria for DP proposed by Hollender and Hirsch (1964). In patients with recurrent DP episodes, other long-lasting dissociative experiences and symptoms, not spontaneously reported, could easily be detected if evaluated. Large-scale surveys about this thesis are still lacking. A similar observation, however, was reported in a case presentation from Canada (Ghadirian, Lehmann, Dongier, & Kolivakis, 1985). In our experience, besides spontaneous incidences, DP may also develop during long-term psychotherapy of DID and related types of DDNOS.

Although DP may be superimposed on a chronic dissociative condition, it may also occur on its own in the face of severe trauma or for unknown reasons. This point needs further study.

35.2.1.2 Symptomatology of Dissociative Psychosis

The clinical symptomatology of DP is not uniform. Overall, it may resemble a schizophrenic, manic, and/or organic mental disorder (table 35.1). Dissociative symptoms may be difficult to identify in the mixture of positive symptoms. Lack of affective flatness, a good premorbid psychosocial functionality, and an unexpected and sudden onset (often leading to emergency psychiatric admission) are very helpful clues for a diagnosis.

Organic mental disorder (delirium) ought to be ruled out immediately, as this might imply a medical emergency. Suicidal and homicidal tendencies should be carefully evaluated, as any dissociative patient is more likely to act on these impulses during a DP. Admission to a closed unit is advised until the accurate diagnosis is established. Hospitalization itself may have a therapeutic effect, as patients may need to remain at a distance from their environments for a certain time prior to returning to their premorbid levels of functioning.

TABLE 35.1
Symptoms of Acute Dissociative Psychosis

A. Core dissociative symptoms
   1. Dissociative amnesia and fugue
   2. Depersonalization, derealization
   3. Identity confusion or alteration, possession
B. Schizophrenia-like symptoms
   1. Hallucinations (visual, auditory, tactile, olfactory, gustatory)
   2. Schneiderian first rank symptoms, persecutory delusions
   3. Apparent discontinuity in thought flow (due to rapid switching between personality states)
   4. Impaired reality testing
   5. Flashbacks
C. Disorganized behavior
   1. Childlike movements and speech
      Urination and defecation in inappropriate places, childlike speech etc.
   2. Animal-like behavior
      Freezing or submission: stupor, catatonia, mutism, dissociative trance, suggestibility
      Fight-flight: violence, trying to escape
      Movements and voices: unorganized movements ("movement storm"), singing like a bird, etc.
   3. Flashback-related behavior: undressing, stereotypical movements and speech, self-mutilation, etc.
D. Organic-like symptoms
   1. Disorientation to person, place, and time
   2. Pseudoseizures and other somatoform symptoms
E. Affective symptoms
   1. Suicidal ideation and gestures
   2. Anxiety, euphoria, fear, anger, sadness
F. Autohypnotic symptoms
   1. Trance states, altered consciousness
   2. Altered time perception
   3. Suggestibility
G. Symptoms that exclude schizophrenia:
   1. Rapid fluctuation in mood and overall symptomatology
   2. No affective flatness
   3. Sudden onset, abrupt and dramatic improvement

Visual and auditory hallucinations and disorganized or grossly unusual behavior are predominant symptoms. Thought form may appear discontinuous, and reality testing may be impaired. Childlike behavior, trying to escape, catatonia, unorganized, or animal-like, behavior may be observed. There may also be flashback experiences. The patient's overall behavior and level of cooperation may change. The patient may appear quite improved and transiently cooperative. The patient may have total or partial amnesia for the episode.

Spiegel and Spiegel (1978) mention that patients with a previously good level of functioning may respond to severe environmental stress with rapid psychotic decompensation. They may be delusional and have ideas of reference, loose associations, and affect disturbance that may range from bland indifference or flatness to intense agitation. They frequently mobilize tremendous attention and anxiety from their social network. These patients often recompensate rapidly, especially when an appropriate intervention is made in their environment. The differential diagnosis between DP and bipolar mood disorder can be difficult as well.

35.2.2 Conditions That Mimic a Psychotic Disorder

Symptoms that can be explained simply by a diagnosis of DID do not warrant an additional diagnosis of DP.

35.2.2.1 Persecutory personality state deriving from a real person in the environment of the patient

Most DID patients have so-called persecutory personality states with hostile tendencies toward the host personality. In some cases, such a personality state derives from a person in the environment of the patient, for example, a family member, spouse, close friend, neighbor. The patient may temporarily confuse the alter personality state (in the internal world) with the corresponding person in the external world. For example, the threats of a persecutory personality state may be attributed to the person in the real world. In this case, the confused patient perceives the real person as the origin of threat and reports her experience correspondingly. It is not possible to distinguish this situation on a phenomenological basis from a paranoid psychosis unless the clinician suspects the presence of a dissociative disorder and explores this link. The observation of switching to the persecutory personality state and resolving of the persecutory delusions following the fusion of this personality state with the host personality makes the distinction possible.

35.2.2.2 Psychotic personality state

Some patients have personality states with psychotic features such as delusions or hallucinations. These features are usually observed when the relevant personality state has executive control. These patients do not warrant any diagnosis beyond dissociative disorder, as these symptoms do not generalize to the rest of the personality system. The relevant personality state might take executive control only episodically during a tertiary crisis. For some patients, their only psychiatric symptomatology might be limited to tertiary crises throughout their lives. A sudden onset and abrupt improvement, and the dramatic nature of the hallucinations (visually hallucinated figures speaking as the origin of acoustic hallucinations) differentiate such dissociative episodes from psychotic disorders.

35.2.2.3 Imaginary companionship by a persecutory personality state

The existence of a distinct personality state is usually felt by the patient as the presence of another person in the environment, a presence that may be very real for some, quite vague for others. In its mildest form, the subject complaints of a feeling as if "somebody is behind me," accompanied by anxious expectation and worrying, particularly if the accompanying personality state is a persecutory one. This situation may mimic an idea of reference, and thus a paranoid psychosis.

35.2.2.4 Features of DID traditionally known as schizophrenic symptoms

DID and schizophrenia share a number of psychopathological similarities such as auditory hallucinations, paranoid ideas, and Schneiderian first-rank symptoms, such as "made" feelings (Kluft, 1987; Ross et al., 1990). The differential diagnosis between schizophrenia and DID is an important clinical task. Two clinical conditions provide especially difficult challenges for differential diagnosis: (1) incipient schizophrenia in adolescence and (2) a dissociative subtype of schizophrenic disorder, as proposed by Ross (2000).

35.3 EXPLANATORY MECHANISMS

DP is thought to be produced in a patient with DID as follows: an acute stressful life event leads to a struggle for control and influence between alter identities who have frightening, fearful, aggressive, or delusional features, and some of whom may have been long dormant (Tutkun et al., 1996). This may take the form of Putnam's (1989) "revolving door crisis" or Kluft's (personal communication, 1995) "co-consciousness crisis." In a DID patient who is controlled by the host personality most of the time (with the alters being suppressed), diagnosing DID may be impossible. However, if a triggering stressful event occurs, this equilibrium may disappear and forceful activities of many alters (including the formation of new alters) may ensue, and severe dissociative symptoms and flashbacks may cause DP. So, DP may also be a "diagnostic window" (Kluft, 1987) for DID. On the other hand, DP can also occur separately as a diagnostic category on

its own; that is, we do not consider DP to be simply an epiphenomenon of DID.

35.4 NOSOLOGY OF DISSOCIATIVE DISORDERS

From a general psychiatric perspective, brief psychoses are poorly understood; they probably are a heterogeneous group of psychotic disorders that have long created diagnostic dilemmas for psychiatry (Susser, Fennig, Jandorf, Amador, & Bromet, 1995). The relationship of these cases to schizophrenic disorder and the mood disorders remains uncertain (Susser & Wanderling, 1994; Susser, Varma, Malhotra, Conover, & Amador, 1995). The ICD-10 provides a special category for acute and transient psychotic conditions that is restricted to brief psychoses of acute onset; there is no equivalent to this group in the DSM-IV (World Health Organization, 1991; American Psychiatric Association, 1994).

Neither the DSM-IV nor the ICD-10 acknowledges that dissociative states can appear as a transient psychotic disorder. DSM-IV has no category appropriate for DP. Accordingly, one must resort to the diagnosis of psychotic disorder not otherwise specified.

We propose the introduction of a new category, Dissociative Psychosis (formerly Hysterical Psychosis), within the dissociative disorders grouping, with an accurate account of its etiology and phenomenology. An alternative to this option would be creation of a new category, Acute Dissociative Disorder with Psychotic Features (as opposed to without psychotic features).

Some famous cases of hysteria (e.g., Anna O. and Emmy von N.), who also manifested DP (Hollender & Hirsch, 1964), are now considered to be examples of chronic complex dissociative disorders (Ross, 1997). In the historical cases section of the DSM-IV casebook, Breuer's famous patient, Anna O., has been discussed (Spitzer, Gibbon, Skodol, Williams, & First, 1994). Anna O. had many symptoms that suggest a psychotic disorder, such as disorganized speech (e.g., "her language was devoid of all grammar, all syntax, to the extent that the whole conjugation of verbs was wrong"), hallucinations (e.g., of black snakes and death's heads), and possible delusions (e.g., she complained that she "had two egos, her real and an evil one, which force her to evil things"). Because of these seemingly psychotic symptoms, rigid use of the DSM-IV criteria might lead to a diagnosis of schizophrenia. The authors added that this diagnosis fails to capture the essence of Anna O.'s illness. They suggested that the problem is that DSM-IV does not recognize hysterical psychotic symptoms, with the exception of the category Factitious Disorder with Psychological Symptoms. Neither the authors, nor Breuer, nor Freud think that Anna O. intentionally produced her symptoms (i.e., factitious disorder).

35.5 DISCUSSION

Epidemiological data about DP are rather scarce. These patients are usually admitted to psychiatric emergency wards and require hospitalization. A retrospective investigation of inpatient admissions to a university psychiatry clinic in Turkey between 1970 and 1980 reported that 0.5% of the patients were diagnosed as having DP (Şar, 1983).

DP may occur in the presence or absence of a preexisting dissociative disorder; this raises the issue of inclusion and exclusion criteria. One approach would be exclusionary: where patients have preexisting DID, DP would be considered merely as an unstable presentation, rather than an additional diagnosis. Indeed, in clinics where DID is recognized as an appropriate diagnostic category, the number of subjects diagnosed as having DP diminishes. This is due to the increased expertise of clinicians who can accurately interpret rapid switching, the appearance of alter personalities, and flashback experiences. However, despite the common dissociative pathogenesis, this approach complicates the phenomenological description of DID as a homogeneous diagnostic category. Moreover, psychosocial functioning in DP is generally much more impaired than in regular DID. The DP category has many useful implications and consequences concerning hospitalization, forensic assessment, and research.

An alternative approach would recognize the diagnosis of DP whereas a concurrent DID might be an exclusion criterion. But this approach would likely further increase the difficulties of differential diagnosis. Moreover, (1) the overall approach of the DSM is basically phenomenological, and (2) a common dissociative pathogenesis should not necessarily lead to a single diagnosis.

The category of DP is typically used by clinicians who are aware of the difference between an acute schizophrenic episode and psychotic dissociative syndromes with a rather benign prognosis, but who are not familiar with DID and its incomplete forms (some of the DDNOS examples). The concept of DP would be one of the starting points for the recognition of DID in countries where professionals are more familiar with the concept of acute psychogenic psychosis.

35.6 NEEDED RESEARCH

The introduction of DP (or Acute Dissociative Disorder with Psychotic Features) as an official diagnostic category may fill the gap that was created by the current narrow definition of schizophrenic disorder. A diagnostic category of DP may provide a basis for research and theoretical studies on nonschizophrenic psychotic phenomena. This strategy seems to be more in accordance with the historical development of psychiatry than would a reintroduction of a broader (Bleulerian) concept of schizophrenia. Here are suggestions for further research:

1. There is a need for diagnostic tools and reliable diagnostic criteria for DP. The differential diagnosis from schizophrenic disorder, bipolar disorder, major depression, and other dissociative disorders should be considered.
2. The relationship between DP, DID, the various DDNOSs, Brief Psychotic Disorder, and Acute Stress Disorder should be clarified. Are all acute, transient psychotic disorders dissociative in nature?
3. Considering their episodic nature, relatively benign prognosis, and phenomenological overlap, a relationship between DP and mood disorders (i.e., manic episode, psychotic depression) should be investigated.
4. Patients with DP, but without an underlying chronic dissociative disorder, need to be researched separately.
5. Comparison of DP with the (proposed) dissociative subtype of schizophrenia might provide important insights for clinicians and researchers.
6. If there are subacute or chronic forms of DP, then how would they differ from schizophrenia?
7. The consideration of DID in forensic settings is controversial (Ross, 1997). The new category of DP would likely have important implications for forensic psychiatry, a point that needs further clarification.
8. Much social-psychological research is needed, especially regarding the role given to the dissociative subject by the family. Many concepts that animated theory and (failed) research into a psychosocial etiology of schizophrenia (e.g., schizophrenogenic mother, double bind, marital schism, pseudomutuality, etc.) may prove to be relevant for dissociative psychopathology (Spiegel, 1986).

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