DISSOCIATIVE IDENTITY DISORDER: A CLINICAL INVESTIGATION OF 20 CASES IN TURKEY

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ABSTRACT

This study describes the presentation and clinical features of dissociative identity disorder (DID) in Turkey. The first twenty consecutive patients in a dissociative disorders program of a university clinic in Turkey who met the DSM-III-R criteria for multiple personality disorder (MPD) and DSM-IV criteria for DID were assessed with clinical interviews, a structured evaluation form consisting of 126 items, and the Dissociative Experiences Scale. Eighteen of the patients were women in their twenties. The median number of alternate personalities was four. Eighty-five percent of the patients complained severe headache. All of the patients had at least one Schneiderian first-rank symptom. Childhood traumas were reported in 85% of the cases. The mean DES score was 47.2. These results are remarkably similar to findings from North America and Western Europe, suggesting the validity of DID across cultures.

INTRODUCTION

We report data on 20 patients meeting *DSM-III-R* criteria for multiple personality disorder (MPD) and *DSM-IV* criteria for dissociative identity disorder (DID). This is the first DID case series from Turkey. We describe the systematic assessment of these patients, comparing them with case series reported from North America. We particularly focus on clinical history, phenomenology, symptom profiles, and histories of childhood abuse and/or trauma.

Literature Review

Dissociative identity disorder (American Psychiatric Association, 1994), formerly known as multiple personality disorder (American Psychiatric Association, 1987), is increasingly understood as a complex and chronic post-traumatic dissociative psychopathology closely related to child abuse (Kluft, 1987a). Until recently, multiple personality disorder was little understood and thought to be quite unusual. Various standardized interview schedules (Ross, 1989a; Steinberg, Rounsaville, & Chiccetti, 1990) and self-rating scales (Bernstein & Putnam, 1986) were developed in order to diagnose chronic dissociative disorders and proved to be valid and reliable. Now multiple personality disorder is known to be more common than previously imagined (Ross, 1991).

Traditionally dissociative disorders have been associated with hysteria (Ellenberger, 1970). Various forms of "hysterical neurosis" have long been appreciated to be common in Turkey. A series of the first methodologically adequate epidemiological studies in the 1980s using the Present State Examination showed a prevalence of 7.5 - 17.5% (Atakan, 1980; Demiriz, 1980; Hancioglu, 1981; Saher, 1981; Satir, 1981). It is one of the most frequent psychiatric disorders seen in the emergency units of general hospitals and emergency psychiatric wards. Such cases constitute 47.0% of emergency Turkish psychiatric admissions according to a representative study in Turkey. (Salgirtay, 1979)

In a retrospective investigation of inpatient cases in a university clinic diagnosed as any form of "hysteria" in the 1970s, 6% of the whole inpatient population in a ten-year period, there was not a single case of multiple personality disorder (Sar, 1983). The sole published Turkish article about multiple personality disorder was a review which questioned why it was not diagnosed in Turkey (Ozmen, Cigeroglu, & Ertan, 1992). The first multiple personality disorder cases in Turkey were reported by our research team recently (Tutkun, Yargic & Sar, 1994; Yargic, Tutkun & Sar, 1994a). There have been suspected cases, but they were not reported because most Turkish psychiatrists do not accept this diagnosis or have considered it as an epiphenomenon of schizophrenia, affective disorders, or borderline personality disorder. According to the responses to a questionnaire sent to the senior psychiatrists in various institutions in our country, only 19% of them have had a patient with MPD (Sar, Yargic, & Tutkun, in press).

Our curiosity in multiple personality disorder started with our interest in so called "hysterical psychosis" (or pseu-

dopsychosis) which is a frequent diagnosis, especially in emergency psychiatric units in Turkey. It is characterized by acute, severe time-limited dissociative symptoms following a life stress, and as its name implies, shows the phenomenology of a brief reactive psychosis (Ozturk & Gogus, 1973; Ozturk, 1993; Ozturk & Volkan 1971). Our first case was admitted to our emergency psychiatric unit, with manifestations typical for pseudopsychosis.

SUBJECTS AND METHODS

Subjects

The subjects of this study were the first 20 consecutive patients with multiple personality disorder who were seen by the authors. All of the subjects were patients at the Medical Center of Istanbul University, Istanbul Medical Faculty, a general hospital including a psychiatric clinic with inpatient and outpatient facilities. Our clinic is one of the referral centers for the metropolitan Istanbul area, with a population of 8 million, and for the whole country as well.

The patients, who were admitted to various units of the psychiatric and neurologic clinics over a ten-month period with symptoms of pseudopsychosis, psychogenic amnesia, fugue and dramatical conversion symptoms, were referred to our research team by their physicians. During the research period, 63 patients were diagnosed as having some form of dissociative disorder. They were called for follow-up. Twenty patients among them were diagnosed definitely as multiple personality disorder during successive interviews and were included in this study. Twenty-four patients, who were diagnosed as "Dissociative Disorder Not Otherwise Specified," and whose relatives described different personalities in detail, were not accepted for the study, because we could not observe these personality states ourselves.

Methods

Because these are the first MPD cases detected in our clinic, data collection for this study underwent a gradual evolution, as our knowledge and experience increased. Newer assessment techniques were added during the follow-up period. We developed an original unstructured clinical interview technique with the aid of the American literature about diagnosing MPD. We relied especially on the SCID-D (Structured Clinical Interview for *DSM-IV* Dissociative Disorders) of Steinberg (1993). The following data were gathered on admission: psychiatric and medical history, mental status examination, physical and neurological examination, EEG, Rorschach's test, Stanford-Binet intelligence test, and neuropsychological tests. A collateral interview with a family member was obtained for all patients.

An evaluation form consisting of 126 items was developed to take information about demographic data, presenting psychiatric and medical symptoms, psychological trauma, legal problems, previous diagnoses, and any family history of psychological disturbance. After the initial diagnoses, information about symptoms of dissociation and MPD were gathered as the follow-up continued. Because this evaluation form was developed after our project began, it was completed retrospectively on four patients.

All patients except one were administered the Dissociative Experiences Scale-DES (Bernstein & Putnam, 1986) after the initial diagnoses of chronic, complex dissociative disorder (MPD or DDNOS). The Turkish version of this scale has a high reliability and validity according to our data (Yargic, Tutkun, & Sar, 1995) derived from a non-clinical and clinical population in Istanbul.

All 20 patients were diagnosed according to the strict diagnostic criteria of *DSM-III-R*. Seventeen of them also fulfilled NIMH research diagnostic criteria; i.e., there was amnesia between at least two personalities and these personalities were observed with full control during therapy sessions at least three times. On the remaining three patients, who stayed under our observation only for a short time, we could observe personality switches two times instead of three, but the patients and their relatives described separate personality states in detail.

RESULTS

Patient Sources

The patients came from different sources. Eight patients had been admitted to the emergency psychiatric unit for amnesia (two), pseudopsychosis (four), fugue (one) and conversion/blindness (one). Five patients had been hospitalized in a psychiatric unit with diagnoses other than dissociative disorders. Four patients had been admitted to the neurologic outpatient clinic for severe headaches when they were detected. One patient was referred from the psychiatric outpatient unit with the diagnosis of chronic post-traumatic stress disorder (due to prolonged childhood sexual abuse and incest). One patient was detected by one of the authors during psychiatric consultation at the neurological inpatient unit. One patient was referred by the psychiatric outpatient unit with the initial diagnosis of MPD: she had aggressive outbursts as chief complaint.

Demographic Characteristics of Patients

Eighteen patients (90%) were women in their twenties or younger. The mean age of the patients was 20.0 (range 11 to 38 years) with an average education of seven years (range 0 to 11 years). Seven female patients were married. One female was living separately. Seven of the patients were employed. One of the male patients was employed, the other one was a student. Five patients were housewives. Two patients had left their jobs, two had interrupted their education because of their dissociative symptoms, two of the employed patients had long periods of sick leaves and could not work regularly. All of the employed patients worked at an occupational

level of semi-skilled or lower.

Onset of Illness

It was impossible to take uniform information about the onset of illness. Most of the patients had had their first dissociative symptoms before the age of 10. Some of the patients could not give reliable information because they had amnesia about their childhood and adolescence.

Diagnostic Procedure

The duration of our follow-up ranged from two interviews to two years. Six patients were followed for less than one month, four patients were followed between one to five months, six patients were followed between five to 10 months and four patients were followed for more than 10 months. The four patients who were followed longer than 10 months included two patients who were diagnosed as MPD before this study began, and two others who were followed as chronic depression. The time spent from intake until MPD was diagnosed varied widely. Three patients were diagnosed (seeing personality switches and intrainterview amnesia) during the first interview, and five patients during the second interview. Three patients were diagnosed between six and 12 weeks, and nine patients were diagnosed after more than three months of follow-up.

Psychiatric Symptoms

All of the patients had depressive symptoms. But because the depressive symptoms were confined to specific personalities and they disappeared with personality switches, we did not consider affective disorder as a definitive diagnosis for any patient.

Chronic and severe headache was one of the most common complaints (17 patients, 85%).

Eight individuals (40%) had previous suicide attempts. Eight patients had chronic self-abusive behavior other than suicide attempt. Thirteen individuals (65%) had demonstrated aggressive behavior.

All of the patients had at least one Schneiderian first rank symptom. Auditory hallucinations expressed as inner voices were detected by 19 individuals (95%). One patient (age 11) did not have auditory hallucinations but had thoughts of passive influence. The mean number of Schneiderian symptoms per patient was 4.0 (range, 1 to 7). Thought withdrawal, thought broadcasting, and thought reading were not experienced by any patient.

Alcohol or substance abuse was not present in any patient.

Previous Psychiatric Diagnoses

Nine (45%) patients had previous psychiatric diagnoses, some of them had more than one. The most common pre-

TABLE 1
Types of Childhood Trauma Reported by Patients with MPD

Type	Number	Percent
Physical abuse	11	55
Sexual abuse (including incest)	11	55
Emotional abuse	10	50
Incest	7	35
Neglect	5	25
Extreme poverty	3	15
Witness to accidental death	1	5

TABLE 2
Characteristics of Alternate Personalities

Characteristics	Number	Percent
Personalities with different names	12	60
Child alternate personality	11	55
Suicidal alternate personality	9	45
Helper/protector alternate personality	6	30
Persecutor alternate personality	5	25
Opposite-sexed alternate personality	5	25

vious diagnosis was schizophrenia or psychotic disorder (30%). The others were personality disorder (15%), post-traumatic stress disorder (15%), depression (10%), and conversion disorder (10%). Nine patients had either been hospitalized before or during our follow up. Ten patients (50%) were known to have consulted paramedical healers and clergy for their symptoms.

History of Previous Trauma

Seventeen patients revealed that they had traumatic life events before age 16. Ten patients had more than one kind of psychic trauma. The types of childhood trauma experienced by the patient sample are listed in Table 1. The mean number of psychic traumas per patient was 2.1.

Only seven patients had alters who related their existence to a specific childhood traumas.

History of Legal Difficulties

None of our patients had legal problems. One of the alters of a female patient introduced herself as prostitute, but whenever she came to the point of sexual relationship one of the host personalities emerged and escaped. Two patients had committed assault and battery but they had not been legally punished. One of the male patients, 11 years old, was a well-mannered and hard-working student until his dissociative symptoms made him unable to attend school. We have very limited knowledge about the other male patient (age 19) due to short follow-up.

Family History

The fathers of nine patients (45%) had either alcohol abuse or excessive gambling or both. Chronic dissociative disorders (DDNOS) were present in the first degree relatives of four patients (20%). No cases of affective or psychotic disorders were reported in any of the first degree relatives.

Four patients had children. All of the children were younger than 15 years of age. Only one of them (nine years old) had had psychiatric admission, and she was diagnosed as DDNOS.

Characteristics of Alternate Personalities

The patients had a mean number of 5.1 personalities (range 2 to 10, median 4, mode 4). Characteristics of alternate personalities are shown in Table 2. In 13 patients (65%) we have not met alter personalities who relate their appearance to childhood trauma.

Medical Status and EEGs

Only one of the patients (5%) had a serious physical illness. She had been hospitalized in the neurological clinic due to blurred vision. Optic neuritis was detected. Her magnetic resonance imaging (MRI) was normal. She was diagnosed as probable multiple sclerosis (MS). None of the patients had epilepsy.

EEGs were completed on 17 patients (85%). Only one of them was definitely abnormal. This was the patient with optic neuritis. There was localized and nonspecific organizational disturbance in the right hemisphere.

Psychological Testing and Standardized Measures of Psychopathology

The 19 patients who received the DES (possible scores 0 to 100) had a mean score of 47.2 (SD = +-17.6, and a range of 10.1 to 76.7).

Rorschach testing did not show overt psychotic features in any patient. IQs (tested with WAIS method) of the patients ranged from borderline to superior.

DISCUSSION

This study is the first series of MPD cases presented from Turkey. In spite of the relatively small sample size, it shows that MPD is much more common than imagined in Turkey (Ozmen et al, 1992; Sar et al., 1994). Coons gathered 50 patients in 13 years (Coons, Bowman, & Milstein, 1988). We identified 20 patients in 10 months, probably because we are one of the few centers giving psychiatric care to a large population in Istanbul.

This study has limitations. First of all, the duration of follow-up was very short for some patients. Extensive and reliable data-gathering was not possible in those cases followed briefly. Also, only one patient could come to the level of fusion during psychotherapy over the period of data collection. Many patients still show clues suggesting that there are additional unmet alter personalities. Unfortunately, some patients dropped out of therapy. Our opinion is that our data do not reflect the real number of alter personalities and frequency of childhood trauma in our patients; rather, they indicate the minimum. Our patients have not been discovered in a representative population of Turkish psychiatric patients. Most of them were found with the efforts of the authors. Therefore our results cannot be seen as definitive of the true features of MPD in Turkey.

In our series the female to male ratio is 9:1. This is the same proportion as the findings of Ross and his colleagues in North America (Ross, Norton, & Wozney, 1989). Our patients are younger than the patients in other series (Putnam, Guroff, Silberman, Barban, & Post, 1986; Coons et al., 1988; Ross et al., 1989). While some symptoms of the patients in this study resemble closely the symptoms of patients in several recent American reports, they are different in some aspects (Coons et al., 1988; Ross et al. 1989; Putnam et al., 1986). The incidence of depressive symptoms and suicide attempts are quite similar. The mean number of personalities of the patients in this study (5.1) is substantially lower than the mean numbers reported by Putnam (13.3), Ross (15.7) and Coons (6.3). The median number (4) is the same with the Coons study but less than the Putnam (9) and Ross

(8) studies. The difference in means is probably due to two factors. In this study the number of personalities was sampled very early during the follow-up, perhaps before all of the personalities had been discovered. Furthermore in all of the other studies there were larger series, providing a greater chance of including patients with large numbers of personalities, occur, could skew the mean upward.

Possession was reported to be the major clinical manifestation of dissociative disorders in India (Adityanjee, Khandelval 1989). We had only one case in 63 patients whose history was typical for "demonic" possession.

Alcohol and substance abuse was reported to be frequent in American studies (Coons et al., 1988; Ross et al., 1989; Putnam et al., 1986). This was not true for our series. There may be two reasons. Our sample is younger, and there is a relatively lower ratio of substance abuse in Turkey, especially among women (Ozturk, O.M., 1993).

The occurrence of headaches in MPD has been reported by several investigators. Coons reported headache in 56% of the 50 MPD patients and Putnam reported 65% (Coons et al., 1988; Putnam, et al., 1986). The incidence of headache may have been over-represented in our study because of our close collaboration with the neurological clinic in our hospital. Headache was often worse either before or during and sometimes after the transition from one personality to another. This pattern is the same with the previous reports (Coons et al, 1988; Putnam, 1984).

It has been suggested that the dissociation in MPD is a manifestation of chronic limbic epilepsy or an interictal phenomenon of temporal lobe epilepsy (Mesulam, 1981; Schenk & Bear, 1981). (Coons, et al., 1988) reported 10% epilepsy in 50 MPD patients, and concluded that it is extremely unlikely that this hypothesis is accurate. It was also demonstrated that there is no etiological relationship between temporal lobe dysfunction and dissociation (Loewenstein & Putnam, 1988). In our series, there was only one patient with an abnormal EEG and she had not had any seizures. It would be unscientific and speculative to consider her three complex alter personalities with different social relationship patterns to be an ictal manifestation. Our data suggest that dissociative experiences in our patients did not have an epileptic origin.

The high incidence of childhood trauma in this study is consistent with the results of previous studies (Coons et al., 1988; Ross et al. 1989; Putnam et al., 1986). Coons reports 68% sexual abuse in 50 MPD patients, and this is more common than our findings (55%). But emotional abuse which was noted in 10% of the Coons study patients is more frequently reported (50%) in our patients. The childhood traumas in our series generally were not as brutal as the ones in American literature (Putnam, 1989; Ross, 1989b). We acknowledge that the lower incidence of trauma in our patients may be due to shorter duration of follow-up and in this series, with consequent incomplete exploration of their alter systems.

In our series 30% of MPD patients had a previous diagnosis of a psychotic disorder. Eleven of the patients had the first psychiatric consultation in their lives by the authors during this study. When we exclude these patients, having a previous diagnosis of a psychotic disorder rises to 66%. This figure confirms reports by other investigators that suggest that MPD is frequently misdiagnosed as schizophrenia (Coons et al., 1988; Ross et al. 1989; Putnam et al.,1986). The low number of previous psychiatric admissions is probably due to the less frequent utility of psychiatric facilities (especially for psychiatric disorders other than psychotic states) in Turkey. Half of the patients had consulted paramedical healers and prayers.

The high frequency of Schneiderian first-rank symptoms in MPD patients confirms that these symptoms are not specific for psychotic disorders. In our series the average number of Schneiderian symptoms per patient was 4.0 (range, 1 to 7). It was reported as 4.54 and 3.4 in two different previous studies (Ross et al., 1989, Kluft, 1987b). Ross reported that the most common Schneiderian symptoms in MPD patients are voices arguing (71.1%) and voices commenting (66.1%) (Ross et al., 1989). Auditory hallucination of commenting voices was the most common one in our series (95%). These were typically described as "inner voices" (Coons et al., 1988).

Patients' IQs in this study were found to range from borderline to superior and are consistent with results found previously (Coons et al., 1988).

MPD was proposed to have a familial tendency in previous studies (Ross et al., 1989; Putnam et al., 1986). Ross reported that the mean number of MPDs is 0.69 in the first degree relatives of 236 cases. In our series, four patients (20%) had DDNOS in their first degree relatives. Two of them were mothers, one was a sister, and the other was the daughter of a patient.

The mean DES score was 47.2, very close to the mean DES scores of MPD patients reported in other studies (Carlson & Putnam, 1993).

CONCLUSIONS

The present study has described the clinical phenomenology observed in 20 consecutive cases of MPD in Turkey. The clinical phenomena of the patients in our series are very similar to those reported from North America. This suggests that there is a stable set of core phenomena found in MPD patients across various cultures. This patient population is largely composed of female outpatients who reported histories of significant childhood trauma.

In many patients, pseudopsychosis ("hysterical psychosis"), although self-limited, did not occur only once in life, as considered earlier. It is usually a manifestation of a more chronic and complex dissociative disorder, MPD or DDNOS. These patients suffered from severe headaches and were mostly misdiagnosed as having psychotic disorder. ■

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