

DISSOCIATIVE IDENTITY DISORDER PRESENTING AS HYSTERICAL PSYCHOSIS

Hamdi Tutkun, M.D.
L. İlhan Yargic, M.D.
Vedat Sar, M.D.

Hamdi Tutkun, M.D., is a psychiatrist in private practice in Istanbul. During this project he was a resident at the Department of Psychiatry, Istanbul University Istanbul Medical Faculty, Istanbul. L. İlhan Yargic, M.D., is a psychiatrist and Coordinator of the Dissociative Disorders Program at the Department of Psychiatry, Istanbul University Istanbul Medical Faculty, Istanbul. Vedat Sar, M.D., is Professor of Psychiatry and Director of the Clinical Psychotherapy Unit & Dissociative Disorders Program at Department of Psychiatry, Istanbul University Istanbul Medical Faculty, Istanbul.

For reprints write Hamdi Tutkun, M.D., Istanbul Tıp Fakültesi Psikiyatri Kliniği, Capa TR-34390 Istanbul Turkey.

ABSTRACT

Dissociative identity disorder (DID), formerly known as multiple personality disorder (MPD), usually presents with associated symptoms rather than with the main features of the disorder. It is necessary for the clinician to keep it in mind as a diagnostic probability and to know its various presentations and associated symptoms in order to recognize it. We observed during long-term evaluation of four cases of hysterical psychosis (HP), that they had DID with long-term histories of dissociative symptoms. Patients applying for care who manifest a single dissociative symptom, a dissociative disorder, a severe acute dissociative syndrome with regressive features, or a dramatic and therapy-resistant conversion symptom should be evaluated for other dissociative symptoms and especially for their chronicity. In our experience, one presenting form of dissociative identity disorder is a hysterical psychosis, a type of crisis situation in the context of the longitudinal course of the dissociative identity disorder.

INTRODUCTION

Hysterical psychosis (HP) which has been defined as a form of hysteria, was a popular term in Europe and North America, early in this century. After a time of diminished interest in the psychiatric literature, Hollender and Hirsch (1964) revived the concept and formulated a descriptive definition. It has never been part of the standard nomenclature but it has lived on without official sanction (Hollender & Hirsch, 1964; Hirsch & Hollender, 1969; Mentzos, 1973; Öztürk & Gögüs, 1973; Spiegel & Fink, 1979; Cavenar, Sul-

livan, & Maltbie, 1979; Öztürk, 1981). The term is still in use, and papers about the subject continue to be published (Modestin & Bachman, 1992; van der Hart, Witztum, & Friedman, 1993; Öztürk, 1994). Books on the subject have also appeared (Maleval, 1981; Libbrecht, 1995).

From the descriptive standpoint, HP begins suddenly and dramatically (Hollender & Hirsch, 1964). The onset is temporally related to an event or circumstance which has been profoundly upsetting. The manifestations may take the form of hallucinations, delusions, depersonalization or grossly unusual behavior. Affectivity is not usually altered. If altered, it is in the direction of volatility but not flatness. Thought disorders, when they do occur, are generally circumscribed and transient. The acute episode in HP usually lasts one to three weeks. The process recedes as suddenly and dramatically as it began, leaving practically no residue, and, occasionally, with amnesia for the episode.

HP has been considered for a long time in the context described by Hollender and Hirsch (1964) and has been discussed from a psychoanalytic perspective. Various theories about the etiology and nature of HP have been proposed. These patients, mostly women, were described as very dramatic, histrionic, attention-seeking, and seductive in their behavior. The clinical picture of HP has been regarded as the endpoint of a continuum beginning with hysterical character. It has been considered as a disorder mostly seen in women with hysterical or histrionic personalities. An episode of HP has been considered as a simple or primitive type of wish fulfillment, a fantasy which may take a vivid and hallucinatory form in patients who have hysterical character structure. It has been thought that at times these patients become so frustrated, so angry, so frightened that they lose control and behave in a psychotic fashion without ever manifesting the kind of pervasive thought disorder or inappropriateness of schizophrenia (Hollender & Hirsch, 1964; Langness, 1967; Richman & White, 1970; Martin, 1971; Mentzos, 1973; Cavenar et al., 1979; Gift, Strauss, & Young, 1985; Modestin & Bachman, 1992).

Some papers which have tried to explain the psychodynamics and precipitating environmental stresses associated with HP, here suggested intrafamilial relationships and environmental stress (Richman & White, 1970), disturbed marriages (Martin, 1971), an unwelcomed or wished for but

not forthcoming sexual advance (Cavenar et al., 1979) and overadjustment to a restrictive environment (Öztürk & Gögüs, 1973; Öztürk, 1981) as etiological factors. Spiegel and Fink (1979) stated that HP patients are highly hypnotizable and in contrast to schizophrenics are curable with psychotherapy. Steingard and Frankel (1985) observed that certain highly hypnotizable persons are prone to experience transient but severe psychotic states.

Various forms of "hysterical neurosis" have long been appreciated to be common in Turkey (Öztürk & Volkan, 1971). Most clinicians in Turkey agree that there is also an entity best described as HP which is distinctly different from schizophrenic disorder (Öztürk & Gögüs, 1973; Öztürk, 1994). It has been a frequent diagnosis in Turkey, especially in emergency admission units of psychiatry clinics. According to a retrospective investigation of 227 consecutive patients hospitalized in the psychiatry clinic of the Hacettepe University (Ankara, Turkey) between 1970-1980, those diagnosed as having some form of "hysteria" constituted 6% of the whole inpatient population over that ten-year period. Of these, 7.8 were diagnosed as HP (Sar, 1983). According to a more recent report, 5.8 % of the whole patient population hospitalized in another university psychiatry clinic (Adana, Turkey) between 1985-1995 were diagnosed as HP (Özpoyraz et al., 1995).

The criteria in use for the differential diagnosis of HP in Turkey have been mainly in accordance with Hollender and Hirsch's descriptions (Öztürk & Gögüs, 1973; Öztürk, 1981; Öztürk, 1994). On the other hand, it has been appreciated in Turkey for a long time that many patients with the traditional diagnosis of hysteria (including HP) usually do not manifest histrionic personality features (Öztürk & Gögüs, 1973; Öztürk, 1981; Sar, 1983; Sar & Savasir, 1984; Öztürk, 1994; Sar, Yargic, & Tutkun, 1995). Öztürk and Gögüs (1973) pointed out, referring to Hollender and Hirsch (1964), that these patients usually have "an ability to accommodate readily to the expectations or requirements of others" which they called "uysal uyum" (complaisant overadjustment), unaccompanied, however, by histrionic features. Sar and Savasir (1984) linked this aspect to a history of multiple frustrations, negligent parents, and a restrictive family environment (Sar, 1983) and concluded, referring to Marmor (1950), that in Turkey hysteria is based rather on oral characteristics in personality than on oedipal conflicts. They did not put their conceptualization into today's trauma paradigm.

Van der Hart and his colleagues, reintroducing Janet and Breukink's forgotten works on HP and drawing upon their own experiences, put the concept of HP in a perspective different from that of Hollender and Hirsch's (van der Hart & Friedman, 1989; van der Hart & Spiegel, 1993; van der Hart et al., 1993). Van der Hart et al. (1993) quoted Janet, who said that for a psychosis to be hysterical, its dissociative nature should be established, as identified by the

following criteria: a) the psychosis is embedded in dissociative phenomena; b) the psychosis itself can be seen as a dissociated state; c) a splitting or doubling of the mind has occurred; d) subconscious phenomena are observed; and e) altered states of consciousness occur. Van der Hart and Spiegel (1993), reviewing the studies of Breukink (1860-1928), explained the usage of hypnosis in the differential diagnosis and treatment of trauma-induced HP. Van der Hart et al. (1993) emphasized the essential role of traumatically-induced dissociation in the genesis of reactive psychosis, and they proposed a new category of psychopathology, reactive dissociative psychosis, which integrates the classical features of HP with the most recent thinking on trauma-induced psychosis. Depending on the case presentations of HP in the literature and their own cases, they believe that the essential characteristic of HP is not its short duration but a dissociative foundation (Breuer, 1895; Janet, 1894; Hoek, 1868; Breukink, 1923; Hugenholtz, 1946; cf. van der Hart et al., 1993).

It has been well known in Turkish mainstream psychiatry that HP has a dissociative nature and, as such, it is qualitatively different from schizophrenic disorder (Öztürk & Gögüs, 1973). It has been considered as a "pseudopsychotic dissociation" (Öztürk & Gögüs, 1973; Öztürk, 1994) which does not indicate a need for neuroleptic drug treatment. Öztürk (1981, 1994) points out that it should be held separate from acute psychogenic psychosis and should rather be classified among dissociative disorders. Short-term hospitalization, supportive psychotherapy, and especially separation from a distressing family environment have been the most useful measures for the management of the disorder. Hypnosis has been avoided for a long time in Turkish mainstream psychiatry and has unfortunately never been used for the differential diagnosis and treatment of HP in Turkey. Although van der Hart and Spiegel (1993) considered hypnosis an effective tool for these purposes, it remains outside the mainstream of Turkish practice.

Dissociative identity disorder (DID), formerly known as multiple personality disorder (American Psychiatric Association, 1994) has followed a route rather parallel to HP throughout psychiatric history. Interest in it diminished during the early twentieth century but it became popular again beginning with the so-called neokraepelinian period after 1980. Previously, DID was little understood and thought to be quite unusual. Various standardized interview schedules (Ross, 1989a; Steinberg, Rounsaville, & Chicchetti, 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 DID is known to be more common than previously imagined (Ross, 1991). It is increasingly understood as a complex and chronic post-traumatic dissociative psychopathology often closely related to child abuse (Kluft, 1987a).

DID usually presents with associated symptoms rather

than with main features of the disorder. Therefore it is necessary for the clinician to keep it in mind as a diagnostic probability and to know its various presentations and associated symptoms in order to recognize it. Kluft (1987b) reported that DID patients can have many first-rank Schneiderian symptoms. The majority of DID patients experience auditory and/or visual hallucinations. These patients may appear to have profound thought disturbances and delusions. But DID patients do not show a true sustained thought disorder, such as is often found in schizophrenia (Putnam, 1989).

Some famous cases of hysteria, (e.g., Anna O. and Emmy von N.), who also manifested HP (Hollender & Hirsch, 1964), are now considered as having had chronic complex dissociative disorder (Ross, 1989b). Van der Hart and van der Velden (1987) stated about one of the first historical cases of HP, Rika van B., that "Janet (1909, 1910) would probably also have characterized Rika van B. as a double personality of the dominating somnambulism (somnambulisme dominante) type – in his view, the prototype of the multiple personality disorder." Van der Hart and Spiegel (1993) considered both HP and DID to be trauma-induced severe dissociative disorder. However, they did not mention a possible overlap between the two.

Our curiosity about DID started with our interest in HP. We observed that in some patients, HP was a transient manifestation of an underlying unrecognized chronic complex dissociative disorder, usually DID or DDNOS, according to the diagnostic criteria of *DSM-IV*. The current paper is the first indicating the overlap between HP and DID.

Indeed we detected our first DID case (Case 1 of this paper) among HP patients in 1992 during long-term evaluation after the acute picture had subsided. This observation gave way to the studies which led to the publication of the first case series from Turkey (Tutkun, Yargic, & Sar, 1995). Among our first consecutive 36 cases of DID patients, nine of them (25%) were diagnosed as HP in the emergency admission unit of our general psychiatry clinic (Yargic, Tutkun, Sar, & Zoroglu, 1995). We concluded that HP is one of the main causes of psychiatric admissions for DID patients in Turkey manifesting itself as an acute crisis situation in the context of the underlying chronic complex dissociative disorder. Here four cases are presented, which were referred to the clinic as HP and were diagnosed by our team as having DID concurrently after the HP had subsided.

In all these four cases the HP disappeared spontaneously or after supportive treatment in a few days and the patients said that they did not have any further complaints. However, detailed psychiatric examination for dissociative symptoms revealed that they had had amnesias, voices inside their heads, unexplained changes in behavior and affect, and feeling that there was someone else inside them. These experiences had waxed and waned over time for many years. The patients did not mention them spontaneously. Thus we could diagnose in these patients classical DID which

had been overlooked previously. One of them (Case 3) reached fusion between her alter personalities after two years of psychotherapy. The others dropped out for various reasons.

CASE PRESENTATIONS

Sema

Sema, a 15-year-old female high school student, was brought to the emergency unit of our general psychiatry clinic by her parents. She was laughing and crying inappropriately. She had horrific visual hallucinations. She said that she heard the voice of a man who threatened to kill her if she did not kill her parents. She was answering this voice loudly, sometimes tearfully, sometimes ironically. Her speech was childish and exaggerated. She was not oriented to time and place. She remembered nothing about herself except her name. Sometimes she attacked her parents physically. She had had several fainting fits, usually lasting a few minutes. Her symptoms started the day before admission, after a visit from her friends. She had been suffering decreased vision for three months. This had started gradually, and she became totally blind for 20 days. Detailed neurological and ophthalmological investigations had not revealed any physical cause. She had had similar symptoms intermittently for six months periodically after her brother's drowning when she was 11 years old.

Sema was hospitalized with the diagnosis of HP. Without any medication her symptoms, including blindness, suddenly disappeared two days later and she returned to her premorbid state. She was amnesic for this three-day period. Sudden and spontaneous remission of these acute dramatic symptoms supported our diagnosis of HP.

A few days later, Sema was sent home for the weekend. Upon her return she again suffered the symptoms she had previously had, except for the hysterical blindness. We thought that HP had recurred. The patient also said something that was very strange for us: She said that she had no name, and that she had just been born; she was illiterate and did not know the names of objects. Although we insisted that her name was Sema and she was 14 years old, she refused to believe us. During her hospitalization, she told us that her parents passed through the wall at night and beat her recurrently. She was hallucinating her parents, crying, and calling nurses for help at night. As the authors were on holiday, Sema was taken in hand by another team. The opinion of the possibility of a schizophreniform psychotic episode led this team to administer 15 mg of trifluoperazine per day. There was no improvement in three weeks. Meanwhile the authors returned and took back the responsibility of the patient. We insisted on our first diagnosis and decided to apply electroconvulsive therapy (ECT) which is considered, in Turkey, as the last choice of symptomatic treatment for HP, even if administered only a few times (Öztürk, 1994).

After only a single administration of ECT, Sema had returned to the premorbid state when she woke up. She was amnesic for her hospital stay and her previous symptoms. This observation also supported our diagnosis of HP.

Sema was brought back 12 hours after she was discharged, exhibiting symptoms similar to those of the previous episode. She did not remember her family members or her therapist. On each occasion, the recurrence of the symptoms had followed a fight with her father. During the third episode we realized that the patient had different attitudes towards her therapist, she introduced herself with different ages and character features, and she was sometimes amnesic regarding the previous interviews.

We considered that the diagnosis of HP alone was not enough to explain the clinical phenomenology of the patient. She reported paternal incest, physical abuse, and having witnessed the drowning of her brother. She had post-traumatic symptoms related to these events. During follow-up we met seven different alter personalities who had their own ways of thinking, relating to, and perceiving themselves and the environment. They were amnesic to each other. This young girl, the first diagnosed DID case in our clinic and the first reported in the Turkish psychiatric literature, remained in psychotherapy for 15 months. During this period manifestations related to different alters confirmed the diagnosis of DID. This first experience in Turkey ended with the patient's dropping out of treatment after stabilization, without integration of her alters. The astonishing similarity of this patient to those reported from North America led us to benefit from the long-term experiences published on the subject previously. This increased our awareness about and accelerated our clinical work on this area of study, formerly little known and practically ignored in our country.

Gülay

Gülay, a 20-year-old housewife, was brought to the emergency psychiatric unit. She was screaming, praying loudly, gesticulating chaotically, behaving violently towards people and objects around her, and hitting her head and fists against the wall. However, she became calm intermittently and subsided into a stupor. She had recurrent changes in her behavior, affect, and consciousness which lasted minutes to hours. She was not cooperative. She answered only some of our questions. She was not oriented to person, place, or time. She talked loudly to herself and laughed inappropriately as if there were other people talking to her. But her speech was incoherent, which suggested a thought disorder. She had visual and auditory hallucinations. Her husband said that she had begun to behave and talk like a man the day after her older brother went to military service, and she had later become uncontrollable. The patient received a sedative medication intramuscularly. When she woke up next morning she did not have any of these symptoms and remembered nothing about this episode. She said that the last things she

remembered were hearing a commanding male voice in her head and suffering a severe headache.

When the HP completely resolved and Gülay returned to "normal," we evaluated her for dissociative and related symptoms, and called her for weekly interviews. She had had pseudo-seizures of dissociative nature which started after a rape attempt when she was 13 years old. She had been diagnosed as having depression one month before she suffered the episode of HP, and was on antidepressant medication. She had attempted suicide several times and showed aggressive behavior episodically. She sometimes experienced depersonalization and derealization. Sometimes she could not remember recent events, short trips or conversations. She found herself doing something or talking to someone at different places, but could not remember how and when she went there. She said that she tried to hide her amnesia from other people. Once she experienced total amnesia for 55 minutes during an interview. Because she sometimes beat her own son claiming that he was a stranger, the patient's parents took care of the boy. Sometimes she disappeared for a day or all night long. When her husband questioned her, she could not remember where she had been. Sometimes she performed religious rituals strictly although she was not religious. Her husband was aware of her behavioral changes. Her EEG and neurological examination did not reveal any pathology. She said that there was someone else, named Hülya, inside her. She sometimes felt as if another body entered into her. She said that she felt as if she had two personalities.

During an interview, following a trance state for five to ten minutes, Gülay's affect, speech, and attitude changed and she introduced herself as Hülya. Hülya was not aware of where she was and did not recognize the therapist. She said that she had been separated from her husband and worked as a prostitute. Her address and the name of her child were different from Gülay's. Hülya said that Gülay was a nice, shy, honorable person and that she was bad, angry, and unhappy. She said that it was she who had done some of the things Gülay did not remember doing. Hülya appeared many times during following sessions. Gülay felt blank spells during these interviews.

The patient had seven more alter identities. She had had a chaotic family environment during childhood. Her father and older brother suffered from alcohol and substance abuse. She had been frequently beaten and confined to a small room by her father when she was a child. She suffered an attempted rape when she was 13 years old. The patient did not mention sexual molestation in the family but her husband reported that her father fondled her while he was drunk and the patient always tried to prevent her father from being alone with her younger sister. The patient dropped out after one year of therapy, but we saw her for a few more times in the emergency psychiatric unit with HP episodes.

Halime

Halime, a 45-year-old housewife, was brought to the emergency psychiatric unit by her cousin with the complaints of amnesia, headache, talking to herself, visual and auditory hallucinations, inappropriate laughing and crying, and talking childishly. Her symptoms had started suddenly when she found herself with the cousin in a hotel room partially amnesic for the previous night. She knocked her head against the wall in the emergency unit. She said that she had a severe headache and heard voices in her head which ordered her to kill herself, her husband, her older brother, and her aunt's husband. She saw her dead father in front of her. She claimed that her father controlled her. Sometimes she gazed at a point and talked to herself. She did not answer questions when in that state. Suddenly she became very joyful and was amnesic for the time and place and why she had come to the emergency psychiatric unit. After talking for a few minutes she began to cry and shake. She became disoriented again and fearfully said that there were insects on her. She was struggling as if she were trying to get rid of the insects. Then she calmed down and became amnesic to this and the rest of the interview. She did not know why she was there. She said she had enjoyed herself the previous night. Ten minutes later she began to cry and shake again. She screamed, "leave me, it aches very much." When she was asked, she said that she was six years old, in her aunt's house, and her uncle was doing bad things to her. Meanwhile she was tearing her clothes with one hand and trying to cover her body with her other hand.

These acute symptoms of visual hallucinations and command auditory hallucinations, rapid affective and behavioral changes, her believing she was controlled by her father, trance states, flash-backs lasted for six days, waxing and waning. When they resolved completely she remembered these six days only partially. The patient said that she had had a similar episode for two weeks, seven years ago.

Psychotherapy began once weekly. Twenty-one identities and personality fragments were identified. The host was a depressive person who suffered flashbacks of sexual abuse by her uncle when she was six years old (including vaginal penetration), by her two older brothers from nine to 12 (including anal penetration), being placed in an orphanage at age six, and various emotional and physical abuses. She was amnesic to the other personalities. "Happy" Halime liked traveling, dressing, went out for entertainment at nights, and did not worry about the childhood traumas. She had had two extramarital relationships about which the host was not aware. Halime also had alter personalities which considered themselves to be 16, 18, and 23 years old. They were amnesic to other personalities and each other. They had their own relatively enduring pattern of perceiving, relating to, and thinking about the environment and themselves. There were six child personalities which were formed during traumas, and two male persecutory alters.

Two identities had been formed from childhood imaginary playmates: "Pamuk Prenses" (Snow White) and "Kralice" (the Queen). They both enjoyed parties at nights where the Queen looked after, protected, and controlled the young "Pamuk Prenses" and enviously competed with her at the same time.

During the interviews different identities and personality fragments took full control spontaneously and they had various degrees of amnesia for one another's activities and different degrees of knowledge about one another. These identities also executed many aspects of the patient's life for which host was amnesic (e.g., extramarital relations, traveling to several places). This patient reached fusion after two years of psychotherapy including inpatient treatment of six months of total duration spread over these admissions. Post-fusion treatment of the patient is under progress.

Ipek

Ipek, a 21-year-old single female clerk, had been hospitalized and diagnosed as HP one year ago in our clinic by a team other than the authors'. From the charts it was learned that she had suddenly had auditory hallucinations which commanded her to harm herself and others, and to escape from her home. She talked to these voices. She also had a visual hallucination of a hanged man. Occasionally she became excited and tried to harm herself. After the complete remission of these acute symptoms in 20 days, she had amnesia for the episode. It was noteworthy that during her hospital stay, she usually remained in bed during the day complaining of anhedonia, weakness, and headache. However, it was noted that she sang and danced merrily in the evenings. She denied this behavior when questioned in the morning.

Ipek did not have psychiatric follow-up. The experiences with the three cases presented above led the authors to make contact with another three patients whom they knew to have had the same diagnosis before. Only Ipek accepted a follow up interview. She had had a similar episode six months before she was contacted and had been hospitalized in another institution. During the first interview she complained of headache, fainting, nightmares which frequently interrupted her sleep, nervousness, self mutilation, blank spells, voices inside her head, and seeing frightening images. She said that she felt as if there were someone inside her head, commanding her to hurt herself and commenting about her. She sometimes found herself in another part of the city and did not remember when and why she went there. Occasionally she had spells of complete amnesia for one to two hours and tried to hide them from others. She had profound depersonalization.

Ipek was interviewed ten times for follow-up. During this evaluation, three alter personalities were detected which were amnesic to each other. Although their names and ages were the same, their perception about themselves and the

environment, their life stories, their way of relating to others, affection, and make-up were different. Each personality had continuity in itself. Ipek-1 ("Calm Ipek") remembered herself from age five. She was silent, calm, benevolent, and religious; liked to stay home alone. She started to work when she was 12 years old and maintained her family economically. She did not have a boyfriend, and she did not drink or go outdoors at night. Her mother claimed that she returned home drunk late at night, but she did not remember anything about this. She also got phone calls from men she did not know. She said that she had been abused by her father starting at age five. Ipek-2 ("Cheerful Ipek") did not care about anything. She liked heavy make-up. She remembered herself from age nine on. She had several boy friends and liked to go to bars and to drink. Her friends in the market where she worked were different from Ipek-2's. She did not remember any childhood abuse. One day Ipek-3 ("Nervous Ipek") came to the interview amnesic to the therapist, to previous interviews, and to other alter personalities. She had come as the appointment was written on her notebook. She was rude and easily began fights. She was depressive and suicidal.

DISCUSSION

The initial clinical presentations of these cases fitted most of the criteria for HP proposed by Hollender and Hirsch (1964). Their dramatic and sudden onset, reactive nature, vivid hallucinations, exaggerated psychotic-like behavior, and the sudden termination of the episode with no residue suggested that these patients had HP. These cases were seen to have DID concurrently during follow up. Recurrent HP episodes of these patients and long lasting dissociative experiences and symptoms which were not reported spontaneously, but could be easily detected if evaluated, led us to conclude that HP can be a manifestation of a more chronic and complex dissociative disorder.

Clinical presentations of these four cases are very similar to those of Hoek's patient Rita van B., one of the first historical reports of HP (Hoek, 1868; cf. van der Hart et al., 1993). Their similarity to many other cases in the literature

TABLE 1
Main Clinical Features of the Cases

	Sema	Gülay	Halime	Ipek
Age	15	20	45	21
Onset	sudden	sudden	sudden	sudden
Life stress	+	+	+	+
Auditory/visual hallucinations	+/+	+/+	+/+	+/+
Delusions or thought disorder	+	+	-	-
Bizarre behavior	+	+	+	+
Affective lability	+	+	+	+
Duration of the acute episode (days)	3	2	6	20
Previous psychiatric admission	+	+	-	-
Amnesia for the episode	+	+	+/-	+
Childhood traumas*	1,2,5	1,2,4	1,2,3,4	2,4,5
# of alters	7	8	21	3

* Physical abuse (1); Sexual abuse (2); Emotional abuse (3); Neglect (4); Other traumas (5)

(Hollender & Hirsch, 1964; Ellenberger, 1970) suggests that the historical category of HP is still a living clinical entity. Various theoretical explanations for HP have been proposed over the century. In the light of the recent literature, the dissociative foundation and traumatic origins of HP have been well understood (van der Hart et al., 1993). This paper is the first one which mainly concerns the relation of HP to DID, which is the most severe form of dissociative disorder.

Although previous reports pointed to the dissociative nature of HP, the current study is the first one in which it is linked to the category of DID. We recognized that in some

patients, HP, although self-limited, did not occur only a few times in life, as considered earlier (Hollender & Hirsch, 1964). It is occasionally a manifestation of a more chronic and complex dissociative disorder (DID or DDNOS). We do not claim that HP is always embedded in a DID or DDNOS, but it is possible that HP points to a chronic, and perhaps subtle, dissociative disorder and to the existence of childhood traumatic experiences. This requires further study.

Hollender and Hirsch (1964) refer to an undated personal communication from Brill, who has described the thought disorders in HP, even though characterized at times by delusions, as rather simple distortions of reality, which disappear when emotional control is achieved, more like those seen in the very angry or fearful child than the more complex, autistic, and chronic thought disorders of the schizophrenic patient. We think that Brill's observation of the "very angry and fearful child" assumes a new meaning in today's perspective. This type of behavior and thinking appears to originate from flashbacks of childhood traumatic experiences, age regressions, and child alters in DID and DDNOS patients.

There are two different approaches to HP in literature. Hollender and Hirsch (1964) described HP depending only on clinical phenomenology. On the other hand, van der Hart et al. (1993), reviewing Hoek, Breukink, and Janet, emphasized the dissociative foundation and traumatic etiology of HP. Hollender and Hirsch's definition required a short duration of no longer than three weeks and emphasized amnesia for the episode. Van der Hart et al. (1993) argue against the criterion of short duration. Their own case had longer duration and did not have amnesia for the HP episode. Van der Hart et al.'s conception defines probably a broader category which includes the former. HP lasted less than three weeks in all of our cases, congruent with Hollender and Hirsch's description. Total or partial amnesia for the episode, and recurrent episodes of short duration in our cases could be a critical feature which points to the probability of a chronic complex dissociative disorder underlying the acute episodes of HP.

We believe that HP in DID patients is a result of decompensation after an acute stressful life event that leads to a struggle for control and influence among alter identities carrying frightening, fearful, aggressive or delusional features, some of whom may have been dormant for a long time previously. This condition has been described as a "revolving door crisis" by Putnam (1989) or as a crises of "co-consciousness" by Kluft (personal communication, 1995) without special emphasis on HP. In a DID patient controlled by the host personality most of the time and whose other alters are suppressed, diagnosing DID may be impossible. However, with a triggering stressful event this equilibrium disappears and forceful activities of many alters (and maybe formation of new alters as well) and severe dissociative symptoms and flashbacks may cause HP. So HP may also be a "diag-

nostic window" (Kluft, 1985) for DID.

As in the case of dissociative amnesia and fugue, HP can occur as a "symptom" during the course of DID, but it can also occur separately as a diagnostic entity of its own. Therefore, we do not consider HP simply as an epiphenomenon of DID. If HP is a condition with a dissociative foundation which develops under stressful circumstances, then the probability of developing it may be especially high in persons who have the most severe dissociative experiences, as in the case of DID.

DSM-IV lacks a category which corresponds to HP. We recommend the introduction of this category in classification systems among dissociative disorders and agree with van der Hart et al. (1993) on a new label as "reactive dissociative psychosis" (as former HP) which refers to its etiology and phenomenology more accurately. On the other hand, the development of studies on DID makes the reevaluation and redefinition of HP possible. The borders between HP, DID, and acute stress reaction should be redefined. This resolution, however, will require further prospective research investigating the relationship of HP to DID.

The category of HP is still used traditionally by clinicians who are aware of the difference between an acute schizophrenic episode and psychotic-like dissociative ("hysterical") syndromes but who are not familiar with DID and its incomplete forms (DDNOS). The concept of HP would be one of the starting points for recognition of DID in countries where professionals are more familiar with more traditional categories of mental disorders. ■

REFERENCES

- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.
- Bernstein, E.M., & Putnam, P.W. (1986). Development, reliability and validity of a dissociation scale. *Journal of Nervous and Mental Disease*, 174, 727-735.
- Cavenar, J.O. Jr., Sullivan, J.L., & Maltbie, A.A. (1979). A clinical note on hysterical psychosis. *American Journal of Psychiatry*, 136, 830-832.
- Ellenberger, H.F. (1970). *The discovery of the unconscious*. New York: Basic Books.
- Gift, T.E., Strauss, J.S., & Young, Y. (1985). Hysterical psychosis: An empirical approach. *American Journal of Psychiatry*, 142, 345-347.
- Hirsch, S.J., & Hollender, M.H. (1969). Hysterical psychosis: Clarification of the concept. *American Journal of Psychiatry*, 125, 909-915.

- Hollender, M.H., & Hirsch, S.J. (1964). Hysterical psychosis. *American Journal of Psychiatry*, 120, 1066-1074.
- Kluft, R.P. (1985). The natural history of multiple personality disorder. In R.P.Kluft (Ed.), *Childhood antecedents of multiple personality* (pp.197-238). Washington, DC: American Psychiatric Press.
- Kluft, R.P. (1987a). Multiple personality disorder: An update. *Hospital and Community Psychiatry*, 38, 363-373.
- Kluft, R.P. (1987b). First rank symptoms as a diagnostic clue to multiple personality disorder. *American Journal of Psychiatry*, 144, 293-298.
- Langness, L.L. (1967). Hysterical psychosis: The cross-cultural evidence. *American Journal of Psychiatry*, 124, 143-152.
- Libbrecht, K. (1995). *Hysterical psychosis: A historical survey*. New Brunswick/London: Transaction Publishers.
- Maleval, J.C. (1981). *Folies hystériques et psychoses dissociatives*. Paris: Payot.
- Marmor, J. (1953). Orality in the hysterical personality. *Journal of American Psychoanalytic Association*, 1, 656-671.
- Martin, P.A. (1971). Dynamic considerations of the hysterical psychosis. *American Journal of Psychiatry*, 128, 745-748.
- Mentzos, S. (1973). Zur psychodynamik der sogenannten "hysterischen" psychosen. *Nervenarzt*, 44, 285-291.
- Modestin, J., & Bachman, K.M. (1992). Is the diagnosis of the hysterical psychosis justified? Clinical study of hysterical psychosis, reactive/psychogenic psychosis, and schizophrenia. *Comprehensive Psychiatry*, 33, 17-24.
- Özpoyraz, N., Ugur, S., Ertürk, R., Evlice, Y.E., & Ünal, M. (1995). Kısa psikotik bozukluk: Geriye dönük bir değerlendirme (Brief psychotic disorder: A retrospective investigation). In *Proceedings of the 31th National Congress of Psychiatry-Turkey* (p. 18). Istanbul Turkish Neuropsychiatric Society.
- Öztürk, O.M. (1981). Histerik nevroz (hysterical neurosis). In O.M.Öztürk (Ed.), *Ruh sağlığı ve hastalıkları (Mental health and diseases)* (pp. 209-219). Ankara: Meteksan.
- Öztürk, O.M. (1994). Histerik psikoz (hysterical psychosis). In O.M.Öztürk (Ed.), *Ruh sağlığı ve bozuklukları (Mental health and disorders)* (pp. 301-302). Ankara: Sevinc Matbaası.
- Öztürk, O.M., & Gögüs, A. (1973). Ağır regresif belirtiler gösteren histerik psikozlar (Hysterical psychoses presenting with severe regressive symptoms). In: 9. Ulusal Psikiyatri ve Nörolojik Bilimler Kongresi Çalışmaları *Proceedings of the 9th National Congress of Psychiatry and Neurology-Turkey* (pp.155-164). Ankara: Meteksan.
- Öztürk, O.M., & Volkan, V.D. (1971). The theory and practice of psychiatry in Turkey. *American Journal of Psychotherapy*, 15, 240-271.
- Putnam, F.W. (1989). *Diagnosis and treatment of multiple personality disorder*. New York: Guilford Press.
- Richman, J., & White, H. (1970). A family view of hysterical psychosis. *American Journal of Psychiatry*, 127, 280-285.
- Ross, C.A. (1989a). The Dissociative Disorders Interview Schedule. In C.A.Ross (Ed.), *Multiple personality disorder: Diagnosis, clinical features and treatment* (pp. 313-334). New York: John Wiley & Sons.
- Ross, C.A. (1989b). *Multiple personality disorder: Diagnosis, clinical features and treatment*. New York: John Wiley & Sons.
- Ross, C.A. (1991). Epidemiology of multiple personality disorder and dissociation. *Psychiatric Clinics of North America*, 14, 503-517.
- Spiegel, D., & Fink, D. (1979). Hysterical psychosis and hypnotizability. *American Journal of Psychiatry*, 136, 777-781.
- Sar, I. (1983) 1970-1980 Yılları arasında. Hacettepe Üniversitesi Psikiyatri Kliniğine yatarak tedavi gören hastalardan "histeri" tanısı alanların değerlendirilmesi (A retrospective evaluation of inpatients diagnosed as "hysteria" in Hacettepe University Psychiatry Clinic between 1970-1980). Unpublished doctoral dissertation, Hacettepe University, Ankara, Turkey.
- Sar, I., & Savasir, Y. (1984). Histeride oralite ve Türk toplumundaki önemi (Orality in hysteria and its importance in Turkey). In *Proceedings of the 20th National Congress of Psychiatry and Neurological Science-Turkey* (p. 30). Bursa: Uludağ University.
- Sar, V., Yargic, L.I., & Tutkun, H. (1995). Current status of dissociative identity disorder in Turkey. In O. van der Hart, S. Boon, & N. Draijer (Eds.), *Proceedings of the Fifth Annual Spring Conference of the International Society for the Study of Dissociation* (p. 76). Amsterdam International Society for the Study of Dissociation.
- Steinberg, M., Rounsaville, B., & Chicchetti, D.V. (1990). A structured clinical interview for DSM-III-R dissociative disorders: Preliminary report on a new diagnostic instrument. *American Journal of Psychiatry*, 147, 76-82.
- Steingard, S., & Frankel, F.H. (1985). Dissociation and psychotic symptoms. *American Journal of Psychiatry*, 142, 953-955.
- Tutkun, H., Yargic L.I., & Sar, V. (1995). Dissociative identity disorder: A clinical investigation of 20 cases in Turkey. *DISSOCIATION*, 8, 3-10.
- Van der Hart, O., & Friedman, B. (1989). A reader's guide to Pierre Janet on dissociation: A neglected intellectual heritage. *DISSOCIATION*, 2, 3-16.

Van der Hart, O., & Spiegel, D. (1993). Hypnotic assessment and treatment of trauma-induced psychosis: The early psychotherapy of H. Breukink and modern views. *International Journal of Clinical and Experimental Hypnosis*, 41, 191-209.

Van der Hart, O., & van der Velden, K. (1987). The hypnotherapy of Dr. Andries Hoek: Uncovering hypnotherapy before Janet, Breuer, and Freud. *American Journal of Clinical Hypnosis*, 29, 264-271.

Van der Hart, O., Witztum, E., & Friedman, B. (1993). From hysterical psychosis to reactive dissociative psychosis. *Journal of Traumatic Stress*, 6, 43-64.

Yargic, L.I., Tutkun, H., Sar, V., & Zoroglu, S. (1995). Comparison of dissociative identity disorder in adolescents and adults. *Proceedings of the Fifth Annual Spring Conference of the International Society for the Study of Dissociation* (p. 64). Amsterdam International Society for the Study of Dissociation.