# Traumatization, Underrepresentation, and Identity Crises

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## INTRODUCTION

Dissociative identity disorder (DID) is the unfortunate result of defenseless individuals being subjected to traumatic childhood events such as emotional abuse, neglect, dysfunctional bonding styles, and physical torture. This illness is prevalent among 5% of psychiatric inpatients.[1,4] Borderline personality disorder (BPD) is manifested by maladaptive behaviors, including aggression, impulsivity, and volatile moods, usually associated with a prior history of childhood mistreatment and a hostile developmental environment. An estimated 15-20% of inpatients suffer from this condition.[2,3] BPD and DID are comorbid with each other; BPD is seen in 30-70% of patients with DID, and dissociative disorders have been detected in 41-72% of BPD patients. Thoughts and acts of self-harm and suicidality are features of both DID and BPD.[3]

## OBJECTIVES

- Review inpatient management of a patient who displayed characteristics of both DID and BPD along with features of PTSD and mood symptoms.
- Outline how DID and BPD manifest given overlapping diagnostic criteria.

## CASE PRESENTATION

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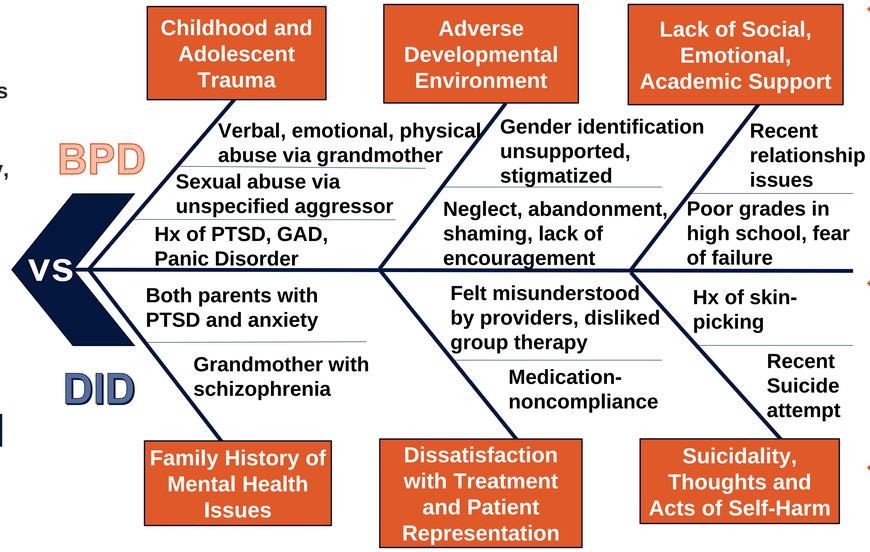
| HPI | 18-year-old African American transgender male presented to ED with suicide attempt via ingestion of 9 Sertraline pills |
| Past Psychiatric History | GAD, MDD, PTSD; completed PHP 12 days PTA; denied illicit drug or EtOH use; self-reported, "DID type OSDD1b" |
| Past Medications | Sertraline 100 mg qd, Hydroxyzine pamoate 10-20 mg BID prn, Mirtazapine 7.5 mg qhs prn |
| Mental Status Exam | A&O x 4; disheveled; bizarre affect; logical thought process; speech normal in rate and rhythm; thought content (+) for hearing alters/other identities; denied current suicidal and homicidal ideations; insight intact; judgment limited |
| Medical history/Labs | Iron deficiency anemia: Hgb 7.7 g/dL, Hct 28.9%, MCV 66.1 fl, TIBC 308 mcg/dL, Iron < 60 mcg/dL, Ferritin < 8 ng/mL |

## PATIENT-SPECIFIC ROOT CAUSE ANALYSIS




## INTERVENTIONS, HOSPITAL COURSE, RESULTS

### PRESENTATION ON DAY 1

Patient gave three distinct alters/identities. He also endorsed fluctuating moods with dissociative episodes and traumatic nightmares.

Plan:
- Aripiprazole 5 mg qd (mood)
- Sertraline 100 mg qd (MDE, PTSD)
- Prazosin 2 mg qhs (PTSD nightmares)
- Group therapy sessions

### PRESENTATION ON DAY 2

Patient reported an improvement in mood, denied nightmares, and denied reemergence of his alter identities or dissociation. He attended one group session and was medication-compliant. Adverse effects included mild nausea, blurry vision, and an episode of tinnitus upon awakening which resolved after a minute.

Continue same treatment + add Ferrous Sulfate for iron deficiency anemia

### PRESENTATION ON DAY 3

Patient denied suicidal ideations and thoughts of self harm; he was sleeping well with a fair appetite. He attended all groups and interacted appropriately with others. He denied hallucinations, paranoia, engaging with his alter identities, or dissociative episodes.

The patient was ready to be discharged home to follow-up at IOP along with scripts for Aripiprazole, Sertraline, and Prazosin.

## DISCUSSION AND TEACHING POINTS

- This patient's presentation offered a unique opportunity to holistically treat two distinct yet closely related disorders embedded in the roots of trauma and social despondency. Psychotropics were used to treat his mood symptoms, alternate identities, dissociative episodes, and trauma. Group psychotherapy sessions provided a supportive environment in which his boundaries and preferred pronouns were respected and acknowledged, and he was given an outlet to safely process his thoughts and emotions. He was also placed on suicide precautions and fifteen-minute safety checks by nursing staff to ensure his ongoing protection from self-harm.
- Challenges faced with this case include this patient's history of discontent with past providers who may have ignored or overlooked his DID symptoms, attributing them to features of depression or trauma. Ensuring comfort with his treatment plan, psychoeducation, and mindful rapport were of paramount importance to engage him in treatment and establish his compliance and adherence.
- Additional specific treatment approaches include Dialectical Behavioral Therapy to treat BPD and Eye Movement Desensitization and Reprocessing therapy for PTSD symptoms.

## CONCLUSION

BPD and DID are well-defined mental illnesses that require specific screening measures and treatments. If a patient presents with characteristics of either disorder, prompt use of appropriate diagnostic measures and treatments will help lower ongoing morbidity. Providers should be culturally sensitive and aware of patients' demographic profiles for holistic, effective treatment. Specialty follow-up may be necessary to improve health outcomes in those with DID and BPD.

## REFERENCES

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