Alpha Psychiatry

INVITED REVIEW
Alpha Psychiatry 2022;23(3):95-103
DOI: 10.5152/alphapsychiatry.2022.21556

Dissociation Across Cultures: A Transdiagnostic Guide for Clinical Assessment and Management

ABSTRACT

The clinical heterogeneity of dissociation constitutes a challenge to the culture-sensitive clinician. Variability in experiencing dissociation, the interplay between acute and chronic conditions, and the predominance of a nosologically interface-type of clinical surface conceal core dissociative symptoms. While the latter (amnesia, depersonalization, derealization, identity confusion, and identity alteration) usually remain underreported, the clinical surface may be dominated by acute (functional neurological symptoms, brief psychosis, an experience of possession, or acute dissociative reaction to a stressful event) or chronic (mood and personality disorders) secondary syndromes. However, these syndromes also constitute gateways in pursuing the clues of core dissociation. Given that culture influences communication between clinician and patient, accurate expression of mental content requires the idiomatic armamentarium describing the experience. The latter is problematic in dealing with phenomena of core dissociation while the secondary representations have a relatively universal character for both clinicians and patients. Nevertheless, this approach requires a transdiagnostic understanding in conceiving this clinical interface. This interface reflects, in fact, complications of dissociative disorders which require to be addressed in the first line. This is either due to the medical and psychiatric urgency (e.g., functional neurological symptoms, brief psychosis) or due to resistance to treatment (e.g., antidepressant pharmacotherapy) which seem to be indicated for the particular condition. This transdiagnostic schema is based on a combined utilization of etic and emic principles in the cultural understanding of psychiatric disorders. Namely, universal medical-psychiatric categories are conceived as tools of communication and mutual understanding rather than being mere appearances or primary disturbances.

Keywords: Dissociative disorders, psychological trauma, culture, psychopathology

Introduction

Closely related to experiences of stress and polysymptomatic character, dissociative disorders (DDs) constitute a culture-sensitive domain of psychiatry.[1] However, a lack of systematic knowledge about the modern understanding of DDs prevented clinicians in many countries from making specific diagnoses on this spectrum, before the introduction of their diagnostic criteria in DSM-III.[2] In fact, the DDs as described in the DSM-5 are not limited to certain cultures.[3]

One major challenge for culture-sensitive clinicians is the intrinsic nature of chronic dissociation to remain hidden. This is mainly due to the avoidance and denial of negative emotions (e.g., shame) and painful memories of a traumatic childhood.[4] Moreover, awareness of potentially traumatic impact of life events and relatively subtle types of developmental traumatization (e.g., insecure attachment and emotional neglect) may differ between cultures. Cultural and local sanctions against open communication and disclosure may also interfere with accurate reporting of developmental adversities, a factor which further boosts dissociation and DDs.

Given the mental avoidance inherent to dissociation, three aspects of clinical psychopathology are critical in better assessment of patients belonging to diverse areas of the world: the

Vedat Şar

Department of Psychiatry, Koç University School of Medicine, İstanbul, Turkey

Corresponding author:
Vedat Şar ✉ vsar@ku.edu.tr

Received: July 10, 2021
Accepted: August 10, 2021

Cite this article as: Şar V. Dissociation across cultures: a transdiagnostic guide for clinical assessment and management. *Alpha Psychiatry.* 2022;23(3):95-103.

variability in experiencing dissociation, the interplay between acute and chronic conditions, and the predominance of a nosologically interface-type of clinical surface which conceals core dissociative symptoms. The diversity in culturally shaped ways of expressing conflict, stress, and of coping further confounds this already existing heterogeneity.

From Possession to Personality State

A distinct personality state is a concept of modern psychiatry. However, possession is a description with long historical past and worldwide recognition. Possession syndromes are considered as the transient replacement of the individual's identity by one or more entities or source of power originating from the external world. Such agents may typically be a culturally accepted jinnie, spirit, demon, or the spirit of a deceased person or any entity of supranatural quality.[5] In fact, either in its lucid or its trance version, an experience of "being possessed" is present in all patients with "modern" cases of Western dissociative identity disorder (DID) or its subthreshold forms as well. However, rather than having external origin, this influence is perceived as a mental intrusion from within; that is, originating from a distinct personality state. Occasionally, "modern" cases may come up with a mixture of both phenomena.

From Secondary to the Core

Dissociative amnesia, depersonalization, derealization, identity confusion, and identity alteration are the core clinical symptoms of dissociation.[6] Studies conducted in diverse geographies have consistently demonstrated that these core symptoms do occur among patients with DDs from various cultures. However, several syndromes secondary to dissociation create a clinical surface which may hide the core dissociative psychopathology underneath.[7] In fact, secondary symptoms do not replace the core symptoms; they exist alongside them. Covering an unusually broad range of psychiatric phenomenology, syndromes secondary to DDs constitute a diagnostic challenge to the clinician due to their variability across patients and cultures. Moreover, almost all psychiatric disorders may be accompanied by dissociative symptoms.[8,9] In communities where information about DDs is not widespread, patients with DDs may not even be aware of the pathological quality of some of their dissociative experiences. They seek help when the DD has led to complications, in the form of secondary symptoms. These syndromes may remain resistant to treatment by interventions shaped for their primary forms, as the underlying dissociative psychopathology would not have been addressed then.

MAIN POINTS

- *As conditions related to traumatic stress, dissociative disorders are critically important for culture-sensitive psychiatry.*
- *Dissociation may cause disturbances of sense of self and altered states of consciousness.*
- *There is a discrepancy between clinical surface and core psychopathology in dissociative disorders.*
- *The clinical surface of dissociative disorders covers a broad spectrum of psychiatric nosology including mood, somatic symptoms, personality, and psychotic disorders.*
- *As an interface between various psychiatric conditions, dissociation represents transdiagnostic consequences of early-life stress.*

From Acute to Chronic

The early predominance of Western empirical research on chronic DDs such as DID and its subthreshold forms led to the impression that they were limited to North America, while acute-transient DDs were considered culture-bound and most prevalent in Asian and African continents. The more dramatic acute dissociative phenomena attract clinical attention more readily as they constitute medical and/or psychiatric emergencies, in particular when functional neurological symptoms (FNSs) or loss of control of behavior prevail. Recognition of chronic types of DDs is affected in particular due to the subtle nature of their core symptoms which may remain hidden behind the polysymptomatic "surface." However, these patients may enter intermittent crisis episodes, whose descriptions are dispersed across a large spectrum; for example, a suddenly emerging functional neurological symptom disorder (FNSD), a brief psychotic disorder, an acute dissociative reaction to stress, or an experience of possession. Such crisis episodes may serve as a "diagnostic window" for chronic DDs in diverse cultures because acute DDs are better-known than the chronic DDs worldwide. However, unless follow-up examinations are conducted, a preexisting and ongoing chronic dissociative process may remain dormant. Once the patient has calmed down and the urgent condition is over, the initial motivation to seek help may diminish despite the presence of subtle dissociative symptoms.

In this paper, clinical presentations of DDs are reviewed in consideration of these 3 perspectives. Six conditions have been chosen for this review as they challenge the widely accepted categories of the general psychiatric nosology. These presentations serve the clinician as gateways leading to the recognition of DDs in their patients. For the sake of clinical utility, these conditions have been presented according to their acute or chronic status.

Acute Presentations of Dissociative Disorders

Dissociation Presenting as a Functional Neurological Symptom Disorder: Clinicians of the nineteenth century (Charcot, Janet, Freud, and others) considered both psychological and somatic symptoms of dissociation under the concept of hysteria.[10] Indeed, a complete separation of somatic and psychological components of dissociation may not fit the clinical reality.[11] Patients diagnosed considering the psychological dissociation also have high scores on measures of somatic symptoms of dissociation, including nonepileptic seizures (i.e., pseudo seizures).[12] While several types of somatic symptoms and related disorders are also prevalent among patients with DDs, FNSD is the one most specifically related. Recognizing this close connection, the DSM-5 covers alteration of somatosensory functions in the diagnostic criteria of DID.[13]

Clinical Presentation: Patients with FNSD often apply to an emergency outpatient unit, considering the urgency of the situation due to its medical nature. Such symptoms may cover a very large spectrum; for example, fainting fits, muscle contractions, disturbances of gait, or blindness. Although FNSs may constitute a disorder on their own, they may also occur in a DSM-5 DD.[14,15] Reflecting this connection, in an epidemiological study among women in the general population in Turkey, presence of a DD was one of the predictors of having ever experienced at least one FNS.[16] In patients with a chronic DD, the superimposed FNSs may have a fluctuating course over time.[14] FNSD may also be part of an acute dissociative

reaction to a stressful event; for example, "ataque de nervios" seen in Latino cultures.[17]

Associated Symptoms: Patients with FNSD may enter transiently into stupor or trance and may report experiences of depersonalization and derealization during the attack. They may remain amnesic to the episode. A 2-year follow-up study on patients with FNSD in Turkey demonstrated that patients with a concurrent DSM-5 DD had an elevated number of general psychiatric comorbidity, childhood trauma history, and self-destructive behavior compared to those who did not have a DD.[18]

Geography: Compared to Western Europe and North America, the figures obtained in Turkey point to a strongly heightened prevalence of FNSD.[18] While a North American review estimated the prevalence rate of nonepileptic seizures as 1/3000 and 1/50 000, in Turkey, their lifetime prevalence was reported as 3.8% among women in the general population.[16,19] In another epidemiological study in Turkey, the prevalence of FNS was 5.6% equally for both genders.[20] In a semi-rural area of Turkey, the prevalence of FNSs in the preceding month was 27.2% and the lifetime prevalence was 48.2% among primary care outpatients.[21] FNSD was the most prevalent cause of admittance in a survey of consecutive admissions to a medical emergency center in Turkey over 1 year. Namely, FNSD was observed in 62.6% of women and 45.9% of men among applications due to a psychiatric reason.[22] The prevalence of fainting spells was 48.1%. In a comparison among patients with a chronic DD, nonepileptic seizures were seen more frequently in the Turkish than in the Dutch group.[23]

Assessment, Differential Diagnosis, and Management: Any neurological symptom requires a medical work-up to determine its functional nature. Besides other psychiatric comorbidities, the possibility of a concurrent acute or chronic DD should be evaluated. In Turkey, 30.5% of patients in a university psychiatric inpatient unit who were admitted due to a FNSD met the lifetime criteria for a DSM-IV DD.[15] The denial by these patients about anxiety-provoking traumatic mental content has led to the historical designation of "la belle indifference," which itself points to the dissociative nature of the condition. Psychoeducation about the potential course of the condition and possible relapse of somatic symptoms is necessary to prevent repetitive emergency department visits. Such orientation is also indicated for the relatives of the patient. Somatic symptoms may have induced fear both in the patient as well as in his or her social network, who may have denied the psychological origin of the problem. Beside events of traumatic scope, even mild levels of stress may be linked to FNSs, which underlines the importance of mediating factors including dissociation.

Dissociation Presenting as a Brief Psychotic Disorder

Culturally structured spontaneous trances that may be reactions to environmental stress and psychological trauma may cause functional psychoses.[24] Formerly called hysterical or dissociative psychosis, a brief psychotic disorder of dissociative origin is the most severe type of acute dissociative reaction to a stressful event.[25] Such an episode may also constitute a transient crisis superimposed on a chronic DD such as DID or its subthreshold forms.[26]

Clinical Presentation: In acute dissociative psychotic episodes, mixed dissociative symptoms may occur such as flashbacks; vivid visual and auditory hallucinations; child-like attitude; disorganized behavior; fugue; suicidal tendency; transient disturbances of reality testing; acute disorientation to person, place, and time, and affective instability. The condition may cease in a few hours or days, or may continue for a few weeks, sometimes ending as suddenly as it began, with no schizotypal residue. Amnesia of the episode may remain. A 3-year follow-up study in India reported that 68.3% of these patients had no further psychotic symptoms, 20% had further dissociative psychotic attacks, and 11.6% had episodes of FNSD.[27]

Associated Symptoms: When in an acute attack, the patient may enter into trance and possession states. Aggression against self or others and mystical experiences or excessive religious behavior (e.g., praying) may occur. Altered states of consciousness and amnesia may be observed. Rapid dissociative personality switches may resemble an organic mental disorder or disturbance of thought flow. Affectivity may be volatile but not flat. Thought disorders are generally circumscribed and transient. Unlike in other types of brief psychotic disorder, FNSs (e.g., nonepileptic seizures or fainting fits) are common.

Geography: Psychotic disorders with acute onset and brief duration which usually occur in response to a stressful event, show a higher prevalence in the developing world than in industrialized societies. A recent opinion paper on the DSM-5 underlined that stress-related brief psychotic disorder is common in India.[28] Among 4390 patients admitted to a psychiatric unit in India, 2% were diagnosed as having acute dissociative psychosis.[27] Compared to those with schizophrenia, these patients tended to be female and young (i.e., before age of 20). In a screening study among 1366 patients admitted to a general hospital in Kingdom of Saudi Arabia between 1988 and 1998, the prevalence of acute and transient psychotic disorders was 8.6%.[29] Most non-Arab expatriates were diagnosed as having acute and transient psychotic, stress-related, or dissociative disorders.

Assessment, Differential Diagnosis, and Management: A patient with brief dissociative psychosis usually presents as an emergency case. A schizophrenic disorder should be excluded on the basis of features such as flattened affect and other negative symptoms. For cases with an underlying DID, a careful observation may lead to recognition of a "revolving door crisis" (as described by Putnam) due to frequent switching between distinct personality states or a "co-consciousness crisis" (as described by Kluft, personal communication, 1995) due to temporary breakdown of dissociative barriers leading to flooding of the consciousness with trauma-related content.[30] Selected questions from the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) are helpful in determining the dissociative character of the episode.[6]

In an Indian study, 50% of a consecutively admitted patients with dissociative psychosis required hospitalization.[27] The condition typically begins to remit in a few days after the patient is hospitalized. Atypical and low-potency antipsychotics may be used in moderate doses, particularly for sedation. Anecdotal reports point to the option of cognitive–analytic psychotherapy which should address current interpersonal problems rather than past traumatic experiences.[31] Suicidality should be carefully assessed and monitored, so that the wrong decision of outpatient treatment is not made. After cessation of the acute episode, screening of chronic dissociative experiences may be helpful to detect an underlying chronic DD.

Dissociation Presenting as an Acute Reaction to a Stressful Event

An acute stress disorder in response to a traumatic experience has been a diagnostic category covering dissociative symptoms since its inception in DSM-IV. However, an adjustment disorder (a milder but longer-lasting form of reaction to stress of non-traumatic scope) with dissociative features has not been defined. The new DSM-5 category of acute dissociative reaction to a stressful event fills this gap in terms of mild severity of the stressor and response; however, unlike adjustment disorders overall, it is limited to conditions of less than 1 month duration.

Clinical Presentation: Acute dissociative reaction to a stressful event is characterized by one or more of the experiences such as depersonalization, derealization, anxiety, stupor, trance, and possession. A frightening experience, tension in a significant interpersonal relationship, an internal conflict challenged by an event, intense anger, or similar circumstances may lead to an acute dissociative reaction.

Associated Symptoms: FNSs, self-mutilation, suicidality, flashbacks, and dissociative amnesia with or without fugue may occur. An Indian study proposed "brief dissociative stupor" as a type of acute dissociative reaction.[32] These patients, mostly women, had significantly more comorbid psychiatric diagnoses and panic attacks. While the dissociative subtype of PTSD is characterized by experiences of depersonalization and/or derealization, FNSs and possession experiences (as a cultural equivalent of depersonalization and/or derealization) may accompany the condition as well.[33]

Geography: The lifetime prevalence of ataque de nervios, an acute transient anxiety episode with strong dissociative features, has been reported as 10.2% in a representative community study in Puerto Rico and as 52-55% in Puerto Rican psychiatric outpatients both in Puerto Rico and the northeastern United States.[17,34] Acute dissociative reaction to stress is expected to be most prevalent in mass trauma populations (refugees, natural disaster and terrorism victims) as well as populations under risk such as those in military and prison settings.

Assessment, Differential Diagnosis, and Management: An acute dissociative reaction to a stressful event has to be differentiated from acute stress disorder, PTSD, adjustment disorders, and chronic DDs such as DID and its subthreshold forms (i.e., other specified DDs or OSDDs). If present, details of the previous episodes may provide hints about vulnerabilities (e.g., possible precipitants of the current episode, if not reported yet) and the resiliency level of the patient. Unless comorbidity is present, such reactions require a supportive approach to assist the patient in grounding. Relatively persistent conditions may benefit from anxiolytics. Psychoeducation for the patient and for the relatives is helpful subsequent to the episode. Family conflicts are not uncommon. Treatment-resistant and repetitive episodes are suspect for comorbidity such as a chronic DD. Hypnotherapeutic interventions may be helpful in resolving a transient crisis superposed on a chronic DD.

Dissociation Presenting as an Experience of Possession

The DSM-5 includes presentations characterized by pathological possession in the diagnostic criteria of DID as a cultural variant of experiencing the disruption of identity.[6] They are distinguished by the experience of incorporation of an external identity rather than fragmentation of internal identity. Indeed, as shown both in Turkey and North America, a subgroup of patients with DID experience, alongside distinct personality states, the presence of possessing entities that cause an alteration in their sense of self and agency.[33,35]

In a Turkish study on women from the general population, possession states were associated with traumatic experiences of both childhood and adulthood.[33] They were related to DDs, depression, and PTSD as well. A North American study conducted in the general population also revealed a significant relationship between experiences of possession and childhood trauma.[36] Pathological possession cases in Uganda had significantly higher exposure to traumatic events than the randomly selected mentally healthy inhabitants of the same villages.[37] However, in accordance with the cultural perception of dissociative symptoms, the affected individuals subjectively did not associate dissociative symptoms with traumatizing events. Childhood trauma histories of women with somatization disorder from a non-industrialized region of eastern Turkey also did not correlate with dissociation but with experiences of possession.[38] Hence, in certain cultural contexts, an experience of possession may point to a traumatic antecedent better than "classical" dissociation.

Dissociative phenomena and experiences of possession are considered non-pathological if they are part of a broadly accepted cultural practice such as a religious ceremony. Culturally accepted incidents are not presented to an expert for treatment unless the affected person or his acquaintances become anxious or fearful due to the experience. These emotions may affect both the patient and his acquaintances as they may interpret this unwanted experience as an indicator of an unknown misconduct or sin or, alternatively, the experience of possession itself may violate or threaten a social code; for example, being invited to sexual relationship or even being "raped" by the "intruding entity" which may be associated with "loss of honor." As there is usually an ambiguity about the origin of such conditions among affected people, a medical person and/or a paramedical healer or a quasi-religious advisor may be approached with questions inquiring this; that is, whether the experience represents a medical-psychiatric condition or an influence by a supranatural entity which may be explained by religious conceptualizations.

Historically, experiences of trance possession have served as culturally accepted practices perceived as equivalent to modern psychotherapy. Paramedical or folk healers seen in some contemporary communities which are in cultural transition may be considered as an anachronistic sequela of such traditions. For example, Stambali, a Tunisian trance-dance practiced as a healing ritual against demonic possession, actually serves as a culturally accepted way of expressing anger.[39] Asian shamanism practices as seen in Nepal serve as rite of passage.[40] Protagonists of such practices cannot be diagnosed as having a DD unless they fit the diagnostic requirements of suffering subjective distress or psychosocial dysfunctionality due to these experiences.[41]

Possession is a strong belief system in the developing world for social factors such as isolation, educational deprivation, polyglotism, and lack of an adequate medical infrastructure. It also represents a need for hope. In such countries, possession, and the practice of exorcism, are not only an explanatory system based on superstition and

folklore but also a social structure that facilitates a first step from the community to the medical system.[42]

Clinical Presentation: In classical DID, the discontinuity in the sense of self and agency is usually accompanied by the experience of being possessed by an entity described as a personality state or an aspect of personality. Although an "alternate" personality state has more or less the quality of estrangement, it is never perceived as originating from an externally located power or source. Alternate personality states represent an individual reality for the affected person; however, possessing entities usually display a collective existence. For example, the same spirit may possess other individuals.[34]

Possession states themselves also show great diversity in developing countries such as Uganda and India.[43,44] In a prospective screening study on psychiatric outpatients in Jordan, the duration of the disorder was longer than 2 years for 53.1% of the patients.[45] The possessing agent (usually labeled as a Jinn) was usually reported by the patient as located in the body such as in the head and neck, chest, upper limbs, or multiple sites. It was perceived in auditory, visual, and/or somatic ways. The most common behavioral changes induced by a possessing agent were loss of control, abnormal movement, nonepileptic seizure, loss of consciousness, and change in tone of voice. The possessing agent may be perceived as male or female (including the opposite gender of the patient); 38% of the patients reported sexual intercourse with the possessing agent and 71.5% of the patients experienced psychosocial stress prior to the onset of their illness. Almost all patients visited a paramedical healer prior to their application to psychiatric treatment.

In a study in Uganda, illness stories described 2 different phases of spirit possession. Namely, passive influence experiences occurred first, and the actual possession states followed this.[37] Shaking movements, changes in consciousness, and talking in a voice attributed to spirits were fitting the DSM-5 DID criteria. Although not explicitly described in the diagnostic criteria of DID in DSM-5, hearing voices, strange dreams, and passive influence experiences, such as feeling influenced by external powers, were common. Possession by Zar spirits is characterized by involuntary movements such as nonepileptic seizures, mutism, and incomprehensible language.[46] In a series of young adults with Djinnati possession in Baluchistan (Iran), episodes of impaired consciousness and unresponsiveness to external stimuli were the chief complaints.[47] The patients were completely amnesic about the "attacks." Behaviors suggesting visual or auditory hallucinations, for example, looking scared and self talking; speaking in a changed voice, accent, or even language; and a change in identity were common. The new identity was strange both to the patients and their relatives. It was typically of the opposite gender, and presented itself as a djinnie. Psychomotor agitation with an urge for escape, often accompanied by screaming, were also common.

Associated Symptoms: In a review of 28 articles reporting 402 cases of patients with dissociative trance disorder worldwide, there were no significant differences in the prevalence between genders. Experiences of possession (69%) were predominant compared with trance (31%). Twenty percent of patients reported amnesia. Hallucinatory symptoms during possession episodes were found in 56% and somatic complaints in 34% of patients.[48] A screening study among women in the general population in Turkey demonstrated that the majority of the individuals who had an experience of possession also reported at least one paranormal experience such as precognition and contact or communication with non-human entities.[33] A factor analysis yielded 4 types: possession and/or contact with non-human entities, extrasensory communications, possession by human entities (dead or alive), and precognition. Most dissociative and traumatized women had the highest scores on all 4 factors. Extrasensory experiences and paranormal phenomena were related to DDs in an Israeli study as well.[49]

Geography: Possession syndromes are observed in certain geographic areas more commonly; for example, in the Middle East, India, and Africa. In many parts of India, health care is delivered through the practice of possession.[42] The prevalence of possession syndrome in rural India has been estimated at 0.97% (over 6 months) to 3.5% (over 1 year), depending on the region, sample, and method of assessment.[22] In Turkey, a screening study among women in the general population revealed a lifetime prevalence of 2.1%.[33] The significant majority (12 of 13) of these women had a DD. A systematic epidemiological and community-based study in South India documented a 1-year period prevalence of 3.7%, and 44.9% of the respondents in the study believed in spirit possession; 6.1% of outpatients and 6.7% of inpatients attending a tertiary referral psychiatric hospital were diagnosed to have DDs over a 10-year period; 11.5% of the outpatients had trance and possession disorder. Among inpatients, this rate was 5.3%. In a prospective screening study conducted on psychiatric outpatients in Jordan, possession syndrome was more prevalent among men than women, with a ratio of 1.6 : 1.[45] The belief in possession by Zar spirits is one of the most common possession phenomena in Africa and in other continents.[46]

Assessment, Differential Diagnosis, and Management: An experience of possession may occur in various ways: as a culturally accepted normative phenomenon, an acute dissociative reaction to a stressful event, or as part of a chronic DD. Although not described as such in the DSM-5, the dissociative subtype of PTSD (with depersonalization or derealization) may have also a cultural variant characterized by possession experiences.[33] A delusion of possession due to a psychotic disorder should be ruled out.[50]

In a review of 114 patients in 19 articles, psychotherapy was the most commonly used treatment (59%) which was helpful for most of the patients.[51] Nevertheless, the attribution of the stress experience to an external source rather than dealing with it as an individual process is a challenge.[52] Psychoeducation is the first step in the intervention. Acceptance of this subjective experience as a legitimate phenomenon by the therapist is important to prevent antagonism and rejection. The therapy should be navigated toward the pathogenesis of the stressful condition, such as facilitating reconciliation in a family to overcome unresolved anger and guilt in the patient.[53,54]

Attempts of "exorcism" ("removal of the possessing entity") have been reported as not being helpful in patients with DID.[55] Experiences of possession may lead to seeking help from paramedical or quasi-religious folk healers. Such unlicensed practices which usually focus on "removal of the possessing entity" may be harmful and abusive as they usually tend to reaffirm oppressive cultural norms rather than allowing the patients an avenue of expressing themselves. In some circumstances, it is reasonable for the modern therapist to work

within the client's belief system and culture-specific components of his or her illness, without necessarily endorsing the validity of such beliefs.[56] The strategic combination of culture-specific and modern psychiatric approach (e.g., joining the patient's explanatory model while adding cognitive-behavioral or hypnotic interventions) may lead to the best outcome in those situations.[57,58]

Chronic Presentations of Dissociative Disorders

Dissociation Presenting as a Mood Disorder

Most of the patients with a chronic DD suffer from a concurrent depressive disorder which tends also to be chronic.[59,60] While the frequent, even daily fluctuations of affect restrict the diagnosis to a dysthymic disorder, a superposed major depression episode ("double depression") may complicate the condition. The vast majority of the patients suffer from affect dysregulation. These daily changes in affectivity constitute almost a "dissociative mood disorder" which may be erroneously perceived as a "bipolar disorder."

Clinical Presentation: The age of onset of the depressive symptoms is unclear to vast majority of the patients. Clear-cut remission periods may not be identified either. The depressive mood of the patient may have an existential flavor. A study on Turkish women in the general population revealed that, compared to non-dissociative depression, those participants with concurrent depression and dissociation had thoughts of guilt and worthlessness, concentration difficulties, weight changes, and suicidal ideas more frequently.[60] Şar proposed the term of "dissociative depression" to differentiate such conditions from a primary depressive disorder.[59,60]

Associated Features: In the same epidemiological study, women with dissociative depression reported passive influence (including possession) in experiences resembling Schneiderian symptoms with borderline personality disorder (BPD) criteria and suicide attempts, more frequently than the non-dissociative depressive group. In a European study, depressive patients with a childhood trauma history in particular reported higher dissociation scores in the form of absorption and imaginative involvement.[61]

Geography: In cultures where self-expression and self-realization are rather restricted, dissociative depression may be more prevalent. The educational deprivation of girls as a predictor of dissociative depression in a semi-rural area of Turkey is such an example.[60] The prevalence of major depressive disorder accompanied by a DD was 4.1% among Turkish women in the general population.[60] A type of chronic depression due to dissociation is endemic in Japan (affecting more than one million individuals) and called "hikikomori" (social withdrawal).[62] Representing a chronic DD composed of only 2 personality states, this condition is characterized by sequestration of emotions (anger toward parents in particular) in a personality state ignored by the depleted "host" personality. In a series of 35 patients with hikikomori, 71% had high levels of dissociative symptoms in general, 26% had depersonalization, and 23% had dissociative amnesia.[63] In this series, 90% of the patients reported parental neglect in childhood. In a Korean study on firefighters, the relationship between posttraumatic stress symptoms and dissociation was mediated by depression.[64] In another Korean study on patients with a history of psychological trauma, depression alongside infrequency, hypomania, and hypochondriasis scales of the MMPI correctly discriminated 86.8% of the population with elevated dissociation scores.[65]

Assessment, Differential Diagnosis, and Management: To identify a dissociative depression, the clinician should first recognize the irregularity of the depressive mood. The onset of depressive symptoms is reported to be early in life, even in childhood. The irregularity of depressive mood may be both due to the subtle shifts between personality states as well as the affect dysregulation which characterizes patients with developmental traumatization in general.[66] The latter phenomenon should not be confused with cyclothymia or bipolar disorder. Namely, mood changes of the dissociative patient may occur instantly and may hold even only a few minutes if not hours. Patients may describe this as feeling "down" or "up" without any reason suddenly. These changes may also be triggered by external cues and also turn into anger or fear.

Such patients may be subsumed under the rubric of treatment-resistant depression and multiple attempts at treatment interventions may be exhausting for both the clinician and the patient. To prevent an eventual disappointment, the potential limits of drug treatment should be explained to the patient and attendance to psychotherapy should be encouraged, which should be extended beyond an episode of major depression. This is crucial to prevent loss of hope, which provokes suicidal ideas. Dissociation is one of the strongest predictors of multiple suicide attempts in the psychiatric outpatient population.[67] The reason of suicidality cannot be well-articulated by the patient. From a qualitative perspective, the immense feeling of being oppressed "from within" is usually accompanied by thoughts of death or suicidal ideas, whereas completed suicide is relatively uncommon unless the condition becomes complicated by a more pervasive major depressive episode.[59,68] The latter is characterized by the presence of depressive mood across a vast majority of distinct personality states of the patient and may be the main reason of psychiatric help-seeking due to the temporarily increased suffering. An episode of a pervasive major depression superposed to the DD and persistent dysthymia should not be overlooked and should be treated rather aggressively.

Dissociation Presenting as a Personality Disorder

While a DD may resemble or may be involved with any personality disorder, BPD is the one which has the most explicit relationship with DDs.[69,70] The DSM-5 criteria of BPD cover transient dissociative symptoms in response to a stressful event.[13] However, the scope of dissociation exceeds the boundaries of this criterion in many of these patients.[69-71] Subtle dissociative amnesias in these individuals may be difficult to identify by direct questions.[72] Identity alterations unrecognized by the clinician lead to a diagnosis of BPD rather than a DD.[73]

Clinical Presentation: Dissociative conditions resembling a personality disorder may apply by means of suicidality and self-mutilative behavior. Such appearances affect a relatively young population covering adolescence and young adulthood. Switching between personality states carrying different moods may be subtle; for example, relatively identical personality states differing in mood are not uncommon among dissociative children, adolescents, and young adults in particular.[73]

Associated Features: In patients having a condition resembling a personality disorder, dissociation is experienced in the interpersonal field as well, influencing the therapist–patient relationship immediately. Due to a prevailing insecure attachment pattern, striving to control the relationship and testing the reliability of the therapist are common. Personality states related to angry emotions may come forward frequently to control the relationship with the therapist. These patients usually suffer from unstable interpersonal relationships due to insecure attachment, mostly affecting intimacy and marriage.

Geography: In a college population in Turkey, 8.5 % of the students met the DSM-IV criteria of BPD, with 72.5% having a DD.[70] In China, the frequency of BPD among psychiatric outpatients was 5.8%, with a frequency of 3.5% among males and 7.5% among females.[74] In Turkey, this rate was 10.4%.[71] This study proves that BPD does occur in China; however, the detected frequency among outpatients is lower than that reported in North America and Turkey.

Assessment, Differential Diagnosis, and Management: Covert switching in a dissociative patient may be interpreted by the therapist merely as a transference-related reaction or acting-out, inspiring a BPD diagnosis. Many of these patients may be diagnosed with other specific DD rather than DID because the experience of separateness between personality states is not evident and dissociative amnesias are difficult to identify even if they have occurred.

A comparison between Turkish and Dutch patients with DID demonstrates great variability between 2 groups on the BPD criteria fitted. Turkish patients reported intense anger and lack of control over anger, chronic feelings of emptiness and boredom, and efforts to avoid abandonment frequently, whereas this was valid for frequent mood swings, physically self-damaging acts, identity confusion, and impulsive and unpredictable behavior among Dutch patients.[75] Among all criteria, only intense but unstable relationships did not differ between the 2 groups representing the universality of insecure attachment on this spectrum. The differences, however, seem to originate from diversity in developmental traumatization as well as culturally shaped perception of selfhood as a personal and/or interpersonal experience.

The blurred boundary between BPD and DDs is not only important for making the accurate diagnosis but it also may have implications for management of the condition. The clinician should be flexible in approaching such conditions before referring the patient to a treatment program strictly shaped for BPD, which a predominantly dissociative patient may not be able to adjust to unless modified accordingly.[76]

Conclusion

The heterogeneity on the clinical surface of DDs requires a clinician's skill to trace their core symptoms to arrive at an accurate diagnosis and treatment. While the core symptoms of dissociation may be difficult for patients to articulate, their consequences and complications are more easily described.[77] Thus, the culturally sensitive clinician should be able to pursue the traces of dissociation not only by a familiarity with the culturally shaped communication style of the patient but also through the lens of a fragmented nosological appearance. Rather than constituting a hindrance and source of confusion, the familiarity with the relationship between this nosological fragmentation and core dissociation may serve as a gateway to the well-informed clinician in grasping the truth behind the appearance, including the challenges of a cultural interface.

Peer Review: *Externally peer-reviewed.*

Conflict of Interest: *The author has no conflicts of interest to declare.*

Financial Disclosure: *The author declared that this study has received no financial support.*

References

1. Lewis-Fernandez R, Martinez-Taboas A, Şar V, Patel S, Boatin A. In: Wilson JP, So-Kum Tang CC, eds. *Cross-Cultural Assessment of Trauma and PTSD*. New York: Springer; 2007:279-317.
2. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 3rd ed. Washington, USA: American Psychiatric Press; 1980.
3. Şar V. Epidemiology of dissociative disorders: an overview. *Epidemiol Res Int*. 2011;2011:1-8. [CrossRef]
4. Kluft RP. Diagnosing dissociative identity disorder: understanding and assessing manifestations can help clinicians identify and treat patients more effectively. *Psychiatr Ann*. 2005;35(8):633-643. [CrossRef]
5. Somer E. In: Van der Merwe AP, Sinason V, eds. *Shattered but Unbroken: Voices of Triumph and Testimony*. London: Karnac Press; 2016:89-110.
6. Steinberg M. *Structured Clinical Interview for DSM-IV Dissociative Disorders-Revised (SCID-D)*. Washington, USA: American Psychiatric Press; 1994.
7. Şar V. The many faces of dissociation: opportunities for innovative research in psychiatry. *Clin Psychopharmacol Neurosci*. 2014;12(3):171-179. [CrossRef]
8. Lyssenko L, Schmahl C, Bockhacker L, et al. Dissociation in psychiatric disorders: a meta-analysis of studies using the dissociative experiences scale. *Am J Psychiatry*. 2018;175(1):37-46. [CrossRef]
9. Şar V, Ross CA. Dissociative disorders as a confounding factor in psychiatric research. *Psychiatr Clin North Am*. 2006;29(1):129-44. [CrossRef]
10. Ellenberger HF. *The Discovery of the Unconscious*. New York: Basic Books; 1970.
11. Brown RJ, Cardeña E, Nijenhuis ERS, Şar V, Van der Hart O. Should conversion disorder be re-classified as a dissociative disorder in DSM-V. *Psychosomatics*. 2007;48(5):369-378. [CrossRef]
12. Nijenhuis ER, van Dyck R, Spinhoven P, et al. Somatoform dissociation discriminates among diagnostic categories over and above general psychopathology. *Aust N Z J Psychiatry*. 1999;33(4):511-520. [CrossRef]
13. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Washington DC: American Psychiatric Press; 2013.
14. Şar V, Akyüz G, Kundakçi T, Kızıltan E, Doğan O. Childhood trauma, dissociation, and psychiatric comorbidity in patients with conversion disorder. *Am J Psychiatry*. 2004;161:2271-2276. [CrossRef]
15. Tezcan E, Atmaca M, Kuloglu M, et al. Dissociative disorders in Turkish inpatients with conversion disorder. *Compr Psychiatry*. 2003;44(4):324-330. [CrossRef]
16. Şar V, Akyüz G, Dogan O, Oztürk E. The prevalence of conversion symptoms in women from a general Turkish population. *Psychosomatics*. 2009;50(1):50-58. [CrossRef]
17. Lewis-Fernández R, Guarnaccia PJ, Patel S, Lizardi D, Diaz N. In: Georgiopoulos AM, Rosenbaum JF, eds. *Perspectives in Cross-Cultural Psychiatry*. Philadelphia: Lippincott Williams & Wilkins; 2005:62-85.

18. Martinez-Taboas A, Lewis-Fernandez R, Şar V. In: Schachter SC, La France C, eds. *Gates & Rowan's Nonepileptic Seizures*. 4th ed. New York: Cambridge University Press; 2018:137-149.
19. Benbadis SR, Allen Hauser W. An estimate of the prevalence of psychogenic non-epileptic seizures. *Seizure*. 2000;9(4):280-281. [CrossRef]
20. Deveci A, Taskin O, Dinc G, et al. Prevalence of pseudoneurologic conversion disorder in an urban community in Manisa, Turkey. *Soc Psychiatry Psychiatr Epidemiol*. 2007;42(11):857-864. [CrossRef]
21. Sagduyu A, Rezaki M, Kaplan I, Özgen G, Gürsoy-Rezaki B. Prevalence of dissociative (conversion) symptoms in a primary health care center. *Turk Psikiyatr Derg*. 1997;8:161-169.
22. Aker S, Boke O, Peksen Y. Evaluation of psychiatric disorders among admittances to (112) emergency services in Samsun—2004. *Anatol J Psychiatry*. 2006;7:211-217.
23. Şar V, Kundakci T, Kiziltan E, Bakım B, Bozkurt O. Differentiating dissociative disorders from other diagnostic groups through somatoform dissociation in Turkey. *J Trauma Dissoc*. 2000;1:67-80.
24. Castillo RJ. Trance, functional psychosis, and culture. *Psychiatry*. 2003;66(1):9-21. [CrossRef]
25. Van der Hart O, Witztum E, Friedman B. From hysterical psychosis to reactive dissociative psychosis. *J Trauma Stress*. 1993;6(1):43-64. [CrossRef]
26. Tutkun H, Yargic LI, Şar V. Dissociative identity disorder presenting as hysterical psychosis. *Dissociation*. 1996;9:244-252.
27. Kuruvilla K, Sitalakshmi N. Hysterical psychosis. *Indian J Psychiatry*. 1982;24(4):352-359.
28. Jacob KS, Kallivayalil RA, Mallik AK, et al. Diagnostic and Statistical Manual-5: position paper of the Indian Psychiatric Society. *Indian J Psychiatry*. 2013;55(1):12-30. [CrossRef]
29. Abumadini MS, Rahim SI. Psychiatric admission in a general hospital. Patients profile and patterns of service utilization over a decade. *Neurosciences*. 2002;7(1):36-42.
30. Putnam FW. *Diagnosis and Treatment of Multiple Personality Disorder*. New York: Guilford Press; 1989.
31. Graham C, Thavasotby R. Dissociative psychosis: an atypical presentation and response to cognitive-analytic therapy. *Ir J Psychol Med*. 1995;12(3):109-111. [CrossRef]
32. Alexander PJ, Joseph S, Das A. Limited utility of ICD-10 and DSM-IV classification of dissociative and conversion disorders in India. *Acta Psychiatr Scand*. 1997;95(3):177-182. [CrossRef]
33. Şar V, Alioğlu F, Akyüz G. Experiences of possession and paranormal phenomena among women in the general population: are they related to traumatic stress and dissociation? *J Trauma Dissociation*. 2014;15(3):303-318. [CrossRef]
34. Lewis-Fernández R. In: Spiegel D , ed. *Dissociation: Culture, Mind, and Body*. Washington, DC: American Psychiatric Press; 1994:123-167.
35. Ross CA. Possession experiences in dissociative identity disorder: a preliminary study. *J Trauma Dissociation*. 2011;12(4):393-400. [CrossRef]
36. Ross CA, Joshi S. Paranormal experiences in the general population. *J Nerv Ment Dis*. 1992;180:357-361. [CrossRef]
37. van Duijl M, Nijenhuis E, Komproe IH, Gernaat HBPE, de Jong JT. Dissociative symptoms and reported trauma among patients with spirit possession and matched healthy controls in Uganda. *Cult Med Psychiatry*. 2010;34(2):380-400. [CrossRef]
38. Taycan O, Şar V, Çelik C, Erdoğan-Taycan S. Trauma-related psychiatric comorbidity of somatization disorder among women in Eastern Turkey. *Compr Psychiatry*. 2014;55(8):1837-1846. [CrossRef]
39. Somer E, Saadon M. Stambali: dissociative possession and trance in a Tunisian healing dance. *Transcult Psychiatry*. 2000;37(4):581-602.
40. Peters LG. Trance, initiation, and psychotherapy in Tamang shamanism. *Am Ethnol*. 1982;9(1):21-46. [CrossRef]
41. Delmonte R, Lucchetti G, Moreira-Almeida A, Farias M. Can the DSM-5 differentiate between nonpathological possession and dissociative identity disorder? A case study from an Afro-Brazilian religion. *J Trauma Dissociation*. 2016;17(3):322-337. [CrossRef]
42. Brockman R. Possession and medicine in South Central India. *J Appl Psychoanal Stud*. 2000;2(3):299-312. [CrossRef]
43. Van Duijl M, Cardeña E, De Jong JT. The validity of DSM-IV dissociative disorders categories in South-West Uganda. *Transcult Psychiatry*. 2005;42(2):219-241. [CrossRef]
44. Venkataramaiah V, Mallikarjunaiah M, Chandrasekhar CR, Rao CK, Reddy GN. Possession syndrome: an epidemiological study in West Karnataka. *Indian J Psychiatry*. 1981;23(3):213-218.
45. Bayer RS, Shunaigat WM. Sociodemographic and clinical characteristics of possessive disorder in Jordan. *Neurosciences*. 2002;7(1):46-49.
46. Witztum E, Grisaru N, Budowski D. The "Zar" possession syndrome among Ethiopian immigrants to Israel:cultural and clinical aspects. *Br J Med Psychol*. 1996;69(3):207-225. [CrossRef]
47. Kianpoor M, Rhoades GFJ. "Djinnati," a possession state in Ballooshistan, İran. *J Trauma Pract*. 2005;4:147-155.
48. During EH, Elahi FM, Taieb O, Moro MR, Baubet T. A critical review of dissociative trance and possession disorders: etiological, diagnostic, therapeutic, and nosological issues. *Can J Psychiatry*. 2011;56(4):235-242. [CrossRef]
49. Somer E, Ross CA, Kirshberg R, Bakri RS, Ismail S. Dissociative disorders and possession experiences in İsrael:a comparison of opiate use disorder patients, Arab women subjected to domestic violence, and a nonclinical group. *Transcult Psychiatry*. 2015;52(1):58-73. [CrossRef]
50. Kundakçi T, Sar V, Kiziltan E, Yargıç Lİ, Tutkun H. Reliability and validity of the Turkish version of the structured clinical interview for DSM-IV dissociative disorders (SCID-D): a preliminary study. *J Trauma Dissoc*. 2014;15:67-80.
51. Suprakash C, Kumar S, Kumar S, Kiran C. Dissociative trance disorder: a clinical enigma. *Unique J Dent Sci*. 2013;1:12-22.
52. Bilu Y. *Dybbuk possession and mechanisms of internalization and externalization: a case study*. In: Sandler, J., ed. Projection, Identification, Projective Identification. London: Karnac Books; 1988:163-178.
53. Al-Krenawi A, Graham JR. Spirit possession and exorcism in the treatment of a Bedouin psychiatric patient. *Clin Soc Work J*. 1997;25(2):211-222. [CrossRef]
54. Ferracuti S, Sacco R, Lazzari R. Dissociative trance disorder: clinical and Rorschach findings in ten persons reporting demon possession and treated by exorcism. *J Pers Assess*. 1996;66(3):525-539. [CrossRef]
55. Bowman ES. Clinical and spiritual effects of exorcism in fifteen patients with multiple personality disorder. *Dissociation*. 1993;6:222-238.
56. Martínez-Taboas A. The plural world of culturally sensitive psychotherapy. A response to Castro-Blanco's (2005) comments. *Psychother Theor Res Pract Train*. 2005;42(1):17-19. [CrossRef]
57. Daie N, Witztum E, Mark M, Rabinowitz S. The belief in the transmigration of souls: psychotherapy of a Druze patient with severe anxiety reaction. *Br J Med Psychol*. 1992;65(2):119-130. [CrossRef]
58. Martínez-Taboas A. A case of spirit possession and glossolalia. *Cult Med Psychiatry*. 1999;23(3):333-348. [CrossRef]
59. Şar V. Dissociative depression: a common cause of treatment resistance. In: Renner W., ed. *Female Turkish Migrants with Recurrent Depression*. Innsbruck: Studia; 2011:112-124.
60. Şar V, Akyüz G, Oztürk E, Alioğlu F. Dissociative depression among women in the community. *J Trauma Dissociation*. 2013;14(4):423-438. [CrossRef]
61. Serrano-Molina A, Linotte S, Amat M, Soueri D. Dissociation in major depressive disorder:a pilot study. *J Trauma Dissoc*. 2008;9:411-421.
62. Kato TA, Shinfuku N, Sartorius N, Kanba S. Are Japan's hikikomori and depression in young people spreading abroad? *Lancet*. 2011;378(9796):1070. [CrossRef]
63. Hattori Y. Social withdrawal in Japanese youth: a case study of thirty-five hikikomori clients. *J Trauma Pract*. 2006;4(3-4):181-201. [CrossRef]
64. Kwon TH, Hyun SY, Chung YK, et al. Depression as a mediator of the relationship between resilience and posttraumatic stress symptoms and dissociation in firefighters. *Korean J Psychosom Med*. 2016;24:109-116.

65. Kong SS, Bae JH. Discriminating power of dissociation in patients with psychological trauma. *J Korean Acad Psychiatr Ment Health Nurs*. 2014;23(3):125-134. [CrossRef]
66. Briere J, Hodges M, Godbout N. Traumatic stress, affect dysregulation, and dysfunctional avoidance: a structural equation model. *J Trauma Stress*. 2010;23(6):767-774. [CrossRef]
67. Foote B, Smolin Y, Neft DI, Lipschitz D. Dissociative disorders and suicidality in psychiatric outpatients. *J Nerv Ment Dis*. 2008;196(1):29-36. [CrossRef]
68. Kluft RP. Six completed suicides in dissociative identity disorder patients: clinical observations. *Dissociation*. 1995;8:104-111.
69. Şar V, Akyuz G, Kugu N, Öztürk E, Ertem-Vehid H. Axis I dissociative disorder comorbidity in borderline personality disorder and reports of childhood trauma. *J Clin Psychiatry*. 2006;67(10):1583-1590. [CrossRef]
70. Şar V, Kundakci T, Kiziltan E, et al. Axis I dissociative disorder comorbidity of borderline personality disorder among psychiatric outpatients. *J Trauma Dissoc*. 2003;4(1):119-136. [CrossRef]
71. Ross CA. Borderline personality disorder and dissociation. *J Trauma Dissociation*. 2007;8(1):71-80. [CrossRef]
72. Şar V, Alioğlu F, Akyuz G, Karabulut S. Dissociative amnesia in dissociative disorders and borderline personality disorder: self-rating assessment in a college population. *J Trauma Dissociation*. 2014;15(4):477-493. [CrossRef]
73. Şar V, Alioğlu F, Akyüz G, et al. Awareness of identity alteration and diagnostic preference between borderline personality disorder and dissociative disorders. *J Trauma Dissociation*. 2017;18(5):693-709. [CrossRef]
74. Wang L, Ross CA, Zhang T, et al. Frequency of borderline personality disorder among psychiatric outpatients in Shanghai. *J Pers Disord*. 2012;26(3):393-401. [CrossRef]
75. Şar V, Yargiç LI, Tutkun H. Structured interview data on 35 cases of dissociative identity disorder in Turkey. *Am J Psychiatry*. 1996;153(10):1329-1333. [CrossRef]
76. Foote B, van Orden K. Adapting dialectical behavior therapy for the treatment of dissociative identity disorder. *Am J Psychother*. 2016;70(4):343-364. [CrossRef]
77. Lewis-Fernández R, Gorritz M, Raggio GA, et al. Association of trauma-related disorders and dissociation with four idioms of distress among Latino psychiatric outpatients. *Cult Med Psychiatry*. 2010;34(2):219-243. [CrossRef]