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Case Report

Partial dissociative identity disorder and gender incongruence: a case report

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Abstract

Introduction: Gender incongruence (GI) is characterized by a marked and persistent incongruence between an individual's experienced gender and assigned sex, which often leads to a desire to "transition" and a demand for medical treatments. Dissociative identity disorder and partial dissociative identity disorder (PDID) are poorly known mental disorders whose clinical presentation can be confused with GI.

Aims: To provide a case report of a patient with PDID and GI who required treatment for GI.

Methods: A case report and follow-up were described.

Results: The case report describes a person suffering from PDID and GI and asked for hormonal treatment for GI. In view of the complexity of the case, it was decided to start a follow-up to investigate the gender experience of the different personalities. After 4 months of follow-up, the symptomatology changed, and the patient waived treatment for GI and continued psychotherapeutic treatment for PDID.

Conclusion: Our case report shows the complexity of providing treatment for patient with PDID and GI.

Keywords: gender incongruence; dissociative identity disorder; hormonal treatment; gender affirming medical and/or surgical treatment.

Introduction

Gender incongruence (GI) is characterized by a marked and persistent incongruence between an individual's experienced gender and the assigned sex. This often leads to a desire to "transition" to live and be accepted as a person of the experienced gender through gender-affirming hormonal treatment, gender-affirming surgery, or other health care services to make the individual's body align—as much as desired and to the extent possible—with the experienced gender.[1] GI prevalence is estimated at 0.02% to 0.1%.[2] The goal of gender-affirming hormonal treatment is to induce changes in secondary sexual characteristics, generally by using estrogen with an androgen-lowering medication or testosterone. Gender-affirming surgery refers to different procedures designed to align a person's body with one's gender identity, such as vaginoplasty, phalloplasty breast surgery, and facial surgery. These treatments decrease GI and improve quality of life.[2]

The World Professional Association for Transgender Health's standards of care indicate that before one starts gender-affirming medical and/or surgical treatment (GAMST), mental health conditions that may explain the apparent GI must be identified and excluded.[2] Some authors emphasize the importance of considering dissociative disorders when making a differential diagnosis of GI, particularly dissociative identity disorder (DID).[3]

DID is characterized by disruption of identity in which there are ≥2 distinct personality states associated with marked discontinuities in the sense of self and agency. Each personality state includes its own pattern of experiencing, perceiving, conceiving, and relating to self, the body, and the environment. At least 2 distinct personality states recurrently take executive control of the individual's consciousness and functioning in interacting with others or with the environment. There are typically episodes of amnesia.[4] Unlike DID, in partial DID (PDID), there are no episodes of amnesia, and generally 1 personality state is dominant and normally functions in daily life but is intruded on by ≥1 nondominant personality states. The nondominant personality states do not recurrently take executive control of the individual's consciousness and functioning, but there may be occasional and limited episodes in which a distinct personality state assumes executive control.[4] DID prevalence is estimated to be 1% to 3%, and there are no prevalence estimations for PDID.[5] Psychotherapy is the treatment of choice for these syndromes.[5]

Our case report describes the assessment and management of a patient with PDID and GI who asked for GAMST. The goal of this article is to inform clinicians working with patients who ask for GAMST of the possible existence of a rare case of DID or PDID and to inform them of the complexity of providing treatment for these patients.

Case report

A 25-year-old healthy single man referred himself to the Sexology Unit for GI with a request for feminizing hormone therapy (FHT). The patient provided written informed consent. He described suffering for 5 months from an identity disturbance characterized by several distinct personalities, with different

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gender identities (3 males and 4 females) without memory gaps. He explained that 1 of the female personalities, 1 month after discovering his dissociative disorder, could not tolerate the male body, in which she felt incongruent with her female gender identity and wished to undertake FHT to feminize it.

The Dissociative Experience Scale[6] showed a score of 43.21 in December 2021. At the end of the assessment, 2 concurrent diagnoses were retained: PDID and GI. The diagnosis of PDID was retained since the patient described symptoms consistent with DID. However, the diagnosis of DID could not be retained because of the absence of memory gaps. The diagnosis of GI was retained since 1 of the female personalities described symptoms typical of GI.

In view of the complexity of the case, it was decided to start a 6-month psychotherapeutic treatment. In the beginning, treatment focused on offering support and giving information about the effects and potential side effects of GAMST. This was followed by an exploration and a clarification of the experience that the different personalities had of the male body and how they imagined their body experience after the GAMST. Finally, there was an exploration of the function of the personality-splitting mechanism and the possibility that forgotten traumatic events had generated it.

At about 4 months of treatment, the different personalities seemed to have agreed on the project of feminizing the body. Even the male personalities had come to the conclusion that FHT would have brought an overall well-being to all personalities. The therapist also considered proposing FHT following the 6 months of treatment.

But after 4 months of psychotherapy, the patient began to have a vague memory of having been sexually abused as a child. This awareness, despite being vague, had a major impact on the symptomatology and led to a decrease in the intensity of the dissociative symptoms. In July 2022, the Dissociative Experience Scale score was 34.28. In addition, the GI disappeared. The patient gave up his project for FHT, realizing that the feminization of the body could not bring him well-being, as the male personalities would have experienced this negatively. Moreover, he was no longer willing to accept the health risks of FHT and the social difficulties that he might have experienced in making a social transition.

Discussion

This case report shows the complexity of a mental health assessment following a request for GAMST in patients with PDID or DID.

The scientific literature on this subject is poor; the few articles are usually case reports.[3] A few articles show a prevalence of DID in GI cases ranging from 0% to 1.5%: a rate that is not significantly higher than that of the standard population, which is 1% to 3%.[3] Other case reports highlight 2 problems: the difficulty of making a differential diagnosis between GI and DID and the difficulty of treating people with GI and DID at the same time.[3]

Our case can be understood to be at the border of these 2 problems, since the 2 syndromes had coexisted for approximately 12 months. After 6 months of psychotherapy, the decrease of the dissociative symptomatology led to the disappearance of the GI. We therefore concluded that the apparent GI was part of the PDID symptomatology. Our understanding of the change in symptomatology, which was co-constructed with the patient, was that with the recollection of the memories of the abuse, the amnestic function of the personality splitting was no longer needed. As a consequence, this decrease in the need for personality splitting reduced the presence of the different personalities, including the female ones. This made the GI disappear.

Regarding the difficulty of making a differential diagnosis between GI and DID, there are 2 case reports in the literature in which there was a misdiagnosis. These were patients with DID who requested treatment for GI. The diagnosis of GI was made, and an individual treatment plan for GI and care planning was set up. However, 1 of the 2 patients was hospitalized for a depressive reaction with suicidal ideation, and the other was incarcerated following the murder of a woman. Only after hospitalization and incarceration was the diagnosis of GI changed to DID. The authors hypothesized that the depression and murder were related to the tension among the gendered personalities as a result of the misdiagnosis and proposed treatment for GI.[3] Other case reports describe patients who sought treatment for GI, but the diagnosis of DID was withheld; instead of treatment for GI, psychotherapeutic follow-up for DID was offered, which was beneficial.[3]

Concerning the difficulty of treating patients who were concerned with the comorbidity between GI and DID, in 1 case report[7] there was a decrease in GI with gender-affirming hormonal treatment; in another[8] the emergence of GI in the other personalities was described following gender-affirming surgery. In the other case reports, tension remained among the personalities of different genders regarding the gender-affirming surgery.[3]

Furthermore, as stressed by the International Society for the Study of Trauma and Dissociation,[5] it is difficult to diagnose DID because of a lack of information among clinicians about dissociative disorders. When this happens, the undiagnosed patient with DID may undergo a long and frequently unsuccessful treatment for other conditions, such as posttraumatic stress disorder, depression, panic attacks, substance abuse, and eating-disordered symptoms.

Returning to our case report, in light of what we have learned from these articles in the literature, we can wonder about what would have happened if we had given FHT to this patient without psychotherapeutic treatment. We can speculate that at a certain time, the patient would have eventually had memories of the sexual abuse that led to the disappearance of his GI and asked to stop the FHT. However, we can speculate that experiencing FHT might have reinforced his feeling that it was the right option for him. This could have increased the tension among the different personalities with negative consequences for his mental health. The other personalities could have also developed GI.

Regarding the difficulties in making the differential diagnosis between GI and DID, some authors have stressed that patients with DID may frequently experience bewilderment or confusion in their gender identity and in body sex characteristics. They suggest, however, that these patients describe a global identity disturbance, unlike patients with GI, who focus more on the GI.[9] Further difficulty in the assessment of DID in patients asking for treatments for GI is that GI is usually a self-diagnosis and DID is frequently a delayed diagnosis. Patients with DID frequently hide their symptoms; therefore, these symptoms must actively be looked for.[10]

Regarding the appropriateness of offering GAMST to patients with diagnoses of GI and DID, some authors stress that it is highly questionable that these patients should receive

GAMST until the DID has been treated. They stress the importance, in the sessions prior to GAMST, of providing psychotherapy for the dissociative symptoms.

Other authors propose that, while not requiring integration of the alter personality before GAMST, at the very least there should be informed consent or a consensus of all the known alter personalities.[11]

In our case report, where the patient was diagnosed with PDID, the issue of consent was not as problematic because, in the absence of memory gaps, the different personalities were present or activated at any time. In cases of PDID, with major splits among the different personalities, as well as memory gaps about the behaviors and thoughts of the other personalities, the issue of consent to treatment is more complex. We therefore advise offering psychotherapy to understand the experience of the different personalities in relation to the body and their views on GI care before offering GI treatment.

Conclusion

Mental health providers working with patients with GI should be informed that some patients seeking treatment for GI may have DID or PDID, and they should be aware of the possible comorbidity between the diagnoses. They also need to be aware of the complexity of treating these patients in terms of consent and the iatrogenic effects that GI treatments may have.

One should keep in mind that patients asking for GAMST while experiencing DID or PDID are quite rare, so systematic screening of this syndrome in all patients who have GI is not suitable, in line with the guidelines of the World Professional Association for Transgender Health.[2] However, in the presence of any type of dissociative symptoms, it is essential to assess the possible presence of DID or PDID when in contact with patients describing multiple personalities. If this is confirmed, it is advisable to propose an exploratory psychotherapeutic treatment to clarify the body experience of the different personalities as well as their consent to GI treatments.

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