

MULTIPLE PERSONALITY DISSOCIATION MECHANISM OPPOSITE TO SCHIZOPHRENIA



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ABSTRACT

Motivation: Dissociative identity disorder is a mental disorder with a major impact on all aspects of a person's life, affecting in many cases most of its functional areas. The patient in this case study is 40 years old and appears to have good functionality at work, but his personal life is affected. As co-morbid disorders, obsessive-compulsive disorder and substance use can be mentioned. On the other hand, making a differential diagnosis between dissociative identity disorder and schizophrenia is difficult for this patient, because he has symptoms with elements specific for both disorders.

Objectives: This paper aims to assess the current profile and longitudinal dynamics of a dissociative identity disorder in the case of a 40-year-old patient. He was brought to the psychiatrist by his sister, who found some quirks in his brother's behavior and insisted that he consult a specialist to help him. Also, considering the stress-vulnerability model, the factors that contributed to the onset of the pathology will be captured. Simultaneously with the symptoms of this disorder, we will also consider the effects that substance use has on the patient's condition.

Methods: Psychological evaluation, psychodynamic interview, case study, management of the therapeutic alliance and proposal of a long-term treatment, in the absence of which the symptoms may worsen, with the risk of significantly affecting functionality and even suicide.

Results: The study outlines a profile based on the fragility of the ego and personal boundaries, going as far as the splitting of the ego, the patient declares that there are different people in it: "authority, accountant, good will", "Half of the things I say I hear for the first time"), the fragility of the boundaries of reality ("life is not reality", "to stay away from reality and stay in my mind for a while"), confusion between the material area and the immaterial one ("the bottom step of the safety pyramid", "I don't clean the house because it costs; at first it costs detergents and then it costs the mind to force itself to clean it too"), dissociation between body, mind and soul ("I speak with my desires", "the body was born first, I was born after; the desires are his"), dissociative chain of ideas and

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flight of thoughts, to which are added behaviors from the obsessive-compulsive spectrum ("mistakes are a kind of death"; "I am not allowed to spend, not for me either"; "10 pairs of socks. Do you have? We are not talking").

Keywords: Dissociative Identity Disorder, Splitting, Treatment, Psychoanalytical Approach, Schizophrenia

1. INTRODUCTION

1.1 FAMILY HISTORY

The patient grew up with his parents and sister. According to him, he did not feel much affection from his parents as a child, especially from his father, who used to tell the two of them that "I didn't create you". This statement is seen by the patient as a proof of the lack of parental attachment to him („Not that attachment was created and that relationship that parents usually have with children, who are mine and pour into them all kinds of feelings in vain It gave me the opportunity to think and to be myself"). It is known, moreover, that dissociative identity disorder is generally associated with childhood abuse, and in this case one can observe the neglect and emotional deprivation that the patient feels in childhood in the relationship with his father. Moreover, starting from the relationship with him, the patient declares the fact that "I didn't want to be a man when I was little, I was terrified by men, and women are bad because they are living with men. I wanted to be me".

Regarding the relationship with his sister, she remembers that the patient suffered as a child because she had more shoes than him: "He suffered because I have more shoes and he raised money to buy shoes."

The patient currently lives alone in an apartment, but refuses to invest money in cleaning or housekeeping, which is why his sister is worried. The only investment he could afford to make was to buy a very expensive sofa which he damaged and his sister intervened and replaced the sofa. This incident led to a conflict between the two brothers, because the patient considered that piece of furniture as one of his friends and accused his sister of what she did.

Regarding the side of the family history, it seems that in the patient's family there was no one with mental issues. Although they both grew up in the same family and were treated with the same lack of affection by their father, his sister did not face the problems the patient is facing ("He told me the same thing. Why didn't I get there like you?").

1.2 RELATIONAL HISTORY

The subject had a relationship with a girl, A., whom he met a few years ago, after graduating from college. For the patient, A. seems to be the image of the ideal partner ("she is unmistakable"), to whom he cannot find any defect and associates her with hope. However, when asked if he really loved A., the patient replies: "I don't

know how to love”, “I needed her”, which illustrates the patient’s tendency to put need before love. Regarding the feelings in this spectrum, he mentions that “the first attraction is from body to body”, but when it comes to feelings, the patient refuses to see them as part of reality: “feelings hop out and ask for help”, “a thought of affection, of longing, of wanting comes to me”, but “I refuse to introduce these things in reality”, “I refuse to think, I refuse the impulses that generate thoughts”.

Although the relationship seemed to work, the patient decided to break up with her because “I was a slave to my emotions, not having my own opinions. I had no control over reason and at one point I got lost in some mechanisms that began to take control” and “I can’t pay attention to any feeling.” But when he broke up with her, he openly told her that he would continue to use her image, which I “mapped on my brain,” to always have her with him: “I will use your presence as I wish.” However, he added that he would not use it for an erotic purpose, but to embody a “fierce and serious authority” that exists in his mind, which “has one face, very serious.”

After the separation, he stopped the contact with A., but continued to “talk” daily with her image, the representation of her own Super Ego. On the other hand, when asked about the profession that A. has or what she currently does, the patient’s answer is categorical: “I refuse to introduce these things in reality”, “I refuse to think”, but he admits indirectly that he followed her Facebook and that he would have some information about her current situation, such as the fact that A. is a feminist activist: “Should I have a reaction to this? What to do with the reactions? Where do I record them?”

Currently, the patient is not in a relationship, but mentions that there is a voice in his mind that would like such a relationship, but he denies any satisfaction of this desire ([Bliss and Jeppsen \(1985\)](#)):

- “What do you want?
- I want someone too.
- Do you see anyone here? It’s not. Leave me alone!”

1.3 PROFESSIONAL HISTORY

He graduated from a high school in Bucharest with an artistic profile (fine arts), a high school attended by his sister, but, unlike her, he did not continue his studies in the field at university level.

He currently works at a restaurant, which he has been frequenting for over 10 years as a client. The position he holds there is that of cashier. In addition to his salary, he also receives certain benefits, such as meals, which allows him to save money on food. There do not appear to be any significant problems at work.

2. MATERIALS AND METHODS

In this article, we included details from psychiatric evaluation, psychiatric interview, psychodynamic interviews, and psychodynamic interpretations. The patient

has benefited from psychiatric and psychological monitoring of the daily progression under treatment.

3. RESULTS AND DISCUSSIONS

3.1 DISEASE HISTORY

The first signs of the disorder seem to have appeared since childhood, when his sister says that he used to collect all the money given to him and that he felt "hurt" by the fact that she had more shoes than him. At the same time seems to be born his repulsion towards the male gender ("men terrified me") and the conviction that he should not have been a man and that he did not identify with this gender. On the other hand, he also denies that he would have wanted to be a woman, being somewhere in an indefinite area from this perspective.

The current condition lasts for at least 25 years ("I postponed my life for 25 years to raise some money"), an interval in which he has moments when he realizes that this ascetic condition hurts him and he wants to change something ("Let's get out of this state"). A first attempt to overcome these limits that he imposes on himself makes when he decides to buy a very expensive smartwatch, but when he calculates that he spent on it the 10th part of the amount he considers necessary for his survival (respectively € 10,000) he gets scared and sells it, to get back at least some of the money ("When I heard that I spent 10% of my goal, I got scared and immediately sold those things, I sold them. I am not allowed to spend even for me if I have no purpose"). In a second attempt, he buys a very expensive sofa, but justifies his expense by the need to isolate himself from reality "I was going to close the territory, so that no one enters", "that's why I'm so upset to stay far from reality and to stay in my mind for a while". The patient also develops feelings of attachment to this object: "it is one of my friends", but "I can't afford the attachment to friends", and currently the sofa is "in a place I don't know".

The problems that the patient encounters have started to affect his functionality from several points of view. First of all, at the level of interpersonal relationships, he comes into conflict with his sister, who wants to repair his couch after it "burned", he separates from A. because "I was the slave of my feelings". Then, even the area of personal care seems to be affected by the disease, insofar as the patient refuses to clean his own home, because this would involve an expense of money and effort: "I do not clean the house. It costs", "If I clean the house, that cleaning has consequences inside too".

The patient has had a psychiatric consultation in the past, after which the doctor gave him a diagnosis that he does not remember exactly ("nonspecific psychopathy"). When asked if he told the same things during that consultation, the patient confirms: "the same character spoke then, the one I identify with now." The patient confesses that, in addition to the character he identifies with at the time of the interview, in the mind there are three more "voices" he called the authority ("Don't let me be wrong,

especially when I was alone. He doesn't show up in the group, I had to be and share what I had. I wasn't the only one in the group"), the accountant ("(he) speaks through me, although I would not say") and "the one who wants the good, to help, to turn the cheek" ("but he does it all for my selfishness"). The patient states that he is aware of this split in his personality, which has existed since childhood: "I used these mechanisms less when I was a child because I had other activities, not all of them required money", "He was born first, I was born after – I as a conscience. It works without me, with lobotomy. He does a lobotomy: I disappear, he breathes, he eliminates, he moves without me."

Against this background of mental disorder, the patient has a history in terms of substance use: "I smoke to live", "if I don't smoke in the evening, I don't fall asleep", "that's why I smoke the grass I smoke, it's something which allows me to stop wanting for more."

3.2 PSYCHIC EXAMINATION OF THE PRESENT CONDITION

The patient is brought to the psychiatrist's office by his sister, who finds certain quirks of his behavior (he never spends money, not even for the hygiene of his own home, "he quarrels with himself", "it's like a scene with three chairs, he positions each time on a different seat").

Regarding the patient's expectations, he says that he does not want the psychiatrist to help him in any way and that he came there only because his sister forced him to, so he will say what is going through his mind at that moment, because speaking, he also learns certain things about himself. To convince him, his sister paid for his consultation, but agreed to offer him the same amount of money because he agreed to talk to the doctor.

Observation: The patient is accompanied by his sister. It has a very neat physical appearance, the clothes are chosen and matched with good taste. At first glance he seems cooperative, although he did not come to the doctor on his own initiative, but he is not open to giving answers to certain questions, out of refusal to think about those things, rather than out of refusal to talk to the doctor ("I refuse to think", "I am under the control of a state, I cannot access anything"). The tone of voice is normal, consistent with its state, except when there is a neurotic laugh when asked a question to which he does not want to answer. However, the tone of his voice becomes bitter and authoritarian when he refuses to cooperate (answers such as "I refuse to ...") and even raises his voice when it seems to him that others (sister and doctor) do not understand his point of view (when he is asked why he does not clean the house, he shouts: "It costs!").

The patient is temporally-spatially oriented, auto and allo-psychic. He does not behave violently.

Perception: The way he talks about mapping A. on his brain, the fact that he is extremely convinced of the "reality" of this phenomenon, of the fact that she will be with him all the time, suggests a pathology of pseudo-hallucinatory representations.

A. is an ex-girlfriend, with whom he had a brief relationship and whom the patient "mapped" on his brain - "I told her with my mouth, even if we will no longer have a relationship, I will use you. I hope you don't mind; I'll use the image you have and the presence I knew physically and I'll put it in my head and use it as I see fit. As she became an authority for me, I used her in that sense."

Thinking: At the level of thinking, the patient manifests quantitative disorders, through an acceleration of the ideational rhythm. It loses the thread of ideas, the formal logical connections and offers tangential answers: "I refuse to think about these things, because they are part of reality and I do not enter into reality because, likewise, I should have a reaction and not have the he reacted and then I refuse to think."

His thinking is disorganized and full of contradictions, illogical constructions. For example, he makes the following statements, "One of the few people I know, I'm not one of them," "I refused to live, to review my whole set or much of what happened to me, for that I had no answer for them."

The slip from one world to another is noticeable, the jumps from the concrete to the abstract: "I can no longer pursue my goal because it has been destroyed, people have started to need money in the meantime. My goal was to be me, and I didn't have to open my mouth and talk to people, because as soon as I opened my mouth, I was empty. I was going to feed some ants and either I had money or I had to get other food for the ants."

Memory: The patient does not have memory disorders, being well anchored in reality. He remembers and relates information about childhood, parents, relationship with A., work.

Attention: Answer the doctor's questions with interest, focus on expressing complex answers, but there is also a level of hypoprosexia in some places.

He admits that he has difficulty keeping up with his thoughts and expresses the following explanation: "I am at the mercy of feelings and what they want." I am not in control now because I have no clear intentions and no purpose and then I leave what is left to what it wants to come out. I obey"

"Personally, now I'm getting carried away. I do not intend anything from this discussion, not even to put you in touch with some things and find out who I am. I'm just talking out of inertia, I'm saying the things I've said before, which you know, maybe I'll find out something when I hear it. That's why I tell them."

"Many of the things I say, half of them, especially in analysis, and when my mind enters certain segments, I hear them for the first time."

Affectivity: At the level of the thymic function there is an affective flattening, a reduction of the affective tension and of the vital momentum in general: "After feeling all kinds of feelings directed towards me, I started to run I could tell them now because I didn't tell them either. I refused to live, to review my whole set or a large part of what happened to me, because I had no answer for them. For example, a girl makes a big and beautiful drawing next to my house. Normally, I have a reaction.

I should have a reaction, but the reaction I wanted to have was my inability to have it. He wasn't fluent, I couldn't do it, I couldn't answer, and more and more this person started talking to me, I felt more and more that I couldn't talk".

But, specifically, in relation to the situation of the clinical interview, the patient is irritated and nervous. The world is poor, that is why it is bad. Stupidity is not the basis of all, not even evil, but poverty, the inability to have an opinion and to act according to one system or another, emotionally or rationally.

The elements that support the affectivity characterized by emotional coldness are related to the way they relate to the relationship with the parents "certainly not created that attachment and that relationship that parents usually have with children" and the relationship with others "attachment for friends, I can't afford it because I can't afford to live and react the way I want to react: to help them, to take them in my arms"

Another argument stems from the way he describes the feeling of love, which he considers a process of the body, being a witness, "In recent years I have learned that I do not know how to be loved, and to find out or tell someone that you don't know how to be loved is like telling that you can't breathe. I mean, you don't do it anyway, because love or feelings of love are processes of the body through which it communicates something to me, and I should react. He's talking to me; he's interested in that person. I can't get to know her, I'm a witness to that moment. People believe that they are the masters of those states and moments, that they choose to fall in love, and I found out that it is not so". He denies and projects feelings outside of him, "emotional attachment is meant to be communicated."

Language: At the level of language there is an accelerated rhythm and a slippage of speech, which is characterized by talkativeness.

At the same time, we are struck by impersonal speech, the use of passive diathesis in structures such as "I hear how to think a thought is generated and I block it." (Trifu et al. (2015))

We notice the presence of an unusual laughter, emphatic and with hysterical notes, which we can see as a defense mechanism (Ludwig et al. (1972)).

Another particular aspect of the patient is his tendency to philosophize: "The proposed reality, because this is not reality, is the proposed and accepted reality. The reality is bigger, it includes sun, clouds, ant, many more things that you take into account or not".

Motivational system: In the case of this patient we find a marked inhibition - he wants to save as much as possible, not to spend anything, not even to meet their own needs or desires.

We can also talk about parabulia, because its physiological needs are voluntarily denied by the consumption of grass, a substance with a sedative role "the weed I smoke, is something that allows me to no longer want. By going through the grass filter, all desires can be stopped more easily".

This tendency is also observed at the level of sexuality, in terms of thinking and phantasmagoria, because he cannot use his image of A. in an erotic sense, "I have mapped it on eroticism only very rarely".

Personality structure: According to the patient's confessions, there are several voices in his mind, which are in permanent conflict and which he describes as follows:

1. Authority (is from the beginning) – "Is that entity that saw me, especially when I was alone. Don't let me be wrong, especially when I was alone. He doesn't show up in the group, I had to be and share what I had. It wasn't just me in the group. When I was left alone, I judged the universe, it tormented me. The lesson he was trying to teach me when I was wrong was at the level of ... it wasn't from today to tomorrow ... it was an eternal mistake or its repair, it lasted forever if I was wrong".
2. The accountant - the one obsessed with control, there in the immaterial area I am told "I don't want to hear anything until: 10 pairs of socks! Do you? We're not talking! 5 pairs of pants. Do you have? We are not talking! Until I have the lowest level of safety provided for at least a month, I cannot trust myself and any thought that is generated is subject to error."
3. The good one - who wants to do good, to help, but does not do in vain, does everything for me, for my selfishness. For example, because if I have a piece of chocolate and it's me and 4 people, I think I'm more selfish if I give it to them. There are 4 brains that take advantage of an action of mine than just my brain. I'm one and I eat the piece, great thing. But are they 4? Who knows what these 4 people can do after eating chocolate? Maybe one comes up with an idea, maybe one does something".

The patient notices the fragmentation of the Ego and manifests multiple symptoms of dissociation, "Desires belong to the body, it can work with lobotomy"; "For a long time I was guided by feelings that are not me. Seeing them, I dissociated myself, having my own opinions, saying that the woman I had mapped on my brain (A.) is unmistakable".

Awareness of the disease: Asked about the time when these mechanisms appeared, these voices, he says that it worked all my life, I used these mechanisms less when I was a child because I had other activities, not all of them required money. And then the part that decided, the analysis did not have as much work as it has now. I've been abusing these mechanisms for a while, that's why I smoke the grass I smoke, it's something that allows me to stop wanting it. Going through the grass filter, all the desires can stop them more easily, without frustrating them, I can give them some explanations, I can be more understanding, I can have a communication. It's something I haven't had before. More recently, I'm starting to talk to them, whatever their nature. Because they belong to the body, and the body is before me. He was born first, I after - I as consciousness. It works without me, with lobotomy. He does a lobotomy: I disappear, he breathes, he eliminates, he moves without me".

However, the patient does not consider a priority the efforts that his sister wants to make in treating his mental state, he being concerned about his financial condition: “I agreed to come because I tried to teach her that negotiating anything is recommended. And she told me she was going to pay me the same money she was paying you. I’m saying that the money you gave for the pills and the meetings, if they were in my pocket, as much as I have now, is almost half the security I would have. My safety is doubled”.

3.3 TREATMENT

Currently, the patient is undergoing a pharmacological treatment, in a relatively low dose, with an antipsychotic, Ziprasidone, prescribed in an attempt to reduce his ideational agitation, to keep him cognitively “gathered” (Trifu and Trifu (2020)). He started treatment about 3 months ago and responded well to it. The continuation of long-term pharmacological treatment is a sine qua non condition for a favourable evolution, complemented, of course, by psychotherapeutic intervention. According to specialized studies, psychoanalysis is the recommended form of therapy in the case of dissociative identity disorder, because it involves a profound restructuring of the personality (CORYELL (1983)).

The main diagnosis is that of dissociative identity disorder. The diagnostic criteria according to DSM-V are:

1. Fragmentation of identity, characterized by two or more distinct personality states, which can be described, in some cultural groups, as living a state of possession. Fragmentation of identity implies the marked discontinuity of self-awareness and action, accompanied by associated disturbances of affect, behavior, consciousness, memory, perception, cognition, and / or sensory-motor functioning (Kluft (1985)). These signs and symptoms may be noticed by others or may be reported by the patient.
2. Recurring gaps in the recollection of everyday events, important personal information and / or traumatic events, which are not commonplace.
3. Symptoms cause clinically significant discomfort or dysfunction in the social, professional, and other important areas of functioning.
4. The disorder is not part of a widely accepted religious or cultural practice
5. Symptoms cannot be attributed to the physiological effects of a substance (e.g., short intervals of amnesia [blackout] or disorganized behavior from ethanolic intoxication) or to another medical condition (e.g., complex epileptic seizures).

The patient meets all the above criteria, except for criterion B, because his identities are known to each other and there are no switches that cause memory gaps (Ross (1997)).

The following fragment highlights the existence of distinct personality states, “I hear how a thought is to be generated and I cut it off, block it, ignore it. For example,

a thought of affection comes to me, of longing. To want, to want for me. And when that state is to be generated, I come and say to him:

Voice 1: What do you want?

Voice 2: I miss you; I want to

Voice 1: No. Do you want now, what do you want me to give you?

Voice 2: I want to hold in my arms, I want someone to look at me too.

Voice 1: Do you see anyone here? Not! We don't have anyone now, please leave me"

3.4 DIFFERENTIAL DIAGNOSIS

It will be made with that of schizophrenia and obsessive-compulsive personality disorder (Trifu and Trifu (2020)).

Schizophrenia: The arguments in support of this psychopathology are emotional coldness towards the sister, loss of the ability to relate, isolation, social withdrawal.

From the patient's speech we can observe a pressure to speak, which leads to a fragmentation of thinking, to a disorganization at the cognitive level. (Trifu and Trifu (2020)) Another argument of schizophrenia in the sphere of cognition is related to hyper analytical thinking and the presence of many contradictions, listed above.

Also, the use of passive diathesis, the impersonal speech "I hear how to generate a thought and block it" is specific to individuals diagnosed with schizophrenia.

The counter-arguments for this diagnosis are that the negative dimension of schizophrenia is missing and that the patient is well cared for. Another counter-argument is that the patient is self-tuned, rigid, fixed on certain things (for example, monitoring). (Braun (2018))

Obsessive-Compulsive Personality Disorder: According to DSM-V, patients with dissociative identity disorder often have identities that appear to contain various characteristics of severe personality disorders, suggesting the need for a differential diagnosis with these disorders. In this case, the obsessive-compulsive personality disorder is embodied by the voice of the "Accountant", who monitors losses of any kind, "I do not clean the house because it costs. At first it cost detergents and then it cost the mind to force itself to clean it as well. If I clean the house, that cleaning also has consequences inside. They always come at a cost. The reality costs, it starts with the bills and ends with your wishes".

The main argument of this diagnosis is related to the problem of damage, the need for control, to monitor everything, obsessive thoughts, energy consuming (McWilliams (1994)), 10 pairs of socks. Do you have? We're not talking! 5 pairs of pants. Do you have? We're not talking! Until I have the bottom stage of safety assured for at least a month I can't trust myself and then I have no intention and I get carried away by the moment which means just raise money, put the million aside, you don't care about anything you don't want anything"

4. CONCLUSIONS AND RECOMMENDATIONS

4.1 PSYCHODYNAMIC INTERPRETATION

Mental According to psychodynamic theory, we find strong mechanisms of denying reality and psychotic denial of it (Brende and Rinsley (1981)), "I refused to accept the natural course of things", "I refuse to introduce it into reality and ignore it with all being these things to me".

After the separation from A., being in a state of denial of suffering and in a moment of fixation, he internalized through a psychotic mechanism the image of the beloved as a figure of authority.

He describes it as "a fierce and serious authority that none of me could fight." From a psychoanalytic point of view, it can be stated that A. was mapped as a Patient Superego, a figure invested with authority, about which the other voices could not say anything bad (Mcwilliams (1994)).

Based on information about early childhood and the relationship with parents, we can speculate that the relationship with them was cold and distant.

Although the patient consciously claims that the father's words "see that I did not make you", had a positive contribution on his personal development because "that attachment and that relationship that parents usually have with the children, who are mine and pour into them all kinds of feelings in vain. It gave me the opportunity to think and be myself", unconsciously there is a deep pathology of cluster B attachment. That severe narcissism stemming from a "primary wound" on the attachment, in which the affective needs of the young child has never been satisfied, and he seeks in adult life validation from others. The need to cling to objects, the attachment taken to the extreme to the sofa, which then burns, are examples that support the pathology in the area of attachment.

Through the statements that the patient makes regarding his sexuality, such as that he is neither a woman nor a man, we find a problem on the line of separation, individualization and association of an identity disorder, "I did not want to be a young man. I saw the men's moustaches, some monkeys, the men terrified me, and the women are stupid to be with them. I can't be a man, I can't be like that, and I had nothing to do with a woman. I liked being with them because they had a mind that fed me and I found all sorts of things more interesting in them than in men".

"I haven't found out who I am and I don't think I'll have time to find out who I am, with the mechanisms and resources available, it's too much to go."

The obsessive area is focused on greed, stinginess, the need to control, to monitor losses of any kind. From the classical psychoanalytic perspective, it can be stated that the patient has a strong fixation in the anal stage.

His problem seems to slip between obsessive and paranoid. After a period in which he has fully assumed control, there follows a period in which the other thoughts are sent out, the other personalities are expelled and no longer belong to the Self.

In this mechanism of hyper analysis, the obsessive zone joins the paranoid zone in an attempt by the unconscious to choose the least evil. Thus, he chooses to give up control and become psychotic. For example, he gives up (in a psychotic sense) the control of the clock. You would take a smart watch, which you put on his hand and he always monitors you. So, you see that one is a security guard, be careful what you do with that one on his hand that gives you away. You have that watch and a relationship begins with him”

4.2 POSITIVE PROGNOSIS FACTORS

- family support, both from an emotional point of view (the sister is the one who insisted on going to a psychiatric consultation and psychotherapy), and from a financial point of view (parents pay the rent, utilities, etc.);
- favorably responded to pharmacological treatment;

4.3 NEGATIVE PROGNOSIS FACTORS

- severe impairment of general functionality;
- current substance use (“if I don’t smoke weed, I don’t fall asleep in the evening”) and the possibility to associate other maladaptive coping mechanisms;
- alienation from others, inability to form and maintain real relationships.

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