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Психопатологические загадки расстройства множественной личности (диссоциативного расстройства идентичности). Случай Даниила А.

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АННОТАЦИЯ

В статье приведён уникальный клинический случай Даниила А. с расстройством множественной личности (диссоциативного расстройства личностной идентичности по Международной классификации болезней 11-го пересмотра) — первое в русскоязычной научной литературе развёрнутое описание редко встречающегося синдрома. У пациента, помимо расстройства идентификации, были обнаружены диссоциативные двигательные нарушения в форме псевдоэпилептических пароксизмов. В клинической картине заболевания доминировали симптомы «замены личности», «второй сущности», «Альтер эго» и «голоса». В статье приведён клинический анализ правомерности обозначать выявленные феномены как галлюцинации и бред. Теоретический анализ включал оценку возможности диагностики психотических симптомов в рамках непсихотических расстройств.

Ключевые слова: *расстройство множественной личности, диссоциативное расстройство идентичности, психотические расстройства, галлюцинации, галлюционоиды, бред, бредоподобные фантазии, истерия*.

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Psychopathological riddles of multiple personality disorder (dissociative identity disorder). The case of Daniel A.

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ABSTRACT

The article presents a unique clinical case of Daniil A. with multiple personality disorder (dissociative identity disorder according to ICD-11) — the first detailed description of a rare syndrome in the Russian-language scientific literature. The patient also had dissociative movement disorders in the form of pseudoepileptic seizures. The clinical picture of the disease was dominated by the symptoms of "alternative of personality", "second essence", "Alter ego" and "voices". The article provides a clinical analysis of the legitimacy of designating the identified phenomena as hallucinations and delusions. The theoretical analysis included an assessment of the possibility of diagnosing psychotic symptoms within non-psychotic disorders.

Keywords: *multiple personality disorder, dissociative identity disorder, psychotic disorders, hallucinations, hallucinoids, delusions, delusional fantasies, hysteria*.

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Stable diagnostic rules have been formed over the years of clinical psychiatry development, and they are not vulnerable to drastic revision even when classifications change. Such unshakable canons include classifying psychopathological symptoms as psychotic and nonpsychotic, which serves as the foundation for forensic psychiatric examination. Until recently, it was believed that the appearance of individual psychotic phenomena in the structure of nonpsychotic (neurotic) disorders inherently qualifies this disorder as psychotic.

In recent years, psychiatry has faced a new challenge when individual psychotic manifestations (hallucinations and delusions) have increasingly begun to occur in autism spectrum disorders [1], borderline personality disorder [2, 3], and some other mental disorders, necessitating a revision of the scientists' opinions on the patterns of psychogenesis [4]. In this case, it is referred to as interspersing psychotic symptoms within a nonpsychotic disorder rather than comorbidity.

A special place among such mental disorders is occupied by dissociative (conversion) disorders and, in particular, dissociative identity disorder (code F44.81 according to the International Classification of Diseases, 10th revision [ICD-10]) in the structure of which psychotic, pseudopsychotic, or subpsychotic symptoms plays a key role.

The clinical case of Daniil A., 19 years old, described below, is unique not only in that it is the first detailed case of dissociative identity disorder characterized in Russian-language scientific literature but also in that the presence of schizophrenia-like symptoms with clinical phenomena, typically attributed to hallucinations or delusions, registered in Daniil A., poses difficult questions for psychiatrists regarding the qualification of these phenomena and raises problems of the psychopathology interpretation. The problems raised by Daniil A. require a change in psychiatrists' perspectives on some psychopathological symptoms and their differentiation.

Daniil A., 19 years old, went to see a neurologist after experiencing convulsive attacks. He also reported unusual symptoms such as "alternating personality," the presence of a "second thing," irritability, and anxious sleep.

Case history. According to the patient, the first symptoms of the disease occurred when he was 6 years old. He did not place much importance on this or tell anybody about his experiences until he was 15 years old. Daniil's behavior and speech were usual to those around him and his relatives. He kept everything "sort of a secret," stating that he feared others would think he was a "crazy person."

He often woke up with anxiety attacks and could not sleep for long due to fear of dark and terrifying nightmares. During elementary and middle school, he started to hear and converse with a "voice" within his mind. The "voice" was predominantly commentary, sometimes providing support in difficult situations and advising Daniil on how to "be stronger and tougher." Subsequently, the "voice" emerged most often in stressful situations when Daniil was afraid, anxious, or agitated. There was a "transition of the 'voice' into a visual image when 'it' appeared in the form of terrible physiognomies, creepy, burned, and half-dead faces" at some point, which Daniil typically viewed with peripheral vision. Several times, he felt "as if he found himself in another place, in a dark room, alone with this voice-image," and spoke with it incomprehensibly.

During this time, Daniil describes states as "replacing" his personality with "another entity," with durations ranging from several hours to one and a half days. He claims that he could not control his body and actions during these periods. He saw everything as if it were a film and was practically unable to control his actions. He further mentions that "having returned to his body," he at times experienced "memory lapses" throughout the entire period of "personality acquisition" and that after leaving this state, he experienced bursting pain, mainly on the left side of his body.

He believes that this "personality entity" has helped him several times, supporting him in tough situations and resolving conflicts and fights. He associates it with "spirituality" and "courage," but it also has pronounced aggressiveness and proneness to conflict. He considers his attitude toward the "entity" as equivocal. He feels burdened and "afraid" of its appearance, but he also sees it as a "protector" ("he is like an older brother to me").

His symptoms increased significantly when he was 15 years old. He suffered a severe injury that resulted in a thigh muscle rupture, subsequent multiple surgical treatments under anesthesia, and

a long rehabilitation period. The patient's vision became blurry while climbing a rope during a physical education lesson at school. He lost consciousness and collapsed. Nevertheless, no convulsions occurred, and consciousness was rapidly recovered.

Daniil was anxious about his prospects in life, particularly his ability to walk correctly. He had to switch to homeschooling and was apprehensive about it because he had final examinations. His emotional state was unstable. He had angry outbursts, cried, and argued with his family.

During this period, convulsive contractions with tonic tension of the leg/legs and severe pain emerged for the first time. These conditions prompted examinations at neurological children's hospitals when the diagnosis of epilepsy was first suggested. The patient thereafter developed other paroxysmal conditions. Some were bilateral tonic convulsions of the limbs and the entire body with severe pain, whereas others had clonic elements in the form of body and limb "trembling." The degree of muscle tension during repeated attacks changed as the face distortion, opisthotonous posture, and crab position developed.

All attacks occurred while consciousness was wholly preserved. The eyes and the ability to understand spoken speech and answer questions were open. Simultaneously, the speech was distorted and, in some cases, completely lost. The duration of attacks ranged from 30 min to several hours. The attack may have stopped after the ambulance team arrived and administered diazepam, but it may have resumed shortly.

The attacks happened around two to three times a week. In recent months, the patient's mother (a doctor by profession) "learned to interrupt" attacks with intravenous magnesium sulfate administration, and the attack stopped within the first seconds of the drug administration and even when significantly diluted with isotonic sodium chloride solution.

After the attacks, immobility of all limbs or one side and lack of speech occurred several times, sometimes for 2–3 days. In this regard, Daniil was hospitalized several times due to a stroke suspicion. A brain X-ray computed tomography was performed, which ruled out any brain pathology.

With a diagnosis of vegetative crises, encephalasthenia, and syncopal conditions, he was referred to a pediatric neurologist–epileptologist. The epileptologist assumed that the attacks were epileptic in nature and prescribed valproic acid (Convulex). According to the patient, while using Convulex, he had nocturnal sleepwalking and eating disorders as he walked to the refrigerator and took food. During this time, the patient's previously existing psychopathological symptoms significantly intensified, which he recognized and felt as a burden. Fear and a "déjà vu" appeared, which he considered "a continuation of dreams." Episodes of anger and irritability also began to appear, which he explained as the presence of a "second entity" that lived in his body.

In response to the attacks, he heard a "voice" more often, and cases of "substitution" with a personality entity became more frequent. In the presence of deep-seated emotions, when he was unaware of what to do, he told his mother everything, saying that he had been hearing a "voice" for many years, had communication with a "personality—Alter Ego," and "entered into an agreement with it." Daniil was hospitalized in the department of a psychiatric hospital for evaluation after his anxious mother insisted on consulting a psychiatrist.

He often experienced emotional reactions in the hospital, cried, complained of anxiety and restlessness, and slept at night with awakenings. "Convulsive attacks" were repeated three times. According to the description, "the hallucinatory symptoms stopped" during treatment (hydroxyzine, fluvoxamine, carbamazepine, phenobarbital, and valproic acid [Depakine]). He was discharged with a diagnosis of organic personality disorder due to epilepsy, with frequent polymorphic paroxysms and psychotic states, as well as temporal lobe epilepsy.

After discharge, the psychoneurological state did not return to normal; "personality substitution" states persisted, which the patient's mother considered "quirks," so she forced Daniil to undergo an "exorcism" procedure, which did not lead to the disappearance of these experiences. He was nevertheless bothered by stereotypical "convulsive attacks."

For 3.5 yr, anticonvulsants were administered as monotherapy with valproic acid carbamazepine and in combination with phenobarbital and lamotrigine. During the follow-up period, he received 2,000 mg of valproic acid (Depakine Chrono), 250 mg of

lamotrigine, and 200 mg of phenobarbital daily. There was no reduction in the incidence of attacks over the entire course of treatment.

He was repeatedly consulted by epileptologists, who diagnosed him with focal epilepsy combined with organic personality disorder caused by epilepsy. Electroencephalography (EEG) with video monitoring was performed to confirm the diagnosis, but no epileptiform activity was detected. During last night's video-EEG monitoring, a motor "epileptic" paroxysm was observed that was not accompanied by changes in the patient's electrical activity. The study concluded with no epileptiform activity recorded based on EEG data. The presence of nonepileptic (dissociative) attacks is suspected based on the clinical presentation.

On the neurologist's request, a series of home video recordings of the attacks were performed during the present examination of the patient, revealing multiple signs of their functional (conversion) nature. During the follow-up period, the patient was informed about the nature of his attacks. The treatment regimen was changed so that phenobarbital and valproic acid (Depakine) were progressively discontinued, the dose of lamotrigine was reduced to 100 mg/day, and the dose of fluvoxamine was increased to 150 mg/day.

In this context, the incidence of "convulsive" attacks decreased significantly to once per month. Conversely, Daniil "heard a voice" and experienced "substitution by another personality entity." The patient is currently in a dispensary follow-up group at a psychoneurological dispensary. He lives at home, rarely ventures outdoors, and is well-cared for by his mother. The scope of interests was reduced to watching TV shows and playing online games. He is concerned about his inadequacy, has no idea about the future, and thinks himself unwell, desiring to fix the existing medical problem.

Curriculum vitae according to the patient, his mother, and medical documentation. There is no family history of mental disorders. The patient was born from the first pregnancy and delivery. The pregnancy was accompanied by early toxicosis. Obstetric forceps were used to deliver the baby. The patient was born with asphyxia, scoring 2 points on the Apgar scale. On Day 10, he was discharged from the maternity hospital in good condition. He grew and developed in line with his age. Regarding mental and physical development, he was not retarded compared with his peers. At the age of 5–7 yr, somniloquence was observed in simple muttering sounds and inarticulate words. Past medical history includes acute respiratory viral infections and "childhood" infections (measles and chicken pox).

From early childhood, he experienced frequent headaches and a low tolerance for stuffiness, and therefore, he was under the care of neurologists with a diagnosis of residual encephalopathy. He had a hypersthenic physique, was obese his entire life, and never felt discomfort. He was not examined by endocrinologists. He sustained traumatic brain injuries during fights and sports games without losing consciousness, fractures, and sprains. The patient denies having had blood transfusions, tuberculosis, sexually transmitted diseases, and hepatitis.

He attended kindergarten when he was 2 years old. When he did not want to go there, he would start screaming and crying until he vomited, but only in front of his mother. He stayed with the children in the group and obeyed the teachers, but he only talked to one or two males. He did not like being a "ringleader" or a leader; he preferred quiet games. He participated in matinees, read poems, sang songs, cheered, loved being stared at, and gained attention. By nature, he was impressionable, vulnerable, touchy, and irritable and sometimes had conflicts with his peers.

He started attending high school on time. In primary school, he studied well and showed a noticeable interest in the humanities. Beginning in fifth grade, he began to study less well; "C" showed more often among the grades. During his school years, he strived to communicate with his peers, but relationships with most children did not go well due to Daniil's arrogant and touchy character. In the fourth grade of school, he was on the same squad with troublesome children; thus, he was constantly a victim of their attacks but still sought to stand up for himself in the case of trouble. Over the course of 2 yr, the relationship between him and other pupils improved during the joint work of the school psychologist and the home form teacher.

At school, he often argued with teachers over grades and enjoyed proving that he was right. He believed that there were regular undervaluation of grades, unfair disciplinary penalties, and simply "misunderstandings"; thus, his family decided to

transfer him to another school in the eighth grade. At the new school, he did not make friends with his peers and spent much time studying at home due to his leg injury. He passed the final state attestation satisfactorily. After ninth grade, he enrolled in an agricultural college specializing in land management. He only completed his first year of study before taking an academic leave in year 2 "for mental health reasons," which is still ongoing.

Family history. Under normal living conditions, he grew up as the eldest child in the family. He has a younger sister with a 10-yr age gap. According to the patient's description, the mother is a medical laboratory technician who is kind, warm-hearted, and sometimes overprotective. The father is colder in nature and aloof but generally understands his son. All his life, he worked as an engineer on business trips and so had little involvement in the life of his family.

The parents are currently divorced. The patient lives with his mother and sister, and his family relationships at home are smooth. Daniil spent most of his free time studying and helping his mother at home. Sometimes, he walked with a small group of children, discussed studies films, and played football. One of his favorite pastimes is computer games. For the last few years, he has been actively involved in online games, often playing them all night.

He enjoyed sports throughout school and participated in the athletics section, sambo, and karate. He had achievements and participated in small competitions but stopped attending these clubs due to frequent injuries. He has no work experience or part-time job. He also has no police reports; he has never been charged with a crime or held administratively liable. Puberty began at the age of 13; he briefly felt pity for a classmate girl, walked with her, and went to the movies several times. He is not sexually active and has no sexual experience. On holidays, he seldom consumes alcohol with his friends. His tolerance is limited to a beer bottle; he has no binges and is practically never intoxicated. He has been a smoker since the age of 15 years old, preferring electronic cigarettes. He has never tried drugs or other psychoactive substances.

Mental status. At the beginning of the meeting, he was noticeably anxious. He stated that it was difficult for him to speak about his experiences at the case conference, which was attended by several dozen doctors. He requested not to look at the audience during the talk. He made contact readily and acknowledged the importance of consultation but believed that medications could not change his condition. He refused to answer some questions, citing that it was difficult to remember, and joked that "the doctors present may not be able to stand it when they hear details about his psychopathological conditions."

He talked about "convulsive attacks" and the symptoms accompanying them in detail but without excessive detail. He did not insist but was inclined to believe that they were almost always provoked by stress and scandals in the family. He noted that the incidence of attacks had noticeably decreased after switching to homeschooling. The attacks never occurred in crowded places (such as a community college, on the street, or in a store) and could only happen at home. Daniil characterized the family situation as tense.

He made no complaints about periodically occurring "personality substitutions"; he accepted it as a part of his life. The attitude toward "substitutions" and "voices" was ambiguous; on the one hand, he claimed that the other personality supported, protected, and helped him to get out of difficult everyday situations; on the other hand, he was afraid of losing control of the different personality and committing something dangerous. He recalled that once, near the community college, unknown young people approached him, and "suddenly this other one took possession of him," got into a fight, and helped him defeat the attackers ("I couldn't have done this myself").

He described himself as emotional, impressionable, and shy, although he admitted to being irritated recently, mainly when communicating with his mother and sister. He claimed that he realized what had happened during the fight only after he saw blood on the face of one of the attackers and "realized" that it was "his doing." He did not remember the details of the fight. He added that in some cases, he could foresee an attack of "personality replacement." He said that once, during a lecture at the community college, when there was "incredible noise" in the classroom, he felt anxiety and an impending "replacement of personality." He left the class and sought medical

attention. He took a sedative pill, and his condition returned to normal.

The patient expresses a desire to understand what is happening to him. He does not characterize the "voice" that appears in him in detail; he either claims that it is his "second essence, which has a rougher voice and character" or reports that the "voice" is muttering in nature. He sees no contradictions in the changes in this phenomenon. The patient has difficulty determining the "voice" location and tries not to clarify whether the "voice" is "heard" from outside or inside the head.

The emphasis is on the characteristics of the "second entity," and his attitude toward the "voice" and the "second personality" is equivocal, although he has "already got used" to it. At the same time, he is sometimes burdened by states of "substitution by another personality." He readily and in detail discusses his feelings during the so-called replacement, emphasizing that similar phenomena also occur in situations of stress, danger, and conflict. This "entity" can "hit someone" during periods of "taking possession of him" but does not become the initiator of conflicts. It merely "answers" and "stands up for him."

He says that at times, even in a calm environment, "the personality asks to come out," this happens about once every 3 days because he has such an agreement with his "Alter ego." He cannot explain what he means by "Alter ego." He says that sometimes, he completely forgets what happens during "replacement," and individual images can be recalled after leaving such a state. It should be noted that the patient's complaints about these symptoms are not burdensome; he reports them separately from his complaints about convulsive paroxysms and sees no direct relationship between them.

The patient does not consider himself mentally ill but rejects his mother's version of what is happening as "the instilling of demons in him." He speaks with enthusiasm about his exorcism experience. When this topic was raised in a conversation with a psychiatrist, he turned to the doctors in the audience. He spoke about the procedure for exorcizing demons in a preachy tone. He said that he chose this procedure due to under pressure from his mother, despite his strict scientific views. He told the doctors, with an ironic tone, how people around him performed "dances with a tambourine" to relieve him of "personality substitution," he showed no embarrassment or confusion that had accompanied the conversation up to that moment.

Attention is focused correctly, memory and mental capacity are not impaired, and consciousness is clear. Thinking is logical, consistent, and productive without associative disorders. The speech is competent. When asked whether he could arbitrarily implement a "substitution" and appear as a different personality during a conversation with a psychiatrist, he answered that it was impossible as "it comes spontaneously."

Consultation with a psychologist. The patient works quickly, assimilates instructions, and keeps them in the execution process. He completes tasks diligently and with interest, and in case of difficulties, he seeks the help of an experimenter. During the experiment, he revealed active attention with reduced focus and signs of exhaustion in stress tests. According to the Schulte table, the results were 54″, 1′02″, 1′02″, and 1′24″. Mechanical immediate memory slightly decreases memorization (4, 5, 5, 7 out of 10 words, with five delayed).

The associations in pictograms are mainly attributive and standard, and in isolated cases, these are individually significant with adequate explanations. The drawings are arranged in an orderly fashion, and they are labeled with signs of an organic symptom complex.

When studying the mental sphere (methods of excluding objects, classification, comparison of concepts, and simple analogies), with the availability of understanding complex generalizations, the presence of a categorical level of thinking, and the ability to abstract, a reliance is detected on latent signs of objects ("a fan is odd, but a nail, a bee, and an airplane are energized by wires"); in speculations, the patient reflects the peculiar, far-fetched side of phenomena, with the decrease in critical thinking level.

When comparing simple and complex pairs of concepts, the patient is guided primarily by significant signs and functional differences; when comparing individual pairs of concepts, he is guided by latent features ("glass–rooster"—"both can contain something, a glass can contain liquid, a rooster can contain organs"; "barrel–butterfly"—"words are similar in sound"). The ability to establish

logical relationships is not impaired; when forming analogies, he selects the right concepts within the established framework.

The figurative meaning of proverbs and idioms is accessible at the metaphorical level. He provides quality explanations with an understanding of the essence while explaining the meaning of the story "Egg of Columbus." The patient correctly establishes the sequence of events through a series of pictures of moderate complexity, making the story understand the plot's meaning.

With the availability of understanding of complex generalizations, the presence of a categorical level of thinking, and the ability to abstract, the patient shows unclear semantic differentiations, far-fetched judgments, and lack of criticality in combination with a reduced concentration of attention with exhaustion in short-term tests (with a sufficient pace of work in the experiment), with a slight decrease in mechanical memory when improving logical–semantic memorization.

According to the Minnesota Multiphasic Personality Inventory, personality profile shows the hypersthenic type of accentuation, impulsiveness, affectability, angry, intolerance to others opinions, stubbornness, distrust, suspiciousness, protest, reduced mood, dissatisfaction with the circumstances, emotional tension, and outbursts of hostility.

Consultation with a neurologist. Residual encephalopathy manifested as frequent vegetative crises, cerebroasthenia, cranialgia, and syncopal attacks. Is it possible to have cryptogenic focal epilepsy?

Consultation with a neurologist professor. Functional (pseudo-epileptic) seizures in a patient with anamnesis of possibly single epileptic seizures.

Routine EEG revealed no focal slow-wave or epileptiform activity at the time of recording.

Magnetic resonance imaging of the brain revealed that all brain structures, the ventricular system, and white and gray matters have no pathology.

Magnetic resonance angiography of the cerebral arteries revealed no signs of pathological changes in the intracranial arteries, suggesting that the arterial circle of Willis (not closed) might have developed.

Consultation with an ophthalmologist. Angiopathy of the retina of both eyes.

Discussion

The clinical case of Daniil A. poses challenges in diagnosing a particular mental disorder according to ICD-10 and the precise qualification of the identified psychopathological phenomena. Similar problems arose among neurologists studying the causes of convulsive paroxysm development. The patient's clinical presentation can be divided into two groups of symptoms: paroxysmal movement disorders and schizophrenia-like disorders. It was hypothesized that these two groups of symptoms might be related and represent phenomena independently within the diagnostic search.

For psychiatrists, the differential diagnostics of epileptic and nonepileptic (functional and dissociative) paroxysms are known to be based on the so-called negative diagnostics, which are made only after neurologists rule out an "organic" basis [5].

An anamnestic and video analysis of the characteristics of the course of paroxysms showed that the structure lacked criteria that would allow them to be classified as really epileptic. These included high duration of attacks, preservation of consciousness during "convulsive generalized" paroxysms, pretentious motor phenomena of an attack with the presence of, among other things, a crab position and opisthotonus posture, and rapid relief with the use of drugs that cannot lead to the interruption of epileptic paroxysms.

Data from video-EEG monitoring of the attack enabled us to conclude the "nonepileptic" (functional and dissociative) nature of the paroxysms. The subsequent discontinuation of a significant part of antiepileptic therapy and an educational conversation with the patient regarding the nature of the attacks also complemented the assumption about their functional origin.

The analysis of psychopathological schizophrenia-like features presented significant challenges. Phenomena that required a clear psychiatric interpretation included complaints about "voices" and the patient's assertions about a "replacement of (his) personality" periodically occurring in him, and a "second essence," his "Alter Ego," appears. Daniil's descriptions of the "voices" were vague, as he did not claim to have "heard a voice" but rather to have "conducted an internal dialogue with his "Alter Ego" and did not believe that this "voice" belonged to a specific outside living person or creature.

At the same time, the patient claimed that "the voice that belonged to his other essence" differed from his own in its rough sound and harshness. He could not and did not strive to localize the source of the "voice" because he believed it was his slightly distorted voice. We cannot conclude from psychopathological analysis that the clinical presentation of patient Daniil's illness involves verbal true or pseudo-hallucinations. They had neither the character of reality nor the parameter of artificialness, and the patient denied hearing them. This phenomenon could be interpreted as hallucinoids [6].

According to Krylov [7], hallucinoids do not "fit" into reality; they lack a feeling of artificialness or being induced, and the patient's attitude toward images is critical to recognizing their unreality. There is often confusion between the concepts of "sounding (his own) thoughts" and the "voice."

Bekhterev's work, "On Hearing Your Thoughts" [8], was devoted to this phenomenon, in which the author argued that "hearing hallucinations are nothing more than a pathology of thinking that hallucinations occur when the patient fixates on his thoughts" and that "if the patient's attention is focused on his thoughts, then the auditory echo, turning into a hallucinatory image, is apperceived following the apperception of the patient's thoughts, and then the patient hears only the repetition of his thoughts."

A point of view on the relationship between inner speech and verbal hallucinosis has been expressed [9], and it has been pointed out that the phenomenon of inner hearing (inner speech) can predispose to verbal hallucinosis [10]. In this series, the concept of "verbal imagination" stands out, similar to the concept of "inner speech" [11], which, in turn, are close to verbal hallucinosis but are not the same [12].

According to Moskowitz and Corstens [13], "hearing voices should be considered a dissociative experience, which can have pathological consequences under some conditions. In other words, although voices may occur in the context of a psychotic disorder, they should not be considered a mental disorder."

Another phenomenon, the patient's statements that a "replacement of (his) personality" periodically occurs in him and "another entity," his "Alter Ego," appears, required differentiation between the concept of delusion and delusion-like fantasies.

If we assume that the clinical presentation of Daniil's illness was delirium, then it could only be delirium of metamorphosis, and its confirmation would require evidence of the patient's conviction that he was not transformed of his own free will into some animal bird, mythical creature, or inanimate object. This type of delirium is sensuous, occurs abruptly, is often associated with Kandinsky–Clerambault syndrome, cannot be manifested from other forms of delirium, and occurs paroxysmally [14].

Consequently, Daniil's claims that his personality is periodically replaced by another cannot be recognized as delusion (paranoia). In the psychiatric literature, "delusion-like fantasies" are defined as nondelusional weird, fantastic ideas [15], which are sometimes referred to as "pathological fantasies" and "transfiguration symptoms" in the analyzed case of Daniil A. Delusion-like fantasies are classified as pseudology rather than delusional syndromes [16].

Thus, the clinical presentation of Daniil A.'s disease, externally manifested by schizophrenia-like symptoms, does not meet the diagnostic criteria for paranoid schizophrenia but does coincide with the diagnostic criteria for dissociative identity disorder (ICD-10 code F44.81) or dissociative identity disorder (DID). These include the following:

a. the existence of two or more different personalities within an individual when only one of them is present at any particular (given) time;

b. each personality has its memories, preferences, and behavioral characteristics and, at times (periodically), seizes complete control of an individual's behavior; and

c. an individual is unable to remember information vital to him to a greater extent than ordinary forgetfulness.

In the clinical presentation of Daniil's disease, DID was associated with dissociative motor disorders (pseudo-epileptic paroxysms).

As previously stated, the problem of psychotic symptoms arising in the structure of nonpsychotic disorders should be recognized as one of the most complex and pressing problems in modern psychiatry [4]. In this regard, DID is a demonstrative example of a psychopathological conundrum.

Most researchers agree that hallucinations and delusions are the rule rather than the exception in this disorder [17–36]. Scientists describe the same symptoms but label them differently, such as

hallucinations and delusions or hallucinations and delusion-like fantasies, as we did in our analysis of the clinical case of Daniil A. However, we should agree with most authors that the differential diagnosis of DID with schizophrenia and other mental disorders is challenging [37–39].

The differentiation between DID and the so-called temporal lobe epilepsy (absent in ICD-10 and ICD-11 in the psychiatric sense) is the least difficult. It is distinguished by episodic paroxysmal psychoses that occur strictly in time and replace motor epileptic paroxysms. In the case of Daniil A., the diagnosis of epilepsy was rejected, and the pseudopsychotic symptoms did not have characteristics typical of so-called temporal lobe epilepsy.

One of the fundamental issues in forensic psychiatric assessment is whether DID is classified as a nonpsychotic or psychotic mental disorders [30, 40]. It is well known that when faced for the first time with the need to decide on the competency of DID defendants to stand trial, American courts relied almost entirely on the opinion of mental health specialists, resulting in several court decisions declaring defendants with DID mentally incompetent. Later, American courts began to take a stricter approach to the issue of admissibility as evidence of psychiatrists' conclusions about the presence of signs of DID in the accused and particularly about the mental state of the accused during the commission of criminal acts [41].

Brand et al. [42] spoke out against the myths around DID. In their view, DID is a complex post-traumatic developmental disorder with a solid research base for understanding it. However, there are several misconceptions about the disorder. These include the following:

a. the belief that DID is an oddity;

b. the belief that DID is primarily diagnosed in North America and that there is overdiagnosis of the disorder;

c. the belief that DID is rare;

d. the belief that DID can be an iatrogenic and not a trauma-related disorder;

e. the belief that DID is the same as borderline personality disorder; and

f. the belief that treatment for DID is harmful to patients.

In relation to the foregoing, the need to distinguish actual DID from false one [43], formed under the influence of "strangeness" and popularity in mass culture, was emphasized.

Some authors still classify DID as a "fashionable" mental disorder whose significance and representation in psychiatric practice are significantly exaggerated [44]. The basis for considering DID a fashionable diagnosis was the statistical data that showed that from 1922 to 1972, less than 50 cases of DID were registered, whereas by 1990, there were already 20,000 cases reported [45]. This process has been called an "epidemic of mental illness," resulting in the involvement of significant financial resources, the establishment of specialized treatment facilities, and the emergence of many self-proclaimed experts [41].

According to Pietkiewicz et al. [43], there are five criteria for distinguishing a false-positive DID from a real one:

a. approval of the presence of a diagnosis and identification of one's symptoms with it;

b. the use of the concept of dissociative parts of the personality to justify confusion in self-identity and conflicting ego states;

c. acquired knowledge about DID influences the clinical presentation;

d. DID becomes a captivating cause and an important topic for discussion with others; and

e. ruling out the diagnosis of DID leads to disappointment or anger in the patient.

The listed criteria cannot be considered reliable because they are subjective.

Thus, a clinical case of a rare DID in a 19-year-old patient, Daniil A., draws attention to the challenge of diagnosing psychotic disorders within nonpsychotic pathology, which is widespread in modern psychopathology. Furthermore, the clinical aspects of the case raise the question of the need for a clear differentiation of hallucinations from hallucinoids and delusions from delusion-like fantasies. This will help to avoid diagnostic errors.

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