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Identity diffusion as a psychological and psychopathological phenomenon. A non-binary religious person case

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ABSTRACT

The article analyzes the problem of psychological and psychiatric affiliation of identity diffusion as illustrated by the clinical case of 17-year-old Samiha, a girl with an Arabic name who decided to change it to the Korean unisex name Ha-neul. The patient considered herself to be a non-binary person, but sought help at a psychiatric care facility due to suicidal thoughts/tendencies and self-harming behavior rather than gender dysphoria. The article presents a differential diagnosis between the identity diffusion included in the diagnostic criteria for borderline personality disorder, and autopsychic and somatopsychic depersonalization. It is concluded that identity diffusion may be both a psychological phenomenon and a psychopathological symptom. This requires a deeper understanding and inclusion of the new symptom in the psychospathology catalogue. The article suggests that it is important for modern psychopathology theory to keep track of social postmodernist changes as they led to emergence of a new subdiscipline, Neo-Psychopathology, in psychiatry.

Keywords: identity diffusion; gender dysphoria; non-binary; depersonalization; Neo-Psychopathology.

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Диффузная идентичность как психологический и психопатологический феномен. Случай небинарной религиозной персоны

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АННОТАЦИЯ

В статье проведён анализ проблемы психолого-психиатрической принадлежности феномена диффузной идентичности на примере клинического случая 17-летней Самихи — девушки с арабским именем, решившей сменить его на корейское унисексуальное имя Ха-Ныль. Пациентка считала себя небинарной персоной, но обратилась в психиатрический стационар не по поводу гендерной дисфории, а по причине наличия суицидальных мыслей/намерений и селф-харм-поведения. В статье проведена дифференциальная диагностика между феноменом диффузной идентичности, причисляемым к критериям диагностики пограничного расстройства личности, с аутопсихической и соматопсихической деперсонализацией. Сделан вывод о том, что феномен диффузной идентичности может представать не только в форме психологического феномена, но и психопатологического симптома. Это требует углублённого осмысления и нахождения места новому симптому в реестре психической патологии. Высказана идея о том, что для теории психопатологии на современном этапе развития важно отслеживать общественные постмодернистские изменения, именно благодаря им психиатрия обязана рождению нового раздела — неопсихопатологии.

Ключевые слова: диффузная идентичность; гендерная дисфория; небинарность; деперсонализация; неопсихопатология.

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Психологик һәм психопатологик феномен буларак диффуз тәңгәллек. Бинар булмаган дини шәхес очрагы

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АННОТАЦИЯ

Мәкаләдә үз исемен Ханыль (кореяча унисексуаль исем) дип алыштырырга карар кылган гарәп исемле 17 яшьлек Самиха дигән кызның клиник очрагы мисалында диффуз тиңдәшлек феноменының психологик-психиатрия проблемасына анализ үткәрелгән. Пациентка үзен бинар булмаган шәхес дип саный, ләкин психиатрия стационарына гендер дисфориясе уңаеннан түгел, ә суицидаль фикерләр/ниятләр һәм селфхарм-үз-үзен тотышы аркасында мөрәҗәгать итә. Мәкаләдә шәхеснең чик тайпылышын диагностикалау критерийларына кертелгән диффуз тәңгәллек феномены арасында аутопсихик һәм соматопсихик деперсонализация белән дифференциаль диагностика үткәрелгән. Диффуз тиңдәшлек феномены психологик феномен формасында гына түгел, психопатологик симптом формасында да күзалланырга мөмкин дип нәтиҗә ясалган. Бу әлеге яңа симптомны тирәнтен аңлап, аңа психик патология реестрында урын табуны таләп итә. Психопатология теориясе өчен үсешнең хәзерге этабында Иҗтимагый постмодернистик үзгәрешләрне күзәтү мөһим, психиатриядәге яңа бүлек — неопсихопатология бүлеге барлыкка килү дә нәкъ менә шул үзгәрешләргә бәйле.

Төп сүзләр: диффуз тәңгәллек; гендер дисфориясе; бинар булмаганлык; деперсонализация; неопсихопатология.

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BACKGROUND

The concept of identity disorder is hardly used in psychiatry and is not among the diagnostic criteria for mental and behavioral disorders. Exceptions include the recently incorporated to ICD-11 diagnosis of dissociative identity disorder, formerly called multiple personality disorder, and certain characteristics of gender dysphoria, which was excluded from the psychiatric section of ICD-11. However, at the current stage of development of psychiatry, there are grounds for recognizing identity disorders not only as psychological phenomena, but also as psychopathological symptoms. First of all, this refers to the phenomenon of identity diffusion (ID), which is regarded as instability and uncertainty of self-esteem, self-perception of a person's self, which are experienced as a lack of authenticity and integrity of one's own life story [1–12]. According to Akhtar [13], the syndrome of identity diffusion includes six clinical features: 1) contradictory character traits, 2) temporal discontinuity in the self, 3) lack of authenticity, 4) feelings of emptiness, 5) gender dysphoria, and 6) inordinate ethnic and moral relativism. This syndrome is more common in young adulthood, involves severe character pathology, and is distinct from adolescent identity crisis. Identity diffusion usually creates significant difficulties in the adaptation of a person in society, and is particularly acute in situations of uncertainty or freedom of choice.

In psychiatry, the term *depersonalization* is traditionally used to refer to the "loss of self" and to the fact that a person does not accept (rejects) their own feelings, experiences, and sensations. In some cases, inconsistency in self-perception is referred to as ambivalence or ambitendency [14]. Depersonalization syndrome is a self-consciousness disorder with a sense of alienation of some or all mental processes (thoughts, perceptions, memories, relations to the surrounding world), often realized and painfully experienced by the patient. The autopsychic variant of depersonalization reflects a distorted perception of one's self close to the concept of identity disorder within affective, dissociative, and delusional disorders [15–19]. Thus, it is significant from theoretical and practical points of view to recognize the discovery of clear differentially diagnostic criteria of identity disorders, on the one hand, and autopsychic depersonalization, on the other. An important question is whether identity diffusion should be categorized as a psychological or psychopathological phenomenon.

The following case report of a 17-year-old female patient, Samiha,[1] who decided to change her name to Ha-Neul[2] and presented to a psychiatric hospital after a period of distressing suicidal ideation/intentions and self-harming behavior, can be considered representative in terms of psychopathological analysis of the phenomenon of identity diffusion (non-binary gender identity and religious identity disorder).

CASE REPORT OF 17 Y.O. PATIENT SAMIHA (HA-NEUL)

Anamnesis vitae according to the patient and her father

There is a mental illness in the family history; the father has sought help from psychiatrists for depression, takes antidepressants. The patient was born in a Muslim country in the Middle East, the first of three children (brother is two years younger, sister is five years younger). At the time of Samiha's birth, her mother was 20 years old and her father was 21 years old. There is no data on the course of pregnancy, childbirth and early development. According to the patient, she was an active and sociable child, often hitting her head, and "people thought she would start running up the walls". She attended preschool institutions, spoke Russian with the children and Arabic with the teachers, and had no difficulties in adapting. In elementary school, she was home-schooled by a Russian teacher for the first two grades. A year later, she started going to an American school, which she attended for two years. The school was chosen by her father, who wanted her to know several languages. She got on well with peers, but was friends with only one girl. Her parents were in the family business, tailoring clothes under Sharia law, where her mother was a designer, and her father was a manager. The family was considered religious and all the Islam traditions were observed, including wearing traditional Muslim clothing. The father, in addition to business, studied religious texts in depth. He was irascible, uncompromising, and demanding, especially regarding household duties. He believed that women's role (mother, daughter) in the family is secondary, subordinate, and demanded strict fulfillment of all women's duties, in particular, in servicing the head of the family. He imposed total control over the behavior of other family members, forbade his relatives to show any emotional reactions in his presence: no crying, objecting, or arguing. According to Samiha, "he did not and does not know how to control his negative emotions, he is hot-tempered, and takes out anger and frustration on others", especially when he is in a bad mood. He could raise his hand against his wife and daughter, claiming that "a woman should not say anything in front of a man, and he can even hit her". The patient's mother was dreamy, romantic, and submissive. Her brother was closed, did not like people ("human faces cause disgust"), tended to get angry at people and accumulate resentments. Once he asked Samiha whether she could stab someone in the liver. In Samiha's opinion, if her brother ever took a gun, he would shoot her first. The relationship with him was "cold, he was going through adolescence, and was not very humane". Her

[1] The names are changed. Samiha is a female's name of Arabic origin.

[2] The names are changed. Ha-Neul is a Korean unisex name.

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younger sister was cheerful, smiling, friendly, easily contacted with other people. The patient's relationship with her sister was much better: "she takes after me, she likes me, she finds me interesting, motivating". Her parents' relationship was always difficult, they often argued and fought loudly. "It was scary that something tragic was going to happen". Her parents often mentioned a divorce. The day her mom died there was also a scandal, her father broke a chair in anger. Her mother died of a heart attack when Samiha was 11 years old, which the girl attributes to the prolonged stress her mother was under due to relationships in the family. After her mother's death, her grandmother (her father's mother) was in charge of raising the children and managing the household. Her father tried to build a new relationship, the first stepmother lived with them only two weeks, the second one for two years ("she severely traumatized not only mine, but the others' mental state too, she was very narcissistic, gained the children's trust, believed that I should be grateful to her ..., she put a lot of pressure, was jealous of the father, criticized any actions of other people, suspected everything bad"). Despite this, she could not get along with the patient's father due to his pressure and "left him for her own good".

After completing the second grade of school at the age of eleven, Samiha and her family moved to Russia. She went straight into fifth grade. She studied there for less than one academic quarter and was transferred to home schooling because of being bullied by her classmates ("the boys at school bullied me, everything about me seemed weird to them, they laughed and mocked at me... my dad said that every day I came home from school crying"). In sixth grade the patient moved with her family from the city to the countryside, to a private home, since the father wanted to keep his daughter away from bad influence and make her life safer. Since then, she started online schooling, all the way through 9th grade. During schooling, she liked English and Russian. She had no friends during her studies and mostly socialized online. Her father missed the deadline for the submission of documents for the Basic State Exam two years in a row, so she did not study at all for almost a year and a half. Later, she began to study independently and at the same time studied the Korean language ("I wanted to master the language that my father doesn't understand"). In the middle of 10th grade, depression started and the patient passed the Basic State Exam only at the third try. She then enrolled in a teacher training college, where she is still studying. She started living in a dormitory, separately from her father and family. Her relationships with roommates did not work out ("they are scared of me, do not immediately voice their complaints, try to take me by surprise, as if I would bite them"). Her relationships in the fellow students are normal, without any conflicts.

From the early childhood, in accordance with family traditions and religious rules, the patient prepared herself to wear a headscarf (hijab, niqab[3]). She considered it an integral and obligatory part of Islam, proof of true faith. She started wearing it of her own free will, proud to fulfill the canons of Islam. She has never worried about it or felt embarrassed. However, later on she started thinking differently about wearing the hijab.

Pubertal development

At the age of nine, the patient had her first romantic interest in a woman. A distant relative came to visit and she seemed so beautiful that Samiha "wanted to become a prince, kiss her, and take her away". From the age of 12–14 she started considering some girls cute, and was attracted to them ("we dreamed with a friend that we would marry twins, live in the same house, and the men would be there to observe conventions"). At the age of 16 or 17, she was sexually attracted to a girl. She has never liked men, and fantasies about relationships with them seemed unnatural. Since that age, she has realized that she could not categorize herself as either female or male ("I'm trixic and I only like women"). She did some research on the internet and concluded that she is a non-binary person. "I'm not interested in or comfortable being with a man, I'm not attracted to them at all, I first noticed it when I was 16. When girls listen to Korean bands, they want to be with idol singers, but I don't". She claims that she cannot perceive herself as a lesbian: "It's like I'm out of my element. At the same time, I can only imagine a feminine man to be with". She planned for breast reduction or mastectomy but conceded that she might change her mind. "I still won't become fully male, I can't fight to be perceived as a man, I can only perceive myself as more masculine, but I can't get others to perceive me that way. I present myself as a man in computer games". She told that she had decided to change her Arabic feminine name to the Korean one Ha-Neul, which can be either feminine or masculine. She claimed that she did not like her real name, "I don't feel like a person called Samiha, besides, I want to remove my patronymic". Menarche was at the age of 12, she had irregular menstruation and amenorrhea for up to eight months in the year. She has not had sexual experience, has masturbated since 10–11 years old, and experienced orgasm.

Anamnesis morbi

The patient believes that her psychological problems began at 11, when she experienced "state of shock" because of witnessing her mother's death. At the time of her mother's death from myocardial infarction, she was in the next room and had to help her father perform resuscitation measures. In doing so, she "felt her mother's body exhaling air, heard the sound of her voice". Since that time, it was as if she had "fallen out of reality", things around no longer seemed

[3] Hijab and niqab are traditional headdresses for Muslim women.

real, she perceived herself as in a video game, not in reality: "I was not a real person, I did not exist during that period, I perceived myself as something inferior, subhuman, I could not understand my own essence, I did not control my body directly, I looked in the mirror and did not feel that it was me, my reflection looked at my body, for some time I did not even understand what I liked and what I did not like, what I wanted and what I did not want, I just existed, with no personal interests, I did not believe and still do not believe that my mother died..".

Samiha's father became even more irritable after her mother's death, reproached her for being insensitive, she realized that she should "bottle up her emotions and help to cope with the situation, rather than deal with her own problems, she should not have the right for a personal space". Samiha's father expected her to help him in business instead of her mother. Sometimes he behaved "like a kid", demanding that his daughter emotionally support him and even "stroke his back and massage his head". Samiha adamantly refused to touch him, which made him even more angry and annoyed. At times, she suddenly had her previous energy level back, tried to get a lot of things done, managed to be productive. Such periods lasted for 2–3 days, but then everything became dull again, desires disappeared. She called such a state burnout. Later, the "bright periods" stopped.

At the age of 15, she first noticed signs of "serious depression", she had no strength to get out of bed or talk to people, her mood decreased, she did not want to do anything, she isolated herself from everyone both physically and morally, gained weight (10 kg), she had "no strength to cry, especially since at home tears were still considered as something bad, and it was still forbidden to show emotions, as it was perceived as manipulation". Samiha's father noticed symptoms of depression in her and referred her to a psychiatrist. She was prescribed sertraline up to 200 mg/day, which she took for two years. She did not notice any significant effect from the treatment: "The medicine suppressed emotions, but the mood did not return to normal. I could not cry, nut the medicine helped limited extreme emotional manifestations". While taking sertraline with no improvement, she started to think about suicide, and wanted to cut her wrists and die. She thought over the strategy of suicide: "I will spread cellophane in the bathhouse, as it is a place where I can have privacy and where it is easy to clean up after me. I will put a towel next to me so that they can wipe the blood afterwards, and I will put a basin nearby. I felt no pity for myself". She often had suicidal thoughts in the form of images: she imagined killing herself in various ways, such as crushing her head or something else unusual. She "was being creative" in such a way. Subsequently, as her psychiatrist prescribed, she started taking venlafaxine up to 300 mg, aminophenylbutyric acid 500 mg, trazodone 100 mg daily without significant improvement. Along with suicidal thoughts, she had the desire to cut herself. She cut her thigh with a blade, which helped her cope with too many thoughts in her head. She thought she was partly doing it to spite her father: "He didn't see it, I was protesting quietly, I couldn't protest out loud". Self-cutting made her feel better. One day her father "freaked out", grabbed her roughly by the hair, and slapped her on the back of the head. Another time he was extremely annoyed that his daughter had created a new telegram channel, which he strongly disapproved of. Samiha's memories of him once taking her phone away for months came back, with resentment. During the same period, the head of the college group happened to see the cuts on Samiha's arm and insisted on her seeing a psychiatrist, who referred the girl for inpatient examination and treatment.

Mental status on admission to the hospital

In the emergency room she was wearing a hijab, but immediately when discussing this topic, she wanted to take off her headscarf and see whether it was her wish to wear it. She reported that she used to want to close herself off from everyone in this way, as prying eyes were unpleasant. She said she felt like everyone was looking at her. She claimed that this led to a feeling that those around her were violating her personal space. Sometimes she contradicted herself, reporting that she may have "created the illusion of this space herself". When questioned about this in more detail, she recalled that as a child she was looking forward to being able to wear a headscarf. Later, she did so purely of her own free will and with joy.

In the emergency room, she was wearing athletic-type clothing, male underwear, and used a chest binder. "Women's underwear is uncomfortable, there are ruffles, and it is harder to find larger sizes. I like buying the same things so I don't have to worry about it, men's clothes to my taste are easier to find and more comfortable to wear". She said that she did not want to look feminine to spite her father: "My dad is a misogynist, he hates women and used feminine characteristics against me, so now I don't like to look feminine. Moreover, the more feminine you look, the more attention you can get from men, and that's not pleasant. When I try to act feminine, I'm just portraying someone I'm not, I hate being a woman, but I don't think it's disgusting". She said she felt body dysphoria: "I can recognize beauty, but I don't even want to hug men. Friendship is okay, but without any connotation. I'm cautious towards men, whereas girls are safe, I've never liked and I don't like men". In the ward, she took off the headscarf (hijab) almost immediately, as she caught disapproving and uncomprehending looks from others.

She had colored hair. "I bleached it once in the summer, I wanted to dye it pink but chickened out, and I also wanted to dye it green", but "I entered teacher training school and planned to remove my headscarf, because it would have looked unprofessional". She said that she does not use decorative cosmetics and rarely gets her hair cut, because every time she has to convince her dad to go to the hairdresser's.

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At the appointment, she sat cross-legged in the chair, moved her fingers, touched papers on the table, and plucked lint from the socks. She asked to give her a pencil to fiddle with ("I like it, it calms me down"). She maintained little eye contact in conversation, was looking around and spoke in a normal voice. At a doctor's request, she showed the scars on her thigh and forearm, stating the following: "Scars symbolize the struggle for survival, I cherish them, when I cut myself I wanted to have scars, I am satisfied that I went through this, I do not blame myself for it and I am not angry, it is what it is".

She was properly oriented in place, time, and her own personality. She was easily distracted, her attention was attracted and held insufficiently. The pace of speech was normal. She was versatile, outspoken, had an extensive vocabulary. She answered the doctor's questions frankly and was not embarrassed or uncomfortable when discussing intimate topics. She was well-read, and used psychological concepts and terms appropriately. She meticulously analyzed her own experiences and shared them. She was particularly willing to talk about her difficult relationship with her father, tracing how her experiences and feelings stemmed from it: "When asking for money or some kind of permission that my dad has to give me, I feel trapped, flashbacks appear, like I am at home, I am trapped, like I was caught, I can't get out and I will live the rest of my life at home, I see how I have been abandoned again, I have no future again, I am stuck at home, with no connection with the outside world or possibility of free movement, fulfilling my desires". Her mood was lowered, but no external anxiety manifestations were detected, except for stereotyped movements of hands and feet. "It feels like no one is there. I always feel an emptiness inside as if there were nothing to fill it, something bottomless. There is a bottom, but it is too deep and cannot be filled. You can put something there, but the emptiness cannot be removed". "I am ready that anyone could leave me at any time, I would really like to get attached, but I am not ready to be that vulnerable, I can't afford it". There are occasional suicidal thoughts ("maybe screw it all..".). The appetite "dropped significantly when I moved away from my father, earlier I wanted to eat a lot, but now I am more relaxed and have no appetite" (her weight decreased by 1.5 kg in a month). She was thinking at a normal pace, consistently. No hallucinatory delusional symptoms were detected. She ate little in the ward as the food was not halal, and the thought of eating dead meat made her feel uncomfortable. She reported that her sleep was shallow, she woke up unrested in the morning, and had no satisfaction from sleep.

The first days in the ward she slept badly, it took her a long time to fall asleep, she said that "bad thoughts, ugly images, a feeling of dirtiness" interfered. She reported seeing images with her eyes closed: as if her torso was cut "like that of a dead person, and the arms were cut along too, and centipedes and worms were eating the dead carcass". She repeated that she tended to think in images, pictures. At times, she described having flashbacks when she felt like she was losing control, felt trapped, felt like she was going to spend her whole life like that.

Behavior in the ward during therapy (fluvoxamine + psychotherapy)

She noted that during hospitalization she began to feel calmer: "I told myself that I can't change any external problems outside the hospital walls yet, I need to relax and concentrate". "Despite years of isolation, I am not afraid of people, I do not shun them, I am still interested in them, I am curious, and I want people to feel good... Yesterday, as I was given a phone to make a call, I remembered the real world, and I felt sad that I could not be there, but I said to myself: let's imagine that all this is not real, and then I calmed down". During the hospitalization (one month), her mood improved significantly, suicidal thoughts and the desire to self-injure disappeared, and she felt a desire to change her life.

Psychologist's opinion

The patient maintains eye contact, is emotionally responsive, interested in communication, willingly enters into conversation, answers questions to the point, quietly. Regarding herself, she said: "I am studying at a teacher training college, I will be a teacher of junior classes. I like working with children and contributing to their development". She characterizes herself as absent-minded, is dissatisfied with her appearance ("I want to reduce my breasts as much as possible... I have gender dysphoria, but I don't want to change my sex. I am a non-binary person"), as well as her name, surname, and tense relations with her father ("I want to change my name to a Korean one and then change my surname, because my father is always concerned that I will embarrass him"). She told that she loved Korean music and was learning Korean so that there would be an area where her dad couldn't understand or control her. She speaks with gratitude about the psychiatrist who "saved [her] life": "I was preparing for suicide, but I did not want to tell her about it. I thought if she asked me, I would tell her, and she did and sent me to the hospital". She noted improvement in her condition during treatment: "Now depression is gone".

She learns and follows instructions in an experiment, sometimes corrective help is needed. She reacts calmly to criticism. The rate of fulfillment is normal. In the sensorimotor tests, her attention is unstable, exhausts by hypersthenic type (according to Schulte tables: 47"–33"–1'00"–50"–53"). Mnestic abilities are preserved: urgent memorization of 10 words: 6, 8, 10; delayed memorization: 9; productivity of mediated memorization: 100%. She mediates concepts in pictographs with adequate standardized images, more often of specific, singularly attributive content. The drawings are extended, scene-like, overly detailed, with signs of rigidity in graphic characteristics. The verbal associations

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are adequate, of a higher order. The study of thinking activity revealed the categorical level of generalization, logical operation (verbal analogies). When comparing concepts, she relies on essential properties, in isolated cases she actualizes correctable superficial features ("deceit (Russian: «обман») and error (Russian: «ошибка») both start with an O"). She qualitatively establishes the causalities through a series of simple to moderately complex story sequences, understands humor, and composes a detailed narrative. She captures the conventional meanings of proverbs and stories of moderate complexity that she knows. The data of self-assessment and projective methods are as follows: accentuated traits of spontaneity, ease in exposing characterological features, emotional immaturity, lability, rigidity of position, hidden resentfulness and irritability (hypercompensatory attitudes) with increased sensitivity, dependence, insufficient self-control, reduced level of vitality, frustrated affiliative needs, actual unexpressiveness of anxiety and depressive manifestations. In the Draw-a-Person test, the gender signs were undifferentiated; difficulties in contacts, traits of dependence, and lack of support were projectively noted. Self-assessment testing showed no current anxiety and depression (HADS: 4 and 1 points, respectively). *Conclusion:* instability and exhaustibility of attention of hypersthenic type with sufficient intellectual and mnestic abilities in a person with accentuated traits of impulsiveness, hypercompensatory rigid attitudes, emotional lability, immaturity with increased sensitivity, insufficient self-control, decreased level of vitality, relevance of affiliative need.

Other doctors' conclusions

Gynecologist's conclusion: virgo, gynecologically healthy. Neurologist's conclusion: vegetative-vascular dystonia with tension headaches.

Electroencephalographic study

Bioelectrical activity of the brain within the age-appropriate variability. The orienting response to afferent stimuli is adequate. No focal slow-wave activity or significant interhemispheric asymmetry was detected. No epileptiform activity was recorded during the recording period.

Mental status

At discharge from the hospital, the patient was presented at a clinical conference.

She entered the auditorium with a confident stride, without the slightest embarrassment in front of numerous doctors. She was smiling, good-natured, accommodating to the interviewer and clinical discussion. The purpose of the discussion was clear, and she laughed appropriately at jokes. She had a stable mood and was emotionally synthonic. However, when discussing subjectively significant topics, tears came to her eyes and her voice trembled. She was unashamedly willing to discuss intimate issues, both family relationships, gender identity and religiosity. She was inclined to philosophizing, used complex phrases, scientific terms in her speech, but did not look abstruse. She said that she was interested in psychology and would probably change careers after college. She plans not only to change her profession, but also to leave for permanent residence in another country. When asked why Australia was chosen as such a country, she specified that it is the safest place on the planet from her point of view: "there are wars everywhere, the situation is tense, whereas it is calm there". The topic of safety was raised several times during the interview, emphasizing that since childhood she had been subjected to psychological abuse by her father, who she blames for her mother's death. She spoke about her special identity with interest, trying to explain to the audience the essence of the problem and her position. She described how homosexual orientation differs from non-binary identity. Using her own example, she shared that from analyzing her own features as lesbian ones she shifted to recognizing herself as a non-binary person. She understands and clarifies for the audience how non-binary differs from transgender. She does not consider her own desire to reduce her breasts and acquire more masculine features as signs of transsexualism, as she is convinced that she does not aspire to become a man. That is why she chose a new unisex name for herself, which is used in Korea by both men and women. She asked to address her by her new male name, but in the feminine gender. When the professor supported the request, it made her happy. She tends to reason about the fallacy of the binary approach in assessing gender identity. In her opinion, there are multiple genders in the world, and that masculine and feminine are at different poles of the same spectrum.

She evaluates herself as an active, cheerful, creative person with a rich imagination. She also highlights empathy as a feature of her personality. She said that she has the ability to subtly understand her interlocutors' emotions and state, for example, in the ward she was worried about other patients and tried to help them. With barely concealed anxiety, she reported that she is extremely sensitive to loss and betrayal, and used to suffer a lot when someone close to her left her. To somehow compensate for this personal feature, she has developed a viewpoint according to which she initially trusts no one and, starting communication, is ready to part with a person without regret. She noted that now she has only one person whom she is truly afraid of losing. It is an online friend who she has never met in person. She holds her dear because she shares her values and worldview. Meanwhile, she is neither non-binary nor does she belong to the LGBT community.

Samiha is truly grateful to the psychiatrists for relieving her of depression, suicidal thoughts and emotional discomfort during her treatment. When asked what else psychiatrists could help her with, she replied that she could handle all other problems on her own. In particular, she does not think psychiatrists will be able to do anything about gender dysphoria. She is convinced she can handle that on her own

by changing her name and image. In the clinical discussion, she looked masculine, wore wide black pants, a dark-colored over-size jacket, and chunky boots. She spoke freely about religiosity and observance of the traditions of Islam, sincerely trying to explain her own position. She admitted that although she refused to wear the hijab in the ward for the first time in her life, it did not mean that she had given up her faith. She calls herself religious and sees no contradiction in the fact that she has stopped observing certain canonical behavior principles. Nevertheless, she is not sure it will further be like that. She admits she may someday resume wearing the hijab. No evidence of pathology of thinking or perception was found in the interview. She has a high intelligence, and memory and attention without deviations.

DISCUSSION

The presented case report raised several problematic issues for psychiatrists:

1) How can the patient's personal stance on her own non-binary gender identity, fluctuating perceptions of her own religiosity, and professional uncertainty be characterized?

2) Are the listed phenomena psychopathologic or psychological in nature?

3) Do the identified phenomena/symptoms correspond to any diagnosis of a mental or behavioral disorder?

4) Is it possible to recognize that the patient has identity diffusion or is it autopsychic depersonalization?

5) Can these two phenomena/symptoms be combined?

6) Can the patient's identity diffusion resolve in the future, as a "feeling of emptiness" or self-harm usually resolve in adulthood?

The apparent diagnosis of a depressive episode (or dysthymia) observed in Samiha after her mother's death, which met all the diagnostic criteria for this psychiatric disorder, was intentionally not considered diagnostically challenging.

As mentioned above, identity diffusion must be differentiated from depersonalization and ambivalence. The similar qualities of the above conditions are impaired self-perception, self-acceptance, and alienation; the differences include their stability or tendency to fluctuations, as well as different levels of criticality. Ambivalence occupies a different position from the others, it lacks criticality, experiences are destructive, and thinking and behavior are maladaptive. Depersonalization is associated with subjectively emotionally significant, realized as a grievous, experience of "loss of self", the former integrity and wholeness. In contrast, identity diffusion is not usually perceived by the individual as either a loss or a gain of something new, despite the contradictory realization of one's own change and uncertainty.

In Samiha's case, it is possible to note both permanent and multiform identity diffusion and an episode of depersonalization, which was short and associated with acute psychological trauma. After her mother's unexpected death, Samiha "lost contact with reality", things around her seemed unreal, she perceived herself as in a video game, not in reality, she thought she did not exist, perceived herself as something incomplete, could not understand her own essence, did not control her body directly, perceived her image as a reflection, did not understand what she liked and what she did not like, what she wanted and what she did not want. The listed experiences fit into the concept of autopsychic depersonalization, which was dissociative in nature. Further on, this condition did not recur, but Samiha periodically noted a feeling of inner emptiness: "as if there was nothing to fill it, something bottomless, or as if there was a bottom, but it was too deep, you could put something inside, but the emptiness cannot be removed". This experience led the patient to self-harm. The phenomenon of mental emptiness is considered to be a reflection of depersonalization and dissociation [20].

The patient's recognition of herself as a non-binary person is not associated with depersonalization. From our point of view, it is legitimate to state that Samiha's case presents the phenomenon of identity diffusion, covering at least two spheres of her life, i.e. gender and religious identity. According to ICD-11 and DSM-5, this phenomenon is included in the diagnostic criteria for borderline personality disorder (BPD), along with the patient's chronic feelings of emptiness, self-harm, impulsivity, emotional instability, and fear of rejection. Samiha's non-binary identity in BPD differed from its traditional manifestations non-related to BPD. In particular, the patient lacked signs of gender fluid (indifference), that is, a floating, changeable identity over time. Although she claimed to be "*neither* male *nor* female", she still considered the masculine type the ideal one, that is, she actually prioritized a gender for herself. Due to this she planned to change her female name to a male name and modify her appearance (reduce or remove her mammary glands). Ordinary non-binarity is characterized by gender definiteness not in words but in deeds, but presents itself by the desire to avoid using any gender-alternative pronouns (he, she) in relation to oneself. In Samiha's case, this aspect was absent. She requested to be called by her unisex Korean name, but in the feminine gender, which reflected her gender ambiguity.

Another manifestation of the patient's identity diffusion should be recognized as uncertainty about religiosity. For many years she existed in her desired Muslim identity, strictly observed Muslim behavior and dressing rules, voluntarily wore the hijab and niqab, but since a certain time she decided to remove the traditional headdress. However, she kept stating that she remains religious as before, without ruling out that she may return to following Islam traditions in the future. Refusal to wear the hijab is a rare act in Islam (unless to be considered a social protest). One might assume that Samiha protested in such a way against her father's tyranny, but according to the patient herself, she had dreamed since childhood that she would be part of the Islamic tradition and wore the hijab "as it came from her heart".

The concept of identity diffusion usually describes a person's psychological (personality) traits rather than psychopathology. However, the appearance of this concept in the diagnostic criteria of one of the personality disorders (BPD) raised the question of the inappropriateness of unambiguously attributing ID exclusively to psychological phenomena. It can be assumed that in a number of clinical cases ID may present as a psychopathologic symptom. ID, along with the feeling of emptiness, refer to new psychiatry constructs, which is most likely due to the influence of social factors, impaired adaptation to the conditions of postmodernism, characterized by the impossibility of establishing emotional consonance and loss of self [20].

According to a number of authors [21–31], identity diffusion can be observed not only in BPD, but also in eating disorders, depressive, anxiety disorders, schizophrenia and other psychoses, in autism spectrum disorders, and in substance abusers. From the standpoint of classical psychopathology, this syndrome should not be called ID, but it rather reflects somatopsychic and autopsychic depersonalization due to affective, delusional, or other psychopathological motives. The only exception to this is substance abuse self-consciousness disorders, as addictive persons may exhibit dissociation between the identities of the withdrawer and the addict [32–35].

It should be recognized that ID is not actually considered a multiple personality disorder (dissociative identity disorder), since the patient does not mix two or more identities existing in his or her imagination. ID is not related to classical non-binary identity either, as ID should be characterized by uncertainty, whereas a person with non-binary identity has obviously determined that they are both a woman and a man at the same time and that they have a clear place in the identity spectrum [36, 37]. Samiha did not have classical non-binarity, but rather ID, as she claimed to be *neither* female *nor* male, ruling out being addressed as "they". That is, she remained uncertain regarding her own gender position. She demonstrated a similar tendency in religious identity.

Reversibility or irreversibility of ID in BPD becomes a separate topic. It has been proven that most symptoms of BPD are found exclusively in adolescents or young adults, and with age, feeling of emptiness and self-harm disappear (often without any therapy) [20]. In contrast, in classical non-binary identity, the issue of identity persists with age [38–40].

CONCLUSION

Analysis of the problem of psychological and psychiatric assignment of identity diffusion on the example of the case report of 17-year-old Samiha demonstrates that, along with some other psychopathological symptoms (for example, mental emptiness), which have attracted the psychiatrists' attention in recent years and reflect the essence of postmodern transformations, identity diffusion as a symptom requires in-depth understanding and finding a place in the register of psychiatric pathology. We can agree with V.A. Emelin [41] that "the implicit inability to create sustainable models of identification, the blurring of human identity in modern society is based on the fundamental principle of postmodernism, namely pluralism leading to relativism. The loss of stable reference points is mediated by the cultivation of unlimited choice, refusal to formulate preferred vectors of self-identification". It is extremely important for the theory of psychopathology at the present stage to track social changes. Thanks to them, a new scientific area, neo-psychopathology, emerged in psychiatry [42, 43].

ADDITIONAL INFORMATION

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