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Dissociative Suffering: Should we Believe a Patient's Word?

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ABSTRACT

The article presents a clinical case of a 43-year-old patient, Jasmine, who sought psychiatric help due to "affects that interfere with life: dissociations, regressions, anhedonia, flashbacks, social phobia, asthenia, anxiety, and nightmares." The patient reported that she had consciously changed her place of residence and moved to a city "known for good psychiatrists" to receive qualified help. Over several years of "mental suffering," the patient thoroughly studied psychiatric literature, mastered scientific terminology, gained a deep understanding of the etiopathogenesis of mental disorders, and acquired knowledge of various psychotherapy and psychopharmacotherapy methods. The patient positioned herself as an expert in psychiatry. She independently identified dissociative symptoms (depersonalization, derealization, regression), and diagnosed herself with a dissociative disorder. It is concluded that modern psychiatry faces a new challenge in the objective diagnosis of mental and behavioral disorders — in particular, the widespread prevalence of self-diagnosis and the influence of patient expertise on this process. The issue of therapist trust in patient complaints is shifting from differentiating between genuine symptoms and malingering to assessing how "psychiatric literacy" impacts diagnosis.

Keywords: self-diagnosis; psychiatric disorders; dissociative disorders; histrionic personality disorder; psychiatric semiotics; psychiatric diagnosis.

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Диссоциативные страдания, или верить ли пациенту на слово

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АННОТАЦИЯ

В статье приводится клинический случай 43-летней пациентки Жасмин, обратившейся к психиатрам с жалобами на «аффекты, мешающие жить: диссоциации, регрессии, ангедонию, флешбеки, социофобию, астению, тревогу, ночные кошмары». Сообщила, что для получения квалифицированной помощи осознанно поменяла место жительства и переехала в город, который «славится хорошими психиатрами». Пациентка за несколько лет «душевных страданий» досконально изучила психиатрическую литературу, освоила научную терминологию, глубоко проникла в понимание этиопатогенеза психических расстройств, овладела знаниями в области многообразных методов психотерапии, психофармакотерапии и позиционировала себя в качестве эксперта в области психиатрии. Она самостоятельно выявила у себя диссоциативные симптомы (деперсонализацию, дереализацию, регрессию), поставила себе диагноз диссоциативного расстройства. Делается вывод о том, что в современной психиатрии тема объективной диагностики психических и поведенческих расстройств сталкивается с новым вызовом — широкой распространённостью самодиагностики и влиянием на этот процесс экспертности пациента. Тема доверия врача к жалобам пациента переходит из сферы дифференциации с симуляцией в область оценки влияния «психиатрической грамотности» пациента на диагностику.

Ключевые слова: самодиагностика; психические расстройства; диссоциативные расстройства; гистрионическое расстройство личности; психиатрическая семиотика; психиатрическая диагностика.

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Диссоциатив газаплар, яки пациентның сүзенә ышанырга мы

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АННОТАЦИЯ

Мәкаләдә психиатрларга «яшәргә комачаулаучы аффектлар: диссоциация, регрессия, ангедония, флешбеклар, социофобия, астения, борчылу, төнге коточкыч төшләр» белән газапланулары белән мөрәҗәгать иткән 43 яшьлек пациент Жасминның клиник очрагы китерелә. Ул, квалификацияле ярдәм алу өчен, аңлы рәвештә яшәү урынын үзгәртүен — “яхшы психиатрлар белән дан тоткан” шәһәргә күчүен хәбәр итә. Авыру берничә ел “рухи газаплар” вакытында психиатрия буенча фәнни хезмәтләрне җентекләп өйрәнә, фәнни терминологияне үзләштерә, психик тайпылышларның этиопатогенезын аңлауга тирән үтеп керә, психотерапиянең күптөрле методлары, психофармакотерапия өлкәсендәге белемнәрне үзләштерә һәм үзен психиатрия өлкәсендә эксперт итеп күрсәтә. Ул мөстәкыйль рәвештә үзендә диссоциатив симптомнарны (деперсонализация, дереализация, регрессия) ачыклый, үзенә үзе диссоциатив тайпылыш диагнозын куя. Мәкаләдә шундый нәтиҗә ясала: хәзерге психиатриядә психика һәм үз-үзеңне тотыш тайпылышларын объектив диагностикалау темасы яңа күренеш — үз-үзеңне диагностикалауның киң таралуы һәм әлеге процесска пациентның экспертлыгы йогынтысы күренеше белән очраша. Табибның авыру сөйләгән зарларга ышануы темасы симуляция белән дифференциацияләү сферасыннан пациентның «психиатрия өлкәсендәге грамоталылыгы»ның диагностикага йогынтысын бәяләү өлкәсенә күчә.

Төп сүзләр: үз-үзеңне диагностикалау; психик тайпылышлар; диссоциатив тайпылышлар; шәхеснең гистрионик тайпылышы; психиатрия семиотикасы; психиатрия диагностикасы.

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BACKGROUND

The accessibility of psychiatric resources, psychopathological hypervigilance related to lyssophobia (fear of losing one's mind), and increased expectations regarding one's emotional functioning have contributed to the growing prevalence of self-diagnosis of mental disorders [1, 2]. It has contributed to the emergence of so-called subjective mental disorders (diseases), in which individuals suffer from doubts about their own mental well-being and identify signs of disorders in themselves, the presence of which is not confirmed through specialized psychiatric assessment [3]. In recent years, there has been a significant increase in the number of individuals seeking psychiatric consultations with a self-diagnosed condition. The most commonly self-diagnosed conditions include attention-deficit/hyperactivity disorder, autism spectrum disorders, depressive disorder, bipolar disorder, obsessive-compulsive disorder, anxiety disorders and panic attacks, post-traumatic stress disorder, and subjective cognitive impairment [4–10]. Self-diagnosis of schizophrenia, other psychotic disorders, intellectual disability, or dementia is virtually nonexistent in psychiatric practice.

Dissociative (conversion) and hypochondriacal disorders also fall into the category of dissociative disorders that are "unclaimed" in self-diagnosis, patients with these conditions almost never seek psychiatric help. On the one hand, this is due to the perception of "hysteria" and hypochondria as morally questionable personal flaws or weaknesses rather than actual illnesses; on the other hand, it is related to the fact that acknowledging dissociative and hypochondriacal disorders implies renouncing the very beliefs embedded in them — recognizing the experienced phenomena as false, fabricated, or imagined. The clinical case of Jasmine presented below is unique in this respect. Over several years of "mental suffering", the patient thoroughly studied psychiatric sources, mastered scientific terminology, gained a deep understanding of the etiopathogenesis of mental disorders, and became well-versed in various psychotherapeutic and psychopharmacological approaches — to the point of becoming an expert in psychiatry herself. She independently identified dissociative symptoms (depersonalization, derealization, regression), and diagnosed herself with a dissociative disorder. This raised a crucial question for the clinicians evaluating Jasmine: to what extent her complaints could be accepted at face value, how reliable the provided anamnesis was, and whether it was appropriate to build a diagnostic formulation primarily on the patient's self-report.

CASE DESCRIPTION

A 43-year-old patient, Jasmine, sought psychiatric care with complaints of "affects that interfere with life: dissociations, regressions, anhedonia, flashbacks, social phobia, asthenia, anxiety, and nightmares". The patient reported that she had consciously changed her place of residence and moved to a city "known for good psychiatrists" to receive qualified help.

Anamnesis Vitae (According To The Patient And Her Mother)

Born from the second pregnancy, early development without abnormalities. Six months after her birth, her parents divorced; she has never had any relationship with her father. Her mother always spoke negatively about him, describing him as an "unreliable person" (Jasmine has no personal memories of her father). She was raised by her mother and grandmother and has an older sister (three years her senior). She started attending preschool at the age of three but showed little enthusiasm. She consistently remained socially withdrawn, experienced a sense of alienation from other children, and showed no initiative in group activities. She was a quiet child who preferred solitary activities: playing with dolls and applied makeup to herself. She describes her childhood as "extremely difficult, joyless, and bleak". Her existence was overshadowed by family relationships, particularly with her grandmother. She characterizes her grandmother as authoritarian, exercising strict control over all family members and subjecting them to constant "emotional abuse". Her grandmother often initiated family conflicts and arguments with her mother, resorting to harsh insults and "making a scene". Jasmine describes her mother as weak-willed and detached. She denies having any emotional closeness with her and calls their relationship "painfully codependent". From early childhood, Jasmine perceived herself as a "buffer" between her mother and grandmother, constantly trying to ease their conflicts. She recalls, "During terrible quarrels, I would sit on my mother's lap, try to distract my grandmother, and take the hit myself". She regarded her older sister as a role model and sought closeness, but did not receive reciprocal warmth. She recalls, "My mother drew her into a codependent relationship, treated her as a confidante, and emotionally turned her against me". She notes that her sister often mocked her and ridiculed her flaws. She recalls that amid the negative family atmosphere, her sister started having "asthma attacks". Jasmine emphasizes that the only emotionally supportive adult figure in her life was her mother's brother, who occasionally lived with them.

She started school at the age of seven. Her social behavior remained unchanged: she was withdrawn, avoided social interactions, and struggled to establish close relationships with her peers. However, she emphasizes that she had a strong inner need for communication, "I had a rich inner world, but I was forced into silence; within my family, I was emotionally drained and never learned how to form close relationships". She describes her form teacher as being biased, expressing negative emotions, and humiliating her in front of classmates, saying that "she had an ongoing conflict with my sister and mother, and vented

her anger on me". She experienced significant distress due to the school environment but was unable to discuss her problems at home: "It was not customary to share personal feelings; I did not feel safe and constantly lived in fear of an impending family conflict". Until the seventh grade, she had one close friend: "However, we never discussed personal matters; we simply remained silent together, built model boats, and examined objects under a microscope". Later, her friend moved away, and their communication ceased. Her academic performance was average, and she studied without genuine engagement. In her free time, she willingly attended music school and practiced acrobatics. However, her grandmother suppressed any other leisure activities: "She forbade me from going for walks, strictly controlled my life, and read my personal diaries".

Her adolescence coincided with the early 1990s, a time when her hometown was marked by particularly high levels of crime: "There were no people with a high cultural background around me, and it was terrifying to walk the streets filled with street thugs". Due to conflicts with her teacher, Jasmine's mother decided to transfer her to another school, where most of the students were affiliated with criminal gangs. "I could be caught and bullied, sometimes even beaten. The local boys showed excessive interest in my appearance, I felt constantly targeted, was afraid to leave the house, and life became unbearable". At the age of 13, being at the home of a girl who had a preference for casual sexual encounters, she was seduced and had sexual contact with a 30-year-old man. After some time, this became known at school, and "the boys overblew the situation, spreading rumors that it had been rape. After that, I was subjected to bullying, vulgar taunts, and humiliation". Shortly afterward, on Jasmine's birthday, her uncle (the only person she felt close to) passed away. Amidst a series of distressing events and emotional turmoil, Jasmine dropped out of school and extracurricular activities, packed some of her belongings, and left home. She spent nights on the streets, in stairwells, and in video parlors, or with unfamiliar people. For some time, she lived with a member of a criminal group. She said, "I was drawn to the fact that he had a weapon, as I longed for revenge and felt completely unsafe". After her mother reported her missing, she was brought back home. Her family remained indifferent toward her: "No one tried to find out why I had run away, my grandmother severely punished me, my sister slapped me, and only my mother was happy about my return". She continued to skip school, and her family eventually came to accept it. She spent a lot of time in criminal circles, began actively consuming alcohol and drugs, and get engaged in high-risk sexual behavior, including sex for money. She made several attempts to attend night school but discontinued her studies due to emotional difficulties and subsequently obtained a falsified high school diploma. Between the ages of 19 and 21 years, she developed an interest in journalism, successfully passed a television audition, and subsequently worked as a correspondent and later as a news anchor. During that period, she recalls, "I fell deeply in love with a man who was completely different from anyone else. Finally, I started experiencing emotions, colors returned to my life, and I found joy in spending time together". However, the relationship lasted less than a year and ended dramatically: after an unplanned pregnancy, he pressured her into having an abortion and ended the relationship. At the age of 22 years, she started studying at an advertising institute. She developed a passion for studying, attended brand creation workshops, organized parties and show programs, and felt "engaged in life". She studied until her third year but was expelled due to "carelessness", having failed to pay the tuition on time. She continued living with her mother and grandmother. At the age of 26 years, she re-enrolled in university, but soon dropped out after moving to another city. She worked as a manager, then as a seamstress, and video editor. She did not hold onto these jobs for long because of constant fatigue and alcohol-related issues. Some time later, she returned to her hometown to care for her seriously ill grandmother. Currently, she lives alone, has never been married, and has no children (one pregnancy, terminated by abortion), and is unemployed. In her spare time, she practices yoga and occasionally goes swimming. She has no stable friendships or romantic relationships. Occasionally, she gets acquainted with women on dating sites, intending to attend theater performances and jazz concerts together, but she never follows through with these plans. She describes her financial situation as a "subsistence minimum", which limits her participation in desired leisure activities. After stabilizing her mental health, she plans to pursue graphic design studies. Her medical history includes lumbosciatica, osteoarthritis, biliary dyskinesia, chronic viral hepatitis C, and sexually transmitted infections, including syphilis.

Anamnesis Morbi

She believes that the first issues with her mental health appeared in early childhood. As a result of a challenging family and educational environment, she "felt constant alienation from the world and trusted no one". She lived in a state of constant internal tension and felt anxiety about an impending family conflict. During her first sexual encounter at the age of 13 years, she experienced *dissociation* for the first time: "I went into a stupor, had to build a wall in front of myself, disconnect from reality, and resign myself to what was happening". She notes that at that time, she did not feel either sexual desire or disgust. She does not unequivocally characterize the sexual act as rape. She was deeply affected by the mockery and bullying at school that followed the event, continuing "to save myself through dissociation and detachment". Significant deterioration in her condition occurred after the death of her uncle, when "the colors disappeared, everything became gray and gloomy; I felt depressed, overwhelmed by anhedonia, apathy, and suicidal mood without clear plans". She describes two "demonstrative" episodes of wrist self-harm. The first

happened when she ran away from home in the seventh grade: "I lacked adequate attention and wanted to show that I was struggling". The second occurred during yet another family conflict: "I couldn't find a better way to get through to my grandmother, so I cut myself and showed it to her to make her switch her focus". The cuts were sufficiently deep to leave lasting scars.

Since the age of 13 years, she began consuming alcohol and using drugs, engaging in promiscuous sexual relationships. "I drank heavily, and in that state, I would be taken somewhere and subjected to sexualized violence. Out of despair, I would drink again, and it became a vicious cycle. Every attempt to escape reality only led me into a worse reality". At the age of 15 years, she experienced a single orgasm with a desired partner under the influence of marijuana. Since that moment, sexual intercourse and masturbation have not provided pleasure and have not been accompanied by orgasms (she emphasizes that this remains true even when under the influence of drugs). This has caused her significant frustration.

She describes using all available psychoactive substances, including their intravenous use. She is familiar with the effects of cannabinoids, hallucinogens (LSD), and stimulants (ecstasy, cocaine, and synthetic substances), which she used to "loosen up, bring color into life, and gain energy". Since the age of 15 years, she began experiencing signs of social anxiety, feeling insecure in the presence of others, with a particularly strong fear around men. She recalls "feeling pressure from all sides, being harassed on the streets, and having people whistle after me". On public transport, she experienced "pre-panic states" characterized by sudden fear, shortness of breath, and coughing fits. For the next 10 years, she used drugs and alcohol almost daily. During substance use, she experienced increasing anxiety, whereas at other times, she suffered from depression. She struggled to adapt to the work environment, experiencing "*derealization* — time seemed to flow differently, I felt dazed, like I was collapsing, observing everything as if from a distance, feeling tense and on edge". She identifies the breakup of a close relationship with a man, who pressured her into having an abortion, as a significant psychological trauma: "I trusted a man for the first time, but his leaving was a devastating blow. I fell into a stupor and felt that my life had ended". After the breakup, alcohol and psychoactive substance use became a daily habit; she was "constantly haunted by mild paranoid states and a fear of people". Between the ages of 22 and 24 years, while studying part-time at university, she continued using psychoactive substances, which eventually led to her losing her job. Gradually, the substances ceased to produce euphoria, relaxation, or energy; "they drained my vitality, pushed me into depression, and did not relieve my social anxiety". She made the decision to quit abruptly. At the age of 24 years, she attended Narcotics Anonymous meetings for two years: "I was drawn to the spiritual aspect of the program; before that, everything in my life had felt soulless". She was focused on maintaining sobriety, "felt euphoria, a sense of omnipotence and righteousness, and told myself that I must deserve a good life". However, at the group meetings, she did not feel entirely confident and did not receive the support she needed: "self-pity was not allowed there, all the attention was directed toward the guilt of substance use, with *no provision for the development of a nurturing adult for the inner child*". In sobriety, as required by the 12-step program, "I worked through the steps". She believes that the fourth step ("to thoroughly and fearlessly examine oneself from a moral perspective") significantly worsened her mental state: "I decided to work with my inner critic and stand up for myself by writing down, in detail, all the pain that had been inflicted on me", which led to her initiating conflicts with her mother over past grievances. At some point, she struggled to articulate her emotional state and turned to a psychologist, "but she had plenty of her own problems, so the therapy had no effect". She augmented the list daily, fixating on the smallest details of unpleasant memories (*ruminations*), ultimately writing down around 3000 examples: "What I wrote took on a life of its own and began to control me". At the same time, whenever she started a new job, she experienced "anticipatory social anxiety — I was afraid of being harshly judged, too scared to express my opinion, even to eat in front of colleagues, felt ashamed of everything I did, and suffered from overwhelming insecurity". The ongoing symptoms of *derealization* were compounded by *depersonalization*, characterized by temporary loss of bodily sensation, at times accompanied by fear of her own limb, as she was unable to perceive it as part of her body. Episodes of "panic attacks" and "social anxiety" became more frequent and more intense: she could not control her fear, was terrified of encountering people, stopped going outside, and lost the ability to carry out daily activities. In open spaces, episodes of panic would emerge ("the unknown was utterly terrifying, I feared running into people, especially men, and I could freeze in petrification"). Over time, the "episodes of derealization" became significantly more pronounced: she began to see "monstrous faces" in people standing at bus stops, "their necks stretching like snakes, and the asphalt closing in on me". She experienced continuous anxiety and a persistent sense of negative anticipation, often feeling as though someone was following her with the intent to harm. She first became aware of the emergence of "multiple *voices*" with a judgmental tone, lacking a clearly distinguishable gender. She said, "They were not like those typically heard in schizophrenia, but were directly linked to my thoughts. More often, there was a jumble in my head, making it difficult to make sense of things. For example, in the process of watching a makeup tutorial, a voice would say, that someone as unattractive as me should not even attempt that". She emphasizes that she never trusted these "voices" and actively resisted their influence. She started experiencing *regressions* (which continue to affect her): "sudden recollections, typically related to the Fourth Step of the program, causing me to lose touch with reality

and become fully immersed in that past period. For example, applying cream by lightly tapping my face, it *triggers* a reaction, and the next thing I see in the mirror is a bruised and battered face". For approximately a year, she stayed at home, only leaving her bed when absolutely necessary. She was unable to interact with people and remained in a state of *emotional numbness*. She gradually began to study psychiatric books in depth and initially suspected she had dysfunction of autonomic nervous system, depression, panic attacks, agoraphobia, depersonalization, derealization, and social anxiety disorder. She consulted a psychiatrist, who diagnosed her with **borderline personality disorder**. She disagreed with the doctor's diagnosis, as she did not identify all the symptoms of the disorder that she was familiar with in herself. (She noted, "He mentioned impulsivity and black-and-white thinking, but it's not about impulses; there is always a reason or trigger behind my desperate actions"). She started taking an antidepressant from the selective serotonin reuptake inhibitor group (escitalopram) and an antipsychotic (quetiapine), but experienced only minimal effects. During this period, she intermittently recalled negative memories and perceived distorted images in reflective surfaces, feeling that mirrors and windows of opposite buildings posed a threat. "I was afraid of seeing characters or scenarios from my past life and slipping into *regression*". At the same time, she also experienced obsessive urges to harm herself with sharp objects (knife, needle, pencil), accompanied by internal resistance. After some time, she consulted another psychiatrist, who diagnosed her with an **unspecified psychotic episode** and prescribed a different selective serotonin reuptake inhibitor (paroxetine) and a tricyclic antidepressant (clomipramine). With treatment, her mood stabilized, and both agoraphobia and panic attacks almost completely resolved. However, "voices" of a scolding and accusatory nature would still recur from time to time. A few years later, experiencing "tormentingly low mood, the weight of terrifying memories, and nightmares" ("the city itself and the events associated with it were triggering"), she sought psychiatric help again and was diagnosed with **bipolar disorder type 2**. *She believed this diagnosis was incorrect*, as she had never experienced episodes of hypomania, only occasional abrupt mood swings throughout the day. Despite taking mood stabilizers (lithium carbonate), her condition continued to deteriorate, with "persistent obsessive *ruminations*, *regressions*, and *dissociations*". She describes experiencing "paranoia", feeling as though someone was watching her and fearing exposure when posting personal content on social media. She attributes this heightened alertness to a profound distrust of others. Unable to manage these distressing emotions, she resumed the daily consumption of strong alcoholic drinks after 12 years of sobriety, stating that she did so "out of despair". After three years, she abruptly ceased drinking again, as she had done previously. During that period, she was prescribed gabapentin, which was described as "activating emotions, inducing mild hypomania, increasing talkativeness, facilitating the overcoming of oppressive memories, and bringing mental clarity". After a few months, when the effects of the medication subsided, she switched to lamotrigine but did not notice any therapeutic effect.

At that time, she made the decision to move to a city with access to qualified psychiatrists and psychotherapists. Initially, she actively sought consultations with psychologists in an attempt to understand her condition. Some improvements followed body-oriented psychotherapy. However, dissatisfied with the results, she explored various therapeutic approaches, including schema therapy and cognitive-behavioral therapy. Delving deeply into specialized sources, **she identified symptoms of dissociative disorder** and concluded that psychopharmacotherapy was the most suitable treatment approach. Currently, she continues treatment with duloxetine, lithium carbonate, quetiapine, and gabapentin. Due to the lack of therapeutic effect, she sought psychiatric consultation. Following an evaluation initiated at her request, her case was presented for clinical review in a session attended by more than 50 psychiatrists.

Mental Status

She entered the room with confidence and displayed no signs of anxiety or embarrassment upon encountering the large number of specialists. Her appearance was neat and elegant, with well-groomed hair and subtle, well-blended makeup. A strong fragrance of perfume was noticeable. She requested permission to keep her mask on, explaining that she was undergoing dental procedures and preferred to maintain a presentable appearance. Her medical face mask matched the color of her blouse. Previously, she had attended a consultation with her forearms bandaged, explaining that her skin was covered in scratches and abrasions due to an attack by the family cat. To substantiate her words, she presented a video showing that "the cat had gone rabid, was behaving erratically, and had to be euthanized". She recounted memories of two other cats that had also died: "they fell to their deaths; I scraped them off the ledge". In a tragic tone, she stated that she was "cursed, that everything in life must come through suffering and pain".

During the hour-and-a-half conversation, she became even more at ease, using expressive gestures, joking, and engaging in a free-flowing conversation with the doctors. She displayed a high degree of emotional expressiveness and engagement. Her voice intonations and modulations were expressive, with facial expressions that were lively and congruent with the topic of conversation. When describing her symptoms, she emphasized the distressing nature of her experiences. She used numerous psychiatric terms (dissociation, regression, anhedonia, depersonalization, derealization, hallucinations, etc.) When asked what she meant by dissociation, she described feelings of detachment from reality, when "the external world appears to recede and feel numb". Throughout the conversation, she maintained focus

on the questions and answers without distraction. However, she mentioned that over the course of the conversation, she experienced "regressions and flashbacks", feeling mentally transported back to the 1990s, recalling how she had been mistreated by those around her. She did not recognize any inconsistency in maintaining a coherent and continuous conversation at the same time. She believes that for many years, she has been unable to experience joy or pleasure from anything, whether it be food, nature, or social interactions ("I can only occasionally feel something, and even then, just 3%–5%"). She also reports experiencing "overwhelming fatigue from any activity — once this consultation is over, I won't be able to get out of bed for an entire day". She does not find it contradictory that, throughout the hour-and-a-half clinical discussion, she interacted with the psychiatrists in an engaged and seemingly joyful manner, exhibiting neither anhedonia nor asthenia.

She reported that the most distressing experiences and states for her are as follows:

1) A constant feeling of "collapse, pressure, numbness, tension, and stiffness throughout the body", as if after a severe fall; immediate relief is only provided by physical exercises;

2) Regressions, intrusive memories: "My consciousness becomes clouded when I relive a distressing situation from the past. Overwhelming negative sensations arise, along with a feeling of vulnerability, flashbacks, and a sense of fragmentation, it becomes difficult to distinguish between reality and the past. Distractions such as shouting or physical exercises (jumping, push-ups) help. These states are not accompanied by "voices";

3) Derealization, depersonalization: "For example, when I step off my yoga mat, the floor feels like a sheer drop. I can't pull myself up, lose control, struggle to breathe, and feel fear. Sometimes I see myself from the outside, as if I were trapped in a maze of mirrors, with countless reflections of myself. I can't integrate myself and this creates overwhelming tension";

4) Rapid flashes of negative memories and images: "It feels like a sudden shift in scenery, like watching landscapes blur past through a car window at high speed";

5) Dysregulation, difficulty maintaining focus, rapid shifts between activities;

6) Self-hatred, indirect self-harm (alcohol, drugs, etc.), lack of self-compassion, inner emptiness;

7) Perfectionism, "self-criticism in situations where I fail to achieve perfection";

8) Social isolation, lack of examples of appropriate behavior;

9) Unstable self-esteem (more often negatively biased);

10) Panic attacks, during which inhalation triggers spasms in the intercostal muscles;

11) Ruminations, fixation on insignificant situations, for example: "I was rude to a guy on the bus because of loud music, got stuck on it, and ruminated about it for a long time";

12) Suicidal thoughts: "Why am I alive if nothing helps me heal, but for now, a small hope keeps me going, and I give myself another chance".

During the conversation, she attempted to demonstrate her expertise in psychology and psychiatry by citing the sources she had studied, using numerous "scientific" interpretations of her condition, and criticizing and disproving the diagnoses made during previous consultations, offering her own. She stated that the conclusions of the psychiatrists "were of no value, as they were merely a set of clichés". She described her extensive experience with various specialists, *emphasizing the uniqueness and the seemingly insoluble nature of her case*: "Not every psychologist, even a clinical one, can understand how to work with my numerous neuroses. I need continuous psychiatric support with follow-up in time, if anyone is even capable of taking on such a case and making sense of all these symptoms and syndromes. I attended a dialectical behavior therapy training, but it was for people with borderline personality disorder only, and I felt uncomfortable with my broad range of problems. Cognitive-behavioral therapy is too impersonal for me, it doesn't work with emotions, and I have significant emotional dysregulation. Plus, I need therapy that involves working with the body". She noted that she is familiar with certain psychotherapy techniques and had conducted self-administered sessions of "eye movement desensitization and reprocessing, which only intensified my regressive episodes". Currently, she shared that she is *reading a book on the therapy of dissociative disorders*. She provides a detailed account of her experiences, occasionally lapsing into spontaneous and distracted reflections: "I am made up of phobias, and I am constantly afraid of the recurrence of my dissociative episodes, when I fragment and feel vulnerable. In these dissociative states, I always perceive myself as a defenseless child, and during regression, I lose the sense of the boundaries of consciousness. Emotions are overwhelming, and I don't know how to process them; one trigger leads to another..".

During the conversation, her thinking was coherent and free of associative disturbances, with a tendency toward detailed narration, excessive reasoning, and fixation on subjectively significant topics. No hallucinatory or delusional symptoms were observed at the time of the conversation. At the end of the discussion, when the treatment strategy was being discussed, Jasmin expressed *a wish to undergo electroconvulsive therapy*, as, in her opinion, "it is an effective method for eliminating dissociation and regression".

Psychologist's Conclusion

Behaviorally, she appears well-groomed and exhibits demonstrative manners. She is open and communicative, willingly disclosing unfavorable information about herself (substance and alcohol use, cuts on her arms). She sits and gestures freely, uses a large amount of paper when completing test assignments ("is not frugal with it"), does not hesitate to ask for additional sheets, and frequently scribbles

and blacks out entries. She frequently uses psychological and medical terminology ("autism spectrum, social anxiety, endogenous disorder, self-harm", etc.). Regarding the absence of family and children: "It is emotionally difficult... no communication...no support". She displays egocentric and self-centered behavior, constantly talking about herself and her own experiences, rejecting comments without emotional response or reflection. Occasional episodes of "disengagement" from tasks are observed, resembling mental "blocks" when processing emotionally significant information (e.g., when comparing the terms deception and mistake, she fails to recall the learned sequence of actions, becomes distracted, and literally writes down the words "deception" and "mistake"). Attention shows periodic fluctuations, with cognitive load resulting in unstable, hypersthenic-type fatigue (Schulte tables: 45″, 53″, 44″, 58″). Memory showed instability of retention (number of figures recalled out of 9: 4, 8, 7, 7). Delayed recall of information was preserved at the same level (pictogram test: 80%). The level and nature of figurative mediation of concepts are characterized by primitive imagery and pretentiousness of drawings (enlarged scale, "artistry" with clearly underdeveloped graphic skills). The association between images and given concepts is marked by unconventionality and a tendency toward affectation ("justice": an American police officer "like in the movies") and a pronounced reliance on personal experience ("problem": pills, "diagnosis after diagnosis... and everything else"). The associative process is characterized by an initially normal latency and response quality, with no affective blocks to words associated with her reported problems (e.g., crowd... stadium; nerves... creaking). As the process progressed, a decline in spontaneity was observed, with responses becoming more detached and deliberate (e.g., happiness... death; dose... numbness; truth... complexity), indicating a controlled affective-semantic domain and differentiated processing of personally significant versus insignificant information. In incomplete sentence tasks, she frequently brings up themes of boredom and thoughts of ending her life ("I'm tired of my life", "I hide how fed up I am with life", "I regret living this life", etc.) She actualizes the theme of loneliness, limiting relationships to pets and lacking prospects. Her thinking is characterized by a low level of abstraction, while operations of generalization and differentiation are accessible and rely on externally concrete and sensory-based features. Her judgments tend to exhibit banal reasoning ("over-intellectualization"), for example, in the comparison of deception and mistake: "two sides of the same coin" — "which coin?" — "the consequences are the same"; or morning and evening: "wakefulness", "in the morning you rush, in the evening you relax" — "so if you relax, is it already evening?" — "morning is the beginning of the day, evening is its continuation", and so on. There is no evidence of overgeneralization or abstraction from concrete and personal experience, and she is able to adjust her judgments with external guidance. In the subjective perceptions about her illness and diagnosis, *she remains unpersuadable, firmly convinced that she has mental disorders that are difficult to diagnose and treat correctly*. Based on the results of the questionnaire (SMPI, code 12″843679′, F=80), a maladaptive state was identified, characterized by the simultaneous involvement of opposing tendencies and defenses of both sthenic and hyposthenic types (which may reflect a "cry for help" position, an attempt to attract attention, difficulties in self-understanding, and insufficient capacity for reflection). Overall, the predominant symptomatology is "neurotic", with complaints of depression, dissatisfaction, discontent, a tendency to complain, and "hypochondriacal" concerns. On the Beck Depression Inventory, she scored 41 points (indicative of severe depression). Projective testing (method code MCV 51243607) did not reveal significant anxiety. Instead, the patient's state is characterized by dissatisfaction with the emotional sphere (love, harmony), a tendency toward "passionate" involvement, and a strong need for variety in life, vivid experiences, engagement, and a sense of fulfillment. Conclusion: The patient exhibits demonstrative behavioral patterns and a tendency to attract attention to herself as an exceptional individual. The pathopsychological symptom complex resembles an organic type of cognitive impairment, characterized by unstable concentration, fluctuating endurance, incomplete memorization, a low level of abstraction in reasoning, and gaps in intellectual processing driven by affective mechanisms. Underlying problematic themes related to egocentricity and hedonism are evident. The test results suggest a profile consistent with a mixed personality disorder, currently presenting with pronounced complaints and dissatisfaction.

Neurologist's Conclusion

G90.8 Autonomic dysfunction of the hypotonic type Lumbosciatica caused by degenerative-dystrophic changes in the lumbosacral spine at the L2–L3–L4 level, tonic muscle form, with a chronic recurrent course.

Diagnostic Assessment

Endocrinologist's conclusion: drug-induced hyperprolactinemia syndrome.

Magnetic resonance imaging: no focal changes or mass lesions in the brain were detected on MRI. MRI findings show sinusitis of the left maxillary sinus, signs of an angular kink (kinking) in the C1 segment of the left internal carotid artery, and hypoplasia of the V4 segment of the right vertebral artery. No signs of thrombosis, aneurysmal changes, or arteriovenous malformation were observed.

Duplex scanning of the brachiocephalic trunks: ultrasound signs of atherosclerosis in the brachiocephalic trunks. Stenosis (according to ECST) on the right side: carotid system 20%–25%, internal carotid artery 20%, subclavian artery 20%. On the left side: S-shaped tortuosity of the distal segment of the internal carotid artery. The right vertebral artery has a small diameter.

DISCUSSION

The presented clinical case is of particular interest due to the considerable difficulties in evaluating the authenticity of the diverse psychopathological phenomena reported by the patient, which could not be verified. During the examination, the symptoms reported by the patient, such as flashbacks, dissociation, regression, anhedonia, apathy, asthenia, and hallucinations, were not confirmed. This raises the question of **whether a psychiatrist can base the diagnostic process solely on the patient's statements**. On the other hand, it is essential to understand *the phenomenon of the patient's suffering caused by the presence of phenomena she perceives as real*. In other words, the issue of psychopathological interpretation of the examined patient's condition goes beyond this particular case and necessitates the development of theoretical principles concerning trust or skepticism toward the statements of a presumed patient.

In this regard, Jasmine's complaint is particularly illustrative, as she reported experiencing "regression and flashbacks" during the clinical case discussion and interview, without interrupting the conversation with the doctor, at the same time mentally reliving the difficult years of her life and significant psychological traumas. Externally, it was not reflected in any observable behaviors, such as a vacant gaze or emotional detachment. Similarly, the presence of other "symptoms", as anhedonia, asthenia, and hallucinations, was not confirmed.

It is well known that the diagnostic process in psychiatry almost always relies on the complaints presented by the individual, which are based on their perception and understanding of their own experiences and sensations. This applies, for example, to obsessive-compulsive phenomena, voices, depersonalization, and derealization, the psychiatrist cannot objectively verify the truthfulness of such complaints and must take the patient's word for it. The psychiatrist proceeds from the assumption that seeking psychiatric help (unless malingering is involved), despite its stigmatizing consequences, is driven by the individual's suffering and the need for assistance, whether this is classified as a psychopathological symptom or as "emotional distress".

Another noteworthy feature of the presented clinical case is the patient's high level of "psychiatric literacy" and her self-diagnosis of dissociative (histrionic) personality disorder. During the diagnostic process, psychiatrists concluded that Jasmine's self-diagnosis of dissociative personality disorder largely aligned with professional opinions: **mixed personality disorder with predominant histrionic traits** (F61.0). The uniqueness of this case also lies in the fact that patients are usually reluctant to accept such a diagnosis and tend to perceive their symptoms as real rather than imaginary (fabricated). It is well known that the diagnostic criteria for dissociative personality disorder, in addition to a tendency toward dramatization, egocentrism, harm avoidance, novelty seeking, and reward dependence [11], include a pathologically luxuriant imagination, suggestibility, and a propensity for pseudologia. A potential factor contributing to the development of these traits is recognized as childhood psychological trauma [12]. Furthermore, the definition of histrionic personality disorder specifies that the clinical presentation of the disorder should involve typical distortions in experiences and behavior, including disturbances in the perception and interpretation of objects, people, and events, as well as the formation of distorted interpersonal relationships and self-image [13]. At the same time, patients are typically convinced of the accuracy of their self-assessment and their interpretation of reality. Recognition and acknowledgment of the inaccuracy of one's perception of reality, including self-assessment, is inconsistent with the diagnostic criteria for dissociative personality disorder. It can be assumed that the process of self-diagnosing a mental disorder, the desire to undergo unconventional and drastic treatments (such as electroconvulsive therapy), and the dramatization of her experiences may serve as a form of conditional secondary benefit for Jasmine, an attempt to achieve socialization in the context of isolation, loneliness, unfulfilled potential, and lack of recognition in life.

The presented clinical case of the identification of "subjective mental disorders" in the patient further emphasizes the importance of the issue of psychopathological self-diagnosis and the limits of patient expertise [14], particularly in the diagnosis and treatment of mental disorders. In the article by Anselmetti et al. Dissociative Identity Disorder in Adolescents: From Self-Diagnosis to Transient Illness [15], a link is identified between the self-diagnosis of mental disorders and their subsequent manifestation. In particular, the mechanism of excessive fixation on possible symptoms of a disorder is noted, which are later perceived as real. Another article, provocatively titled Down the Rabbit Hole of Self-Diagnosis in Mental Health[1], emphasizes that "a good diagnosis is a collaborative process, with expertise and lived experience meeting in the middle" [16].

CONCLUSION

Modern psychiatry faces a new challenge in the objective diagnosis of mental and behavioral disorders, specifically, the widespread prevalence of self-diagnosis and the increasing influence of patient expertise on this process. The issue of clinician trust in patient complaints is shifting from the traditional focus on distinguishing genuine symptoms from malingering to evaluating how patient "psychiatric literacy" influences diagnostic objectivity.

[1] "To fall into the rabbit hole" (idiom) means to get into a situation, start a process, or embark on a journey, especially one that is strange, difficult, complicated, or chaotic, particularly those that become more and more problematic as they develop or unfold.

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