

CASE REPORT

**THE PHENOMENON OF DISSOCIATION,  
DEPRESSION AND BORDERLINE PERSONALITY  
IN A YOUNG WOMAN**

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**Abstract**

**Objective:** Early life adversities like parental loss during childhood, physical abuse, sexual abuse and emotional harassment may have deleterious consequences in an individual's life, which can manifest under the form of various externalizing or internalizing behaviors. This case study aimed to highlight the impact of unusual early life adversities in a young woman's mental health and related management issues. **Methods:** We reported a case of a young lady presenting with anxiety, low mood, disturbed sleep and appetite for more than six months. She also had episodes of dissociative stupor following any stressful event for approximately 13 years. She was hospitalized, evaluated clinically as well as by psychometric assessment. Relevant pharmacological and psychological interventions were performed. **Results:** She was diagnosed with Major depressive disorder with dissociative disorder and borderline personality disorder. The patient had multiple stressors during childhood like - loss of parents, emotional & physical abuse, which had an impact on her mental well-being. **Conclusion:** Early life adversities are detrimental to the mental health of an individual. The clinical outcome depended upon on the nature of trauma to the mental well-being, mode of intervention done and available psychosocial supports. *ASEAN Journal of Psychiatry, Vol. 17 (2): July – December 2016: XX XX.*

**Keywords:** Early Life Adversities, Major Depressive Disorder, Dissociative Disorder, Borderline Personality Disorder

**Introduction**

Early childhood is a crucial period of development of physical as well as psychological well-being [1, 2]. Studies on human as well as animals revealed that – stress related to the early life adversities had long-lasting effects on emotional processing in the brain [1, 3, 4]. The impact of early life adversities could be manifested the form of various internalizing and externalizing behaviours [1, 5, 6]. The National comorbidity survey revealed that psychological

development of child gets affected by psychiatric disorders in parents, domestic violence, physical and/or sexual abuse and substance use disorder in the family [7]. Loss of a parent in the childhood had a significant impact on the child's life [8]. Loss of a parent in childhood makes them powerless, and it also affects their self-esteem [8]. The impact of parental loss related trauma in a child depends upon the age at parental loss, other parent's or caregiver's role after the traumatic event, child's attachment with the deceased parent as well as the temperament of the child.

In studies, it was found that childhood adversities lead to amplification of the individual's sensitivity to stress, which persists until adulthood and increases the risk of psychiatric disorders in adults [9 – 11]. Women, who were exposed to childhood adversities like family violence or parental alcoholism, are more at risk of developing depression, than women who were not exposed to such an adversities [12]. Childhood adversities also attribute to dysthymia, social phobia, other anxiety disorders, personality disorders in their adulthood [13, 14].

### **Case Report**

A 25-year-old woman of lower socio-economic status, family income of approximately 2000 rupees/month which approximately to USD 30/month, was brought for psychiatric consultation by her relatives. They reported about her episodes of state of unresponsiveness, which were of sudden onset and during which she would not respond to verbal as well as painful stimuli (stupor) for past 12 years. She also had persistent low mood, anxiety, decreased interest in household activities, and decreased sleep since last six months. These symptoms were independent of the stupor episodes. However, during last simonths, the frequency of episodes of stupor increased to two to three episodes per day with each episode lasting 30 to 60 minutes. Rest of the times, (beyond episodes of stupor), depressive symptoms would persist for most times of the day.

She had episodes of stupor from the age of 13 years, just after her marriage. In India, such early marriages are commonly seen among people with illiteracy, poverty from rural areas. Orthodox culture also plays a role in such early marriages. Each episode lasted for 30 to 60 minute and was not associated with any seizure like activity or tongue bite or incontinence. She had never sustained any injury by fall during such episodes. Stupor episodes were never reported, when she was alone or asleep at her home. On stressful situations, stupor episodes used to increase in terms of frequency and duration. Frequency of these episodes ranges from two to three per day to three to four per month. An increase in the frequency of the episodes was observed since last six months. Over this time period,

she also reported about low mood, hopelessness, helplessness, reduced subjective energy, decreased sleep & appetite, death wishes and decreased interest in previously enjoyable activities. Three months prior to consulting in our psychiatric out-patient department, she was hospitalized in another psychiatric hospital, where she was diagnosed to be suffering from of severe depressive episode and was prescribed antidepressant fluoxetine (up to 60 mg per day), and benzodiazepine (clonazepam 0.5mg twice daily) with improvement in her sleep & appetite. Due to partial improvement, the patient discontinued the treatment and her symptoms worsened. She had a recent attempt of suicide by hanging for which she was brought for consultaion.

She was a primary school dropout. She had two children and one stillbirth. History revealed multiple, significant psychosocial stressors in form of loss of both the parents in the early childhood, neglected & overcritical attitude of the maternal aunt who fostered her later on, early marriage (at the age of 13 years against her will), abuse by the in laws, physical & sexual abuse by her alcoholic husband, frequent domestic violence, teen-age pregnancy (pregnancy at the age of 14 years and 17 years respectively) and poor psychosocial support. Due to these stressors, she got separated from her husband four years back and was in a live-in relationship since then. Due to her live-in relationship, her children were forcefully taken by her brother and were not allowed to meet her as it was perceived as a gross violation of the social customs. Her live-in relationship was also not successful. She frequently got annoyed with her partner on trivial reasons like- when she felt ignored or her demands were not met. Very often, she threatened or attempted to harm herself by slashing her wrist or overdosing sleeping pills. She also had frequent altercations with the wife of her partner's brother.

She was hospitalized following her recent suicide attempt. At the time of hospitalization, her blood pressure was 108/ 70 mm Hg and pulse were 86 per minute & of low volume. Mild pallor was present in general physical examination. Systemic examination did not reveal any abnormality. On mental status

examination, she had decreased rate and volume of speech, reduced use of gesture during conversation, psychomotor slowing, poor eye to eye contact & grooming, depressed affect, ideas of hopelessness and worthlessness, subjectively decreased energy level, death wishes with apparently intact higher mental functions (except slowing of task performance).

A diagnosis of severe major depressive disorder with dissociative disorder (dissociative stupor) was made. Her depressive symptoms were rated on HAM-D (Hamilton's rating scale for depression) and the score at time of admission was 28 indicating severe depression. Her oral intake was monitored. Strict vigilance was ensured in view of recent suicidal attempt. Death death wishes on mental status examination and on-going psychosocial stressors. Her routine blood investigations were within normal limits except low haemoglobin level (10.2 gram%). Psychometric assessment was also done. Her IQ was found to be 90 (on Malin's intelligence scale). Rorschach's Inkblot test revealed depressive psychopathology and emotional conflicts. On Thematic Apperception Test (TAT), her stories revolved around the negative marital relationships. TAT revealed that patient's dominant needs were affiliation nurturance; in order to keep her ego intact, she used defense mechanisms like – suppression, wishful thinking and rationalization. Assessment of her personality on SCID – II (Structured Clinical Interview, DSM-IV, and Axis – II) revealed borderline personality traits.

She was prescribed escitalopram 10mg per day, which was later, escalated to 20 mg per day. Benzodiazepine- clonazepam was given for her anxiety, which was gradually tapered off. Zolpidem was prescribed for insomnia. Her anaemia was treated with Iron & folic acid supplementation. Psychosocial stressors were addressed over multiple therapy sessions. She was trained on progressive muscle relaxation technique. Supportive psychotherapy, anger management and training on coping skill were done during therapy sessions. Daily activity scheduling was done. She was engaged in different recreational and group activities. With these interventions, she had shown

significant improvement and was discharged after six weeks of hospitalization.

## **Discussion**

The above-mentioned patient had multiple early life adversities in the form of – loss of parents, critical fostering after loss of parents, early marriage, unwanted pregnancy, domestic violence, physical and sexual abuse by husband, poor psychosocial support. In this case, we have discussed unwanted pregnancy, domestic violence, physical and sexual abuse by husband as early life adversities as all these events happened at an early age (before 14 years) in her early adolescence. In her life time, she had gone through a series of uninterrupted stressors, including loss of both parents at an early age which had made her feeling of powerlessness stronger. Poor psychosocial support, poverty, forced separation from her children further increased stress, resulting in internalizing (depression, anxiety, self-harm) and externalizing behaviours (impulsivity & demanding behaviour).

Her marriage at the age of 13 years, physical and sexual abuse by alcoholic husband, forced pregnancy are the significant stressors, temporally correlated with the onset of dissociative stupor. It was persisting for 12 years (at the time of psychiatric consultation), with fluctuation in its severity and frequency with ongoing stressors. Separation from her kids and on-going interpersonal issues in her live- in relationship might have attributed to the depressive episode.

She was using defence mechanisms like rationalization, wishful thinking and suppression to combat the distress as explored through the psychometric assessment (Rorschach inkblot test and Thematic Apperception Test). Her negative feeling towards marital relationship due to past adverse experiences might be responsible for frequent impulsive and demanding behaviors. She was treated with antidepressant (Escitalopram) and psychosocial issues were addressed by a multidisciplinary team of psychiatrists, clinical psychologists and psychiatric social worker. With pharmacological intervention and psychological interventions like – progressive

muscle relaxation, supportive psychotherapy, anger management strategies and coping skill training, she showed hown significant improvement.

Childhood adversities have many adverse consequences, which may persist until adulthood. Adverse childhood experiences increase an individual's sensitivity to stress in the later part of life, resulting in a spectrum of psychiatric disorders [9 – 11]. In developing countries like India, where there is a scarcity of psychiatric professionals, exploration of childhood adversities in such group of patients is a very difficult task. It poses a challenge to address the issues of early life adversities on an outpatient basis. Multidisciplinary approach is required in such type of patients to address multiple issues, which affect the course and outcome of the illness.

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