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Suicide Ideas as Dissociative Symptoms in Patients with Severe Depression: A Case report

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ABSTRACT: Dissociative symptoms such as depersonalization, derealization, and amnesia frequently occur in patients with severe depression and significantly heighten suicide risk, particularly when childhood trauma is present. This case report presents a 20-year-old woman with major depressive disorder and dissociative symptoms including unintentional self-harm, hallucinations, and nightmares related to past abuse. Clinical data were collected via structured clinical interviews, direct observation, and patient self-report, with diagnostic confirmation using DSM-5 criteria. The case illustrates how dissociation, trauma, and disrupted emotional regulation interact to intensify hopelessness and impulsivity. Comprehensive treatment, including trauma-focused cognitive behavioral therapy (CBT), pharmacotherapy, and emotional expression techniques such as journaling, led to gradual symptom relief. This case highlights the importance of early identification of dissociative symptoms in depressed individuals with trauma history to reduce suicide risk.

Keywords: Dissociative Symptoms, Severe Depression, Suicide Ideation.

INTRODUCTION

Major depressive disorder (MDD) is one of the most prevalent psychiatric conditions worldwide and a leading cause of disability, with significant implications for premature mortality. According to the World Health Organization (Organization, 2022), more than 280 million people globally experience depression, and suicide remains one of its most severe outcomes. Globally, suicide is responsible for more than 700,000 deaths each year and represents the fourth leading cause of mortality among young people aged 15–29 (Organization, 2019). In Indonesia, suicide rates are estimated at 3.7 per 100,000 population (Health & Indonesia, 2021). However, the true prevalence

is likely underestimated due to strong religious prohibitions and cultural stigma surrounding suicide (Sareen, 2016).

Adolescents and young adults are particularly vulnerable, as studies link suicidal behavior to stress, family conflict, and exposure to trauma (Nock et al., 2009). The COVID-19 pandemic further exacerbated depression and suicide risk, especially among youth (Gvion & Levi-Belz, 2018). Recent evidence also highlights the role of dissociation as a crucial, yet often underrecognized, phenomenon in depressive disorders (Pettorruso et al., 2020). Dissociation is defined as a disruption in the integration of consciousness, identity, memory, and perception (Association, 2013). Its symptoms—such as depersonalization, derealization, amnesia, and identity fragmentation—are highly prevalent among patients with severe depression and are strongly associated with elevated suicide risk (Lewis & Caplan, 2021).

Childhood trauma is considered a key contributor to this link. Adverse childhood experiences such as physical, emotional, or sexual abuse and neglect have enduring neurobiological consequences that predispose individuals to both depression and dissociation (Teicher & Samson, 2016). Dissociation initially functions as a coping mechanism against overwhelming trauma, but when chronic, it may contribute to identity fragmentation and suicidality (Johnson et al., 2002). Neurobiological models show that dysregulation of the hypothalamic–pituitary–adrenal (HPA) axis, hippocampal damage, and hyperactivity of the amygdala further mediate these associations (Kupfer et al., 2012 & Mann, 2014). Emerging evidence also suggests that dissociative processes alter decision-making and increase impulsivity in suicidal individuals (Ai et al., 2023; Barch et al., 2023).

Several theoretical frameworks explain how dissociation amplifies suicide risk. The Interpersonal Theory of Suicide Joiner, (2018) proposes that dissociation lowers the fear of death and contributes to acquired capability for suicide. The Integrated Motivational–Volitional (IMV) model emphasizes the volitional role of dissociation in transitioning from suicidal ideation to attempt (O'Connor & Kirtley, 2018; Perroud et al., 2011). The Trauma Model of Dissociation (Kolk, 2014) describes dissociation as initially protective but pathological when persistent.

Cultural factors further complicate this picture. In Indonesia, dissociative symptoms may be misinterpreted as spiritual possession, leading families to seek religious or traditional healing rather than psychiatric care (Rif'ah & Arridlo, 2024). Such pathways delay effective treatment and increase the likelihood of suicide attempts. Addressing these complexities requires culturally sensitive, trauma-informed approaches that integrate both clinical and sociocultural perspectives.

This case report describes a 20-year-old Indonesian woman with severe depression, dissociative symptoms, a history of trauma, and suicidal ideation. It highlights the role of dissociation as a hidden but critical risk factor, and emphasizes the need for integrated, multimodal treatment(Heeringen & Mann, 2014).

METHOD

This case report is based on a comprehensive clinical evaluation of a 20-year-old female patient diagnosed with severe major depressive disorder with dissociative symptoms, according to DSM-5 criteria. The assessment was conducted by a psychiatrist and clinical psychologist through structured clinical interviews, direct behavioral observation, and a review of medical records. A detailed psychosocial history was obtained, with particular attention to trauma exposure using a trauma screening interview adapted from the Childhood Trauma Questionnaire (CTQ). Suicidal ideation was assessed using the Columbia-Suicide Severity Rating Scale (C-SSRS). Ethical approval was obtained from the institutional review board, and the patient provided informed written consent for the publication of this case.

RESULT AND DISCUSSION

Presenting Complaints

The patient, a 20-year-old woman, presented to psychiatric services with persistent sadness, loss of interest in daily activities, feelings of worthlessness, and recurrent suicidal ideation. She reported experiencing overwhelming fatigue, impaired concentration, and frequent crying spells. Suicidal thoughts occurred daily and were described as intrusive, accompanied by a sense of inevitability: *"I often feel that ending my life is the only way to stop the pain."*

In addition to depressive symptoms, she exhibited dissociative phenomena. She frequently described depersonalization episodes, such as *"I feel like I am outside my body"* or *"I am watching myself from afar."* Episodes of derealization also occurred, characterized by perceptions that her environment felt dreamlike or unreal. She reported amnesia surrounding certain self-harming behaviors, including cutting her arms and legs, which she only discovered afterward upon noticing scars or blood.

The patient also reported experiencing auditory hallucinations, particularly voices commanding her to harm herself. These perceptual disturbances occurred in conjunction with nightmares of her mother physically and verbally abusing her. During such episodes, she entered a trance-like state, disconnected from reality, and later struggled to recall the events clearly.

Trauma History

A detailed psychosocial interview revealed a history of chronic trauma:

- **Domestic Violence Exposure:** From early childhood, she witnessed frequent conflicts between her parents, which often escalated into physical violence.
- **Maternal Abuse:** She described her mother as critical, emotionally cold, and physically punitive. She recounted being beaten, slapped, and verbally humiliated in front of peers.

- **Sexual Harassment:** During adolescence, she was subjected to inappropriate sexual contact by an older male relative. The event was never disclosed to her family due to fear of blame and stigma.
- **Bullying at School:** Repeated peer rejection and name-calling further compounded her feelings of worthlessness.

These adverse experiences contributed to her pervasive sense of shame, mistrust, and social withdrawal. They also provided the context for her dissociative coping strategies.

Family and Cultural Factors

The patient grew up in a household where mental illness was stigmatized. Her family interpreted her symptoms—particularly the trance-like states and auditory hallucinations—as evidence of spiritual possession. They initially sought help from religious leaders and traditional healers, who performed rituals and prescribed prayers. Although these interventions provided temporary reassurance to the family, the patient's symptoms persisted and gradually worsened. Only after multiple failed traditional interventions did the family consent to psychiatric evaluation.

This cultural trajectory of help-seeking highlights the delayed referral pathways common in Indonesia, where religious explanations often overshadow psychiatric interpretations.

Mental Status Examination

On initial examination, the patient appeared withdrawn, with poor eye contact and reduced speech. Her mood was described as *"empty and hopeless."* Affect was blunted and constricted. Thought processes were logical but marked by ruminations of guilt and worthlessness. Thought content was dominated by suicidal ideation, sometimes accompanied by fleeting plans of overdosing on household medications. Auditory hallucinations were reported but were episodic and directly linked to trauma-related triggers. Insight was partial: she acknowledged being "unwell" but attributed part of her experience to external forces.

Treatment Interventions

The clinical team implemented a **multimodal treatment plan**, tailored to address both depressive and dissociative symptoms:

1. **Trauma-Focused Cognitive Behavioral Therapy (CBT)**
   - Weekly sessions targeted maladaptive cognitions, such as self-blame and perceived worthlessness.
   - Techniques included thought monitoring, behavioral activation, and gradual exposure to trauma memories through narrative restructuring.

- The therapist emphasized grounding techniques to help manage dissociative episodes.

2. **Pharmacotherapy**
   - Initiated on fluoxetine 20 mg/day, gradually titrated to 40 mg/day.
   - The patient tolerated the medication well, with no significant adverse effects.
   - Mood improvements became evident after six weeks, with reduced crying spells and better sleep.
3. **Adjunctive Journaling Therapy**
   - The patient was encouraged to keep a daily journal documenting emotions, thoughts, and triggers.
   - Journaling served as a safe outlet for unexpressed feelings and improved her self-reflection.
   - Reviewing journal entries during therapy sessions enhanced her awareness of dissociative patterns.
4. **Family Psychoeducation**
   - The patient's family participated in psychoeducation sessions, which explained the psychiatric basis of her symptoms.
   - Emphasis was placed on reducing stigma, fostering empathy, and avoiding blame.
   - The family was guided on how to support her during dissociative episodes and suicidal crises.

Clinical Progression

The patient's progress was tracked over three months:

- **Week 2:** She reported mild relief of depressive symptoms, though dissociation persisted. Auditory hallucinations became less frequent. Journaling increased her ability to articulate emotions.
- **Week 6:** Significant reduction in suicidal ideation was observed. Sleep improved, though nightmares remained. She demonstrated improved ability to reality-test dissociative experiences.
- **Week 12:** The patient reported greater emotional stability, improved mood, and reduced frequency of dissociation. Self-harming behaviors ceased, and she developed coping strategies such as grounding exercises and expressive writing. Her relationship with her family improved slightly after psychoeducation sessions.

Current Status

At the time of last follow-up, the patient continued with outpatient psychotherapy and pharmacotherapy. She expressed cautious optimism about her recovery, stating: *"I still have bad days, but now I know I can survive them."* Dissociative episodes had decreased in frequency and intensity, and suicidal thoughts, while not fully absent, were less intrusive and more manageable.

The complex interplay between depression, dissociation, and suicidality has received increasing attention in recent years, as research continues to reveal the multidimensional pathways linking these phenomena. Dissociation can conceal suicidal intent by disrupting awareness of self and memory, while at the same time reducing pain perception and fear of death, thereby facilitating suicidal behaviors (Yaseen et al., 2020). This paradox positions dissociation as both a defensive

mechanism and a risk amplifier in depressive states. Meta-analytic findings confirm that patients with depression and co-occurring dissociation are significantly more likely to attempt suicide compared to those with depression alone (Lyssenko et al., 2018).

The Integrated Motivational–Volitional (IMV) model provides a useful framework for conceptualizing these dynamics, emphasizing the volitional role of dissociation in the transition from suicidal ideation to attempt . More recent work has refined this model, showing that dissociation mediates the impact of defeat and entrapment on suicidal intent, particularly in young adults exposed to trauma (Taylor et al., 2021). These findings resonate with the present case, where trauma-related dissociation not only concealed suicidal ideation but also intensified impulsivity.

From a neurobiological perspective, dissociation has been linked to dysfunctions in stress-response and memory integration systems. Dysregulation of the hypothalamic–pituitary–adrenal (HPA) axis and sustained cortisol elevation impair hippocampal integration of memory, promoting dissociative amnesia (Teicher & Samson, 2016). Functional neuroimaging studies demonstrate altered connectivity within the default mode network (DMN), particularly between the medial prefrontal cortex and posterior cingulate cortex, which correlates with rumination, detachment, and suicidality (Chase et al., 2021). Moreover, dissociation has been associated with aberrant decision-making processes: Ai et al. (2023) found that suicidal individuals showed altered anticipation and experience of regret, suggesting impaired cost–benefit evaluation, while Barch et al. (2023) reported that dissociation interferes with cognitive effort–based decision-making, explaining difficulties in adaptive functioning and risk regulation.

Emerging evidence also implicates inflammatory processes. Elevated markers such as interleukin-6 have been linked to dissociation and suicidality, supporting an integrative biopsychosocial model (Olié et al., 2020). This reinforces the view that biological vulnerabilities interact with trauma and psychosocial adversity to increase suicide risk.

Distinguishing dissociation from psychosis remains a clinical challenge. Dissociative hallucinations are often trauma-linked and episodic, whereas psychotic symptoms in schizophrenia are persistent and accompanied by thought disorder (Rajkumar, 2022). Misdiagnosis not only delays appropriate trauma-focused care but also exposes patients to unnecessary long-term antipsychotic treatment. The implications for suicide risk assessment are considerable: traditional tools may underestimate risk in dissociative patients, as they may not fully disclose suicidal thoughts during episodes of amnesia or detachment. Innovative assessment methods, such as ecological momentary assessment (EMA) and digital monitoring tools, may improve real-time detection of suicidal crises (Çörekçi & Erermiş, 2022).

Treatment approaches for dissociation in depression and suicidality must be multifaceted. In this case, trauma-focused CBT effectively reduced depressive and dissociative symptoms. Grounding techniques anchored the patient in the present during dissociative episodes, while cognitive restructuring targeted maladaptive beliefs. This aligns with broader evidence supporting CBT as a first-line intervention for trauma-related depression (Cloitre et al., 2019). Other modalities also show promise. Radziwiłłowicz & Lewandowska, (2017) EMDR facilitates integration of fragmented trauma memories and has demonstrated efficacy in reducing suicidality in traumatized

populations (Valiente-Gómez et al., 2020). Dialectical behavior therapy (DBT) remains particularly effective in addressing self-harm and dissociation through skills training in emotional regulation and distress tolerance (Linehan, 2015) .

Pharmacotherapy, including SSRIs, may provide supportive benefits, though recent evidence suggests pharmacological treatment alone is insufficient to address dissociative mechanisms (Shen et al., 2023). Adjunctive strategies such as ketamine-assisted psychotherapy are being explored as novel interventions for suicidality in trauma-related depression, with meta-analyses showing rapid reductions in suicidal ideation(Kılıç et al., 2017). Low-cost approaches such as expressive writing and journaling also remain powerful tools for managing dissociation. They enhance self-awareness and reduce avoidance, as demonstrated in clinical trials (Sloan & Marx, 2019). This resonates with the present case, where journaling helped the patient identify emotional fluctuations and dissociative triggers.

Socioeconomic and environmental factors also significantly shape trajectories of depression, dissociation, and suicidality. Individuals from lower socioeconomic backgrounds experience higher levels of chronic stress, reduced access to mental health care, and greater exposure to trauma (Shah & Patel, 2020). Recent research confirms that economic hardship and unemployment are strongly associated with suicidal behaviors, with dissociation mediating the link between stress exposure and hopelessness (Ibrahim et al., 2019). Addressing social determinants of health must therefore be part of any comprehensive suicide prevention strategy.

Digital and technological interventions have recently expanded the landscape of suicide prevention. Smartphone-based EMA and artificial intelligence (AI)–driven algorithms can track real-time fluctuations in mood, dissociation, and suicidal ideation (Davidson et al., 2022). Mobile mental health applications have demonstrated efficacy in delivering CBT-based strategies to populations with limited access to in-person care (Linardon et al., 2019). In Indonesia and other low-resource settings, such digital tools could provide vital support where psychiatric resources remain scarce and stigma impedes help-seeking. Nonetheless, concerns remain regarding privacy, digital literacy, and the cultural adaptation of these interventions (Melia et al., 2023).

Gender also shapes the manifestation of dissociation and suicidality. Women are more likely to experience dissociative symptoms following traumaMertin & Hartwig, (2020), especially childhood sexual abuse, whereas men often exhibit externalizing behaviors such as aggression and substance misuse (Martínez-Aguayo et al., 2021). Studies confirm that dissociation among women is a significant predictor of suicidal ideation and attempts (Sar et al., 2017). In collectivist cultures, gender-based violence, familial expectations, and limited autonomy can further intensify dissociation and suicide risk. This underscores the importance of gender-sensitive assessment and interventions.

Future directions in research and practice highlight the need for integrative approaches that address biological, psychological, and sociocultural dimensions. Recent reviews emphasize the role of neuroinflammation and epigenetics as promising biomarkers for personalized treatment (Olié et al., 2020). Psychedelic-assisted psychotherapy, including ketamine, is emerging as a potential intervention for treatment-resistant depression with dissociation (Wilkinson et al., 2020).

Longitudinal studies remain essential to trace the trajectory of dissociation across development, as well as to evaluate the effectiveness of combining digital and traditional interventions.

In clinical practice, integrating trauma-informed care into primary health systems is vital, particularly in low- and middle-income countries. Training frontline health workers to recognize dissociation and suicidality, combined with community-based psychoeducation, may reduce delays in care (WHO, 2022). Cross-cultural research is also needed to understand how dissociation is conceptualized in non-Western contexts, and how culturally adapted interventions can improve engagement and outcomes (Rif'ah & Arridlo, 2024).

Taken together, the literature emphasizes that dissociation is not a peripheral symptom but a central determinant of suicidality in depression. Effective management therefore requires a multimodal strategy encompassing psychotherapy, pharmacotherapy, digital innovation, and social interventions, all adapted to cultural and gender contexts. This integrated approach offers the greatest potential to reduce suicide risk and improve recovery among patients struggling with the combined burden of depression and dissociation.

CONCLUSION

This case report underscores the critical role of dissociation as both a mask and a catalyst for suicidality in patients with severe depression. Dissociation impairs self-awareness, disrupts decision-making, and facilitates impulsive suicidal acts. Trauma-focused interventions, pharmacological treatment, journaling, and family psychoeducation demonstrated effectiveness in reducing dissociation and suicidal ideation. Integrating culturally sensitive approaches is essential in contexts such as Indonesia, where stigma and spiritual interpretations often delay care.

Future research should explore combined interventions (e.g., CBT with EMDR or DBT), cross-cultural differences in dissociation, and biological markers of dissociation to support personalized care. Ultimately, early recognition and targeted treatment of dissociative symptoms may significantly reduce suicide risk in vulnerable populations.

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