Dissociative Identity Disorder (Multiple Personality Disorder)

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Introduction

Dissociative identity disorder (DID), once known as multiple personality disorder (MPD) is defined in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) as the presence of two or more distinct identities or ego states in an individual for whom at least two of these ego states recurrently take control of behaviour. Furthermore each state has its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self.

Although thousands of cases of patients with DID have been recorded, it was not officially recognized until 1980 when it was published in the DMV-III as Multiple Personality Disorder. Several years later in 1994, it was renamed to Dissociative Identity Disorder in the DMV-IV.

Despite the different names, the elementary occurrence that underlies this disorder is still the same, dissociation. This is a mental process where a lack of connection is found between a person’s thoughts, feelings, memories, and actions. Originally dissociation is the brain’s defense mechanism against overwhelming stress or life threatening danger. When the situation arises, the brain is able to separate the “dangerous information” to another part of the brain to be processed as the body prepares for the danger. But sometimes when trauma takes place repeatedly, the brain will use dissociation more than necessary.

If dissociation occurs from traumatic events, then without a doubt, trauma is a main cause of DID. Childhood traumatic events, especially child abuse is found to be the greatest factor for causing DID in patients. Although there are other causes as well, for instance, a tremendous amount stress, or abnormal childhood development. Some people with DID even have a family history of the disorder but it is not yet proven that it can be passed on.

A person with DID would appear to have several different personalities which emerge at separate times. The person themselves is not aware of this but often complains of memory lapses. Many other symptoms accompany this disorder such as hallucinations, depression, and sleep disorders. There are five main core symptoms, each with its own set of surface symptoms. The core symptoms are amnesia, depersonalization, derealization, identity confusion, and identity alteration. The affecting symptoms depend on the degree and severity of the disorder.

Since the patient developed this disorder out of severe fear, this makes it difficult for treatment. First of all, many people affected by DID cannot recognize the disorder for themselves to get aid. In fact, it is hard for anybody, even trained professionals to recognize the disorder because of the very little solid research on it. When diagnosed, the greatest problem for treatment is to get all the identities to interact with each other and become a whole. To do this, the patient must be able to confront their trauma, and this is usually done through psychotherapy along with hypnosis. Some medications are used to treat and alleviate the surface symptoms.

Dissociative identity disorder is a difficult disorder to both diagnose and treat. This is because there is not a lot of solid information on it and as a result of that, many people are skeptical about it’s authenticity. Some believe that it is an actual disorder of the brain while others believe that it is just a form of schizophrenia. Like many other scientific topics, this will be debated until concrete evidence is found to prove or disprove.
one of the sides. Until then, documented case studies will be used as the foundation of information for Dissociative Identity Disorder.

History

Before Multiple Personality Disorder was published in the DMV-III, there were accounts of multiple personality many years ago. In 1646, a Renaissance physician Paracelsus described a woman who was amnesic for an alter ego who supposedly stole money from her (http://m-a-h.net). More detailed accounts then emerged in the 18th century. In 1791, Eberhardt Gmelin told of an “exchanged personality” where a 20 year old woman would switch from having a French accent to a German accent (http://m-a-h.net). Gmelin was credited for the first report of MPD with this documentation. Around this same period of time, Dr. Benjamin Rush, “Father of American Psychiatry” began collecting case histories of dissociation and multiple personalities. It was with that information that he theorized that the cause of doubling consciousness related to the disconnection between the two hemispheres of the brain (http://m-a-h.net).

Throughout the 19th and early 20th century, there was enough published case literature on multiple personality to occupy several volumes yet this condition was proclaimed “extinct” by E. Stengel in 1943 (http://m-a-h.net). As a result, there was a virtual blackout of publicized multiple personality accounts, but that was changed in 1957 with Chris Costner Sizemore’s case. The case and multiple personality became popularized by Corbett Thigpen and Harvey Cleckley’s in “The Three Faces of Eve” which later was adapted for film. Another re-emergence was found in H. Ellenberger’s “The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry” where attention was drawn to dissociation and multiple personality.

In the 1970’s many worked to define and establish the legitimacy of the condition and it was Margareta Bowers along with six colleagues that came up with “Therapy of Multiple Personality.” This text, which is still used today, outlines the rules for treatment. The most important clinical case of multiple personality however, is the case of Sybil Isabel Dorsett. As Dr. Cornelia Wilbur worked closely with Sybil, child abuse was proved to be firmly linked to MPD. Although Dr. Wilbur could not publish any of her findings, they were later published in “Sybil” by Flora Rheta Schreiber. The graphic treatment of amnesia, fugue episodes, conflicts among others, and the overall therapy set out a template for later cases (http://m-a-h.net).

Eventually Multiple Personality Disorder was firmly recognized as a disorder when published in the DSM-III in 1980, and it was further developed when it was renamed Dissociative Identity Disorder in the DSM-IV in 1994.

Effects on Brain Functioning

DID is caused by a disturbance in both the memory and identity of a person by the form of dissociation. Dissociation is a mental process in which certain information is not associated with other information as it normally would be and is the brain’s defense mechanism against what is perceived to be as danger. Dissociation seems to be the main effect of the brain as well as the main cause of DID as there is no evidence that DID comes from a physical or chemical imbalance in the body (Kahn, 1993).
To understand dissociation, it is critical to understand the brain’s function as it undergoes a traumatic experience. During normal function, the amygdala receives information through the five senses via the thalamus, and attaches an emotional significance to the incoming information and then sends it to the hippocampus. The hippocampus in turn will be activated to a greater/lesser extent based on the amygdala’s analysis. Once activated, the hippocampus would organize and integrate the information with already existing data in the brain. But if there is trauma, a breakdown occurs where an overwhelming emotional significance is attached to the data by the amygdala and this decreases the hippocampal activation. This results in the data being organized and integrated incorrectly and the memory becomes fragmented. Even after the trauma has passed the memory will remain in fragments that are isolated with anonymous bits of emotion. These amygdalamediated memory traces are easily remembered during situations that are vaguely similar to the original event.

This defense mechanism of the brain creates a two track memory system, one track for emotional information and another for factual information. The track to the amygdala is the emotional one which automatically sets off a trauma response in the whole body. This is the physiological basis for dissociation where the fragmentations of the memories are more complex and extensive (Steinberg, 2000). Both the emotionally charged memories along with parts of one’s sense of self become fragmented, therefore causing separate identities.

**Causes**

The most common cause of DID is severe childhood trauma, most typically repeated physical or sexual abuse (Kahn, 1993). The trauma generates dissociation which continues to develop if the child lives under the same conditions of abuse. The on going trauma changes the dissociative response from a defense mechanism to a fixed and automatic response. Therefore whenever situations that seem threatening to the patient arises, they will “switch” into another personality, originally as a form of protection but later as an automatic response.

In general, as children grow and develop, they have to integrate many complicated and different types of information and experiences. Naturally when learning, different perceptions and emotions are kept segregated through teachings. In situations of trauma, these different perceptions may be used to deal with the distress, and different personalities begin to form (Berkow, 1997).

Other possible causes of this disorder could be an overwhelming amount of stress, a high dissociative capacity in general, an abnormal development before a self-identity is created, and possibly even genetics, although the latter is not yet proven. It is also found that most people with DID have a family history of the disorder as well. When it comes down to it though, DID is most commonly developed in a person who experienced abuse or neglect as a child.

**Symptoms**

Normally around the ages of 20 – 30, a person with DID will “split” with their host personality and begin to develop other personalities in their subconscious. On
average 8 – 13 different personalities may be developed. When this occurs, control of the body is transferred from one personality to another while the whole individual remains in contact with reality (Kahn, 1993). Although they are always in touch with reality, the person will experience time lapses, memory loses, etc. as their personalities switch. The personalities themselves may remember bits and pieces about “each other” or in some cases they even appear to know and interact with one another (Berkow, 1997). To other’s the switching of personalities is sometimes visible. There could be differences in appearance, language, accents and the person might refer to themselves as “he, she, and we”.

On a clinical standpoint, there are five core dissociative symptoms. In no particular order, the first is amnesia and this is where certain memories cannot be recalled by will. The surface symptoms for amnesia includes time loss, substance abuse, and depression. There is also depersonalization, where a person feels detached from themselves as if they are outside of their own body and feelings. These surface symptoms include out of body experiences, suicidal behaviour, and hallucinations. Similar to depersonalization is derealization which involves being detached from the surrounding environment, including the people within it. This leads to obsessive-compulsive symptoms, insomnia, and feelings of numbness. Then there is identity confusion which as the name defines, a person struggles to understand who they are and results in symptoms of sexual dysfunction, mood swings, eating disorders, and phobias. Last but not least, there is an identity alteration in which a shift in role or identity can be observed. Mania, self-mutilation, and irritability are the surface symptoms of this. (Steinberg, 2000)

These symptoms are not set, meaning that any combination of the listed could be experienced. It is even possible for different symptoms to be experienced in the different personalities. These symptoms make it hard for a person with DID to maintain stable relationships, and careers, this often adds to their stress which in turn increases the intensity of the disorder.

Treatments

Since DID is developed through fear and started out as a defense mechanism, it is difficult to treat the patient. As a result, treatment usually takes 3 – 6 years (Berkow, 1997). After DID is diagnosed, the doctor will have to be very patient and use psychotherapy to ultimately integrate all the personalities into one whole personality.

To do this, the patient must be comfortable and feel safe enough to bring back all the memories. The doctor must then begin communicating with all personalities, gain their trust, and start gathering the information like puzzle pieces. Using comfort, communication, cooperation, and connection of all the personalities, integration may be able to occur (Steinberg, 2000). This allows the fragmented information from each personality to join together into one whole memory, as well as joining the personalities together.

Along with the psychotherapy, hypnosis is often used to help reduce fear, teach the person how to identify, express, and nurture the dissociated feelings (Steinberg, 2000). Medications are also used; mainly just to relieve the symptoms of DID such as insomnia, depression, or anxiety. For example, in the early 1990’s Propanolol and Clonidine were used in tertiary settings to reduce anxiety, switching, and impulsivity
In certain cases, anti-psychotic drugs are used to try and help the patient regain control.

With a large amount of patience and time, a patient can recover as they slowly embrace all of their traumatic experiences. The other personalities do not simply go away, but they all unite into one whole personality and allows the person to function without time lapses (http://www.cmhawrb.on.ca).

Conclusion

Dissociative Identity Disorder has come a long way since Paracelsus’ description of the woman who was absorbed about her alter ego who stole money from her. Ever since then, many case studies have contributed to the understanding of DID for patients, doctors, and the general public. What was once thought to be demonic possession within the soul is now known to be a case of dissociation within the brain.

The main parts of the brain affected by dissociation are the amygdala and the hippocampus. The amygdala attaches an emotional significance to all information entering the brain and this information is then sent to the hippocampus. Here, the hippocampus will organize and incorporate the information with existing information. But when trauma occurs, the amygdala will register an overwhelming amount of emotion with the information, which in turns decreases the hippocampal activity. The ultimate result is that the information will be stored in fragments instead of a whole, and this is where the different identities originate from.

Most of these identities have been formed around childhood through traumatic events, as it is these traumatic events that change dissociation from a defense mechanism to a habitual occurrence. As a child develops, the identities develop as well to protect the child from any sort of “threatening” events that parallel the original trauma. That is why childhood trauma is the most common cause of DID, seeing that it takes time for the identities to develop into “separate” personalities. However, there are some cases of DID caused from a tremendous amount of stress.

To a person with DID, everyday stress would be hard to cope with since memory lapses from the personality “switches” would intensify the stress. As a result from the clinical symptoms of DID such as the five core symptoms along with their surface symptoms, a person with DID would have to lead a very difficult life. The constant “switching” of personalities would lead to memory lapses, and amnesia, both which would make keeping intimate relationships and jobs difficult. It would also be hard to keep a relationship when you have trouble understanding yourself when hallucinations, mood swings, phobias, and so much more are eating away at your mind.

Because of the many symptoms involved and the underlying fear, DID patients are very withdrawn and hard to reach. That is why the treatment requires 3 – 6 years despite the weekly visits. The doctor has to be very patient and gradually expose the patient to all of their traumatic memories. This is often hard and could cause another shockwave through the brain so to speak. Therefore the doctor has to be careful while putting the patient through psychoanalysis and hypnosis, as not to expose all the information if the patient is not mentally ready. It is also hard to administer certain medications because it is possible for one “identity” to react positively to the medication while another “identity” reacts negatively.
For the reason that Dissociative Identity Disorder is a very complicated and still new disorder, it is hard for patients, doctors, and society to understand. The debate about the legitimacy of DID does not improve matters. While some health care professionals believe it to be a real disorder of the brain, others believe it to be an exaggeration of symptoms on the patients’ part or an over-analyzed symptom on the doctors’ part. Yet despite it all, more and more cases of DID have been reported and documented, which all contributes to the development of understanding DID. Such case studies will allow doctors to share and analyze this disorder, as well as the treatment, cause, and so on. As Dissociative Identity disorders become increasingly studied, we can hope to find quicker and more effective treatments or even a way of spotting DID before it occurs, and preventing it.
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