Who am i?

They are strangers to themselves. Perhaps this phrase is the most simplistic yet most accurate description of individuals suffering from a dissociative disorder. Their whole life can feel like one big dream, but the worst part is that it isn’t even their dream—it’s someone else’s. Everything seems to operate in slow motion—the outside world can feel like an eternally ungraspable perception—and worse yet the individual feels like nothing more than a perception…. a mere fleeting thought.

This sort of depersonalization is the key characteristic of Dissociative Identity Disorder, separating it from the dissociative amnesias and fugues. DID, previously known as MultiplePersonalityDisorder, possesses a long and storied 300 year history. From the “ demonic possessions” of yesteryear to the sensationalized cases of today (“ Sybil” and “ Eve,” for example), DID is one of the most recognized yet controversial mental disorders in modern society. Although it has become a part of popculture, official diagnoses of DID remain rare, afflicting under one percent of the population (Sidran Foundation 1). While many ealthcare professionals doubt the very existence of this disorder, it nevertheless remains a fixture in theDiagnosticand Statistical Manual of Mental Disorders (DSM) (Barlow and Durand 161).

A further examination of possible causes, symptoms, and treatments of this condition will enhance understanding and, possibly, acceptance. What causes DID? The answers to this question have ranged from demonic possession to schizophrenia to the idea that everyone possesses “ many minds” (a concept known as multiplicity). In contrast, a large number of theorists claim that so-called DID is a direct result f manipulative therapists who convince vulnerable patients that they have multiple personalities (“

Dissociative Identity Disorder,” Wikipedia). Despite the debate and alternatives, most DID proponents believe that the disorder is a prime example of the diathesis-stressmodel. Some sort of biological vulnerability certainly exists, or else we would have a world populated by 30 billion people rather than 3 billion. The higher incidence of DID amongfamilymembers suggests a possible genetic component, although the exact nature of such an assumption is unknown.

One theory explains that some individuals may be born with a higher capacity for dissociation. Such individuals are more hypnotizable (able to separate themselves from conscious awareness), and they find it much easier to enter a trance-like state than the general population (Kaplan, “ Dissociative”). In fact, one may view DID as the extreme end on a continuum of dissociation, with activities such as daydreaming on the “ normal” end (“ Dissociative Identity Disorder,” YahooHealth). The idea of a predisposition for dissociation dates back to the 1880s, when a octor known as Janet theorized that some of his patients were naturally able to split away from conscious thought. Since then, other personality traits have also been linked with DID, including a proneness to fantasy, an openness to experience, and a low threshold for stress (Cherry, “ Multiple Personality Disorder”). The latter trait is particularly important in DID development. It is important to note that not everyone develops dissociative symptoms in response to extreme stress. However, the more horrible the events experienced, the more likely that the person will seek an escape.

War veterans and accident victims often report slight perception problems and memory loss (Barlow and Durand 162). But for individuals suffering form

DID, those perception problems are anything but “ slight” and episodes of memory loss can be lifelong. While incidents such as natural disasters or invasive medical procedures duringchildhoodcan sometimes trigger DID, patients more often than not have the prolonged agony of severe childhood abuse to overcome (98 to 99 percent of cases include documented history of abuse) (Sidran Foundation 3), so their escapes must be more frequent and less fleeting.

In response to the extreme physical and emotional pain accompanying their abuse—and more importantly to the overwhelming shame associated with keeping the secret—highly creative individuals may adapt their rich fantasy life as a lifeline (Sidran Foundation 4). If they cannot deal with the pain, maybe the “ brave little boy” can protect the weak and fragile girl, or the “ sexually promiscuous woman” can suppress those shameful and sickening feelings during sexual acts. DID patients can in essence be their own hypnotist.

The early onset of DID is an important factor to consider in the disease’s etiology. Most DID patients experience their first symptoms before the age of six (“ Dissociative Identity Disorder,” Yahoo Health). At an early age, many feelings and emotions are kept separate within the child’s mind. The toddler years are a crucial developmental period for the young child, as he or she begins to use experience to integrate these thoughts and emotions into a unified identity (“ Dissociatve Disorders,” The Merck Manual). When a child experiences extreme stress during his formative period, integration is interrupted. Rather, the child remains in a state of separation, and learns that perhaps the best way to deal with his or her traumatic experiences is to

separate them as well. In this way, the child can still maintain certain areas of the mind which can function in a healthy manner, while the trauma-filled areas are safely “ tucked away” from conscious awareness (Sidran Foundation 5-6). Traumaticmemoriesare able to be shielded from conscious awareness because such vivid instances of recall are encoded in a different manner.

Rather than relying on words or other abstract methods, traumatic memories are stored at a somatosensory level, dependent on feelings and sensations. Such an encoding method means that these memories, although the most vivid, may be recalled on a more basic and instinctual level than on a conscious, intellectual level. This encoding may explain why after the early childhood onset, the symptoms usually reappear when certain new life experiences (people, emotions, or objects) are encountered. These experiences provide triggers or cues for the painful memories. Such triggers ay even be relatively minor in nature, because the patient’s stress-relieving system has become so highly desensitized. The frequent release of stress hormones during the patient’s develop-mental years results in a low stress threshold, meaning that the slightest provocation can cripple the patient emotionally (Kaplan, “ Dissociative”). Consider the case of Wendy Howe as an example. Wendy had been diagnosed with every type of disorder imaginable, from borderline personality disorder to schizophrenia. None of these diagnoses or subsequent treatments helped Wendy, however.

In fact, her mental health had only deteriorated since the onset of two stressful events in her life: the loss of her job and the entrance of her son into an alcohol treatment program. Desperate for help, Wendy sought

counsel from yet another clinician. After witnessing Wendy's behavior and especially after hearing her family history, the clinician arrived at a quite different diagnosis: DID. Wendy presented with the classic background of a DID sufferer. Almost from the womb, Wendy had endured horrific abuse from her alcoholic and drug-dependent mother.

The atrocities were almost too numerous to account: Wendy had been sold into prostitution; she had been burned, cut, and beaten frequently; the mother had also sexually abused Wendy, inserting objects into her and giving her forced enemas; Wendy witnessed the torture of her four siblings as well, and the siblings were often threatened into torturing and sexually assaulting each other; the mother's boyfriends and Wendy's grandfather also physically and sexually assaulted her, resulting in frequent trips to the emergency room (in fact, Wendy's first child was the result of a rape at the hands of her mother's boyfriend).

Even as an adult, Wendy's circumstances did not improve. She was raped an additional three times and sexually molested by adoctorwhile under anesthesia, and she also developed a drug problem (Brown and Barlow 107-110). Enter the alters. Wendy met all of the diagnostic criteria for DID. She reported ultimately futile attempts to distance herself from her pain, attempting to " put it behind her. " These attempts often left her feeling unreal or inhuman, producing the key diagnostic criteria of derealization and depersonalization.

Wendy also reported large chunks of time when she could not account for her actions, and these instances were not due to drug or alcohol abuse or mere forgetfulness. In addition, she listeddepression, self-mutilation,

concentration problems, sleep problems, frequent flashbacks of her traumas, and occasional suicidal thoughts as additional symptoms (Brown and Barlow 105-106) (all of which are relatively common in patients with DID) (Sidran Foundation 2-3). However, the key diagnostic factor would soon make itself (or “ themselves”) apparent.

After a few sessions with Wendy, the clinician brought forth approximately twenty “ alters” (Brown and Barlow 111). Alters are personalities or states of consciousness (aside from the primary host personality) which are capable of controlling a person’s thoughts and actions. While these manifestations may initially appear to be distinct personalities with their own ways of relating and perceiving, contemporary theory holds that all of the identities are aspects of one singular personality (Sidran Foundation 5). When a person possesses two or more of these “ states of consciousness,” then the primary criterion for DID is fulfilled.

Alters are often drastically different from the primary personality, exhibiting different personality quirks, mannerisms, physical characteristics (such as eyesight and handedness), and even different genders (“ Dissociative Identity Disorder,” Yahoo Health). Case studies suggest that each alter provides a different function for the host personality. In Wendy’s case, for example, each alter dealt with a different type of abuse. One personality, which possessed no sensitivity to pain, emerged to deal with the burnings which Wendy endured.

Another alter, created with no gag reflex, dealt exclusively with the forced oral sex Wendy performed on her grandfather. Yet another alter—this one a boy—emerged so that Wendy could feel invulnerable and strong during her

rapes. Wendy also revealed autistic personalities (emotionally detached to better handle the torture), child personalities (gatekeepers of the earliest abuse memories), sexually promiscuous personalities (to endure the prostitution), and extrovert personalities (for “ normal” activities). (Brown and Barlow 111-114). Another case, immortalized by the movie and book Sybil, documented the functions of alters as well.

Sybil, now revealed as Shirley Ardell Mason, also experienced extreme maternal abuse as a child. In response to the traumas, “ Sybil” developed sixteen distinct personalities. Each of Sybil’s personalities appeared to possess one primary personality trait: anger, fear, intellectuality, impulsiveness, strength, et al. Sybil’s therapist, Dr. Cornelia Wilbur, also brought “ Vicky” into consciousness, the primary, all-knowing alter which some theorists refer to as the gatekeeper. The gatekeeper may be the only alter fully aware of all the other alters, and the only link to the patient’s full memories (“ Dissociative Identity Disorder,” Wikipedia).

Other symptoms of DID, experienced by Sybil and others, may include obsessive/ compulsive behavior, eating abnormalities, panic attacks, sexual dysfunction, substance abuse, headaches, varying phobias, and hallucinations or delusions. Some of these symptoms may be direct results of the DID (such as the “ voices in the head” delusions), while others are byproducts, such as substance abuse (Sidran Foundation 2). Unfortunately, one of the most prevalent “ by-products” of DID issuicide, as it is believed to be the mental disorder most likely to end in the taking of one’s own life.

Like Wendy, DID patients may initially be assigned diagnoses of various mood or personality disorders. In fact, one study suggested that

undiagnosed DID was prevalent in up to four percent of acute psychiatric inpatients (“ Dissociative Disorders,” The Merck Manual). Perhaps the most common secondary diagnosis for DID patients is Post-Traumatic Stress Disorder, due to crippling nature of the traumatic flashbacks evidenced in DID patients (Sidran Foundation 2). Without treatment, hosts and their alters are destined to be locked in eternal battle.

The alters will never simply “ go away,” because they are as much a part of the host, maybe more so, than the host is. Rather, integration should be the primary goal for the therapist. The therapist can teach host and alters how to “ coexist” through long-term psychotherapy. The end result would ideally be an equal combination of patient and all “ alters. ” Sybil, for example, successfully completed integration therapy. Although Sybil was considered the “ host,” her true personality was completely different: a “ New Sybil” who retained all of the key aspects and memories of her other personas.

This Sybil was able to lead a perfectly peaceful and well-adjusted existence in Kentucky until her death in 1998. In fact, her neighbors had no idea who their famous neighbor truly was (“ Dissociative Identity Disorder,” Wikipedia). Keygoalsleading to Sybil’s (and other patients’) successful outcome would be identification and neutralization of “ triggers,” trust with the analyst, and, most importantly, confrontation and reconciliation with those painful memories, emotions, and with the “ alters” themselves (Barlow and Durand 165).

Once a diagnosis is assigned (by screening tools such as the Dissociative Experience Scale and clinical interviews) (“ Dissociative Identity Disorder,” Yahoo Health), treatment may involve a number of different therapeutic

tools. Integration therapies typically involve analytical psychotherapy with hypnosis, in order to bring forth the alters as well as the sheltered memories.

Once the therapist has established trust (vitally important for a patient who has learned since childhood not to trust) and makes contact with an alter, then the goal becomes to understand that alter’s function for the host (safety, stabilization, and symptom reduction). Then, the process removes to retrieving and confronting the painful memories which triggered the dissociation (Chu, “ Guidelines”). Finally, alters and host “ meet” and merge into one identity through hypnotherapy and imagery techniques (integration and rehabilitation).

Long-term integration success rates stand at roughly sixty percent (Kaplan, “ Dissociative”), with five or six years (of one to one-and-a-half hour sessions twice a week or, later, twice a month) being the typical time of achievement for full integration (“ Dissociative Disorders,” The Merck Manual). One recent follow-up evaluation of 135 DID inpatients was illustrative of this success rate, as those patients who had achieved full integration demonstrated immense improvement on symptoms as compared to those patients who were not integrated (Ellason and Ross 832).

For the remaining forty percent of patients or the many patients who resist the idea of full integration, alternative therapies may be needed, such as Eye Movement Desensitization, group therapy, inpatient residential treatment, pharmacotherapy (although drugs have consistently only provided aid as side-effect symptom reducers), or even the controversial electroconvulsive therapy. Further, secondary therapies may be necessary for any concurrent

issues. For example, interpersonal therapy may be a useful tool for improving a patient's social and familial relationships.

Expressive therapy (such as the art therapy described with Wendy Howe) may also help the patient channel long-buried emotions through a " safe" outlet. Relaxation techniques are utilized as well, assisting the patient in better modulating intense physiological reactions to stress. These methods are especially important during the stabilization phase of therapy, as patients need to be as symptom-free and emotionally stable as possible before entering the long process of memory recovery and integration.

Such processes are also important for the integrated patient, who must orient the new self as a functioning and well-adjusted member of society (Chu, " Guidelines"). Just ask Wendy Howe. After four years and 400 treatment sessions, Wendy no longer meets the DSM diagnosis for DID. Wendy's treatment, much like Sybil's, depended on the three aforementioned three key factors: a trusting relationship with her therapist, a confrontation with all of the traumas she had endured, and a true understanding of the role of her alters (as protectors rather than harmers).

Wendy was able to trust an adult for the first time in her life when her therapist offered her a loan to help pay her mounting debts. This act proved vital in breaking down some of Wendy's emotional walls. But Wendy's true recovery was documented in the evolution of her " baby" sketchbook. Through drawings, Wendy took her " baby" through the process of growing up. As she truly began to view her alters as integral parts of herself rather than " diseases" needing to be cured, the " baby" evolved from a mutant,

alien-like creature to a happy, laughing child surrounded by love and family Brown and Barlow 117-122.

This sketchbook is a concrete symbol of the benefits of cognitive restructuring therapy as well. By constantly challenging her assumptions that she was simply “ crazy,” Wendy was able to “ alter” her whole outlook on herself and on life in general. Previously, Wendy could not connect her behaviors with her previous trauma. Through the cognitive aspect of her therapy, Wendy came to realize that she had developed a highly creative coping mechanism which in many ways saved her sanity and her life…. life which now includes a long-desired graphic arts degree, newfound friendships, a sweet romance, a close bond with her granddaughter, and an awakened determination to help other abuse survivors through her artwork (Brown and Barlow 122-125).

Dissociative Identity Disorder remains one of the most enduring controversies within the psychiatric community. In spite of the documented cases and the current DSM recognition, many educated scholars still maintain that the disorder is a popular myth, brought about by socio-cultural factors of role-playing and a thirst for sensationalism (Chaves et al 507).

Skeptics might use cases such as that of Hillside Strangler Kenneth Bianchi as an example. This convicted multiple murderer tried to blame his crimes on a killer alternate personality. He was soon found to be faking, an assumption solidified by the discovery of variouspsychologybooks in his jail cell. Such a case is an obvious argument for the invalidity of DID, correct? If one considers exactly how the murderer’s duplicity was discovered, the

answer is no. In short, Bianchi could not fool the dissociative specialist assigned to evaluate him.

His “ alters” showed no visible personality differences and his behaviors simply did not ring true as a real DID patient (Cherry, “ Multiple Personality Disorder”). The clinician was able to differentiate a false case from a real case. Why?.. because he had actual and very real DID patients as standards… standards of true survival and hope: “ I was Nobody all of my life and then came therapy. I will not believe there ever was a real nothingness--it was and can be a lack of resources--lack of knowledge…My therapy helped me build a solid foundation to who I am. Not me, but for the whole of Myself.

There is a deep emptiness on many occasions. A deep dark hole where there seems no escape. A bottomless pit of despair. A grieving for the what-ifs and the should haves. An unspeakable rage. And an alienation from Myself and anyone else within or outside. There is sadness thathappinessis just a foot away, but too far to actually grasp. Tears of exhaustion, theanxietyand frustrations, a want to sleep for the rest of this miserable life. And on occasion there is a glimmer of hope. Wheredreamsseem to come alive and make me feel alive. Oh yes, I remember... I am... I am alive. ” (“ DID,” Comcast)