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A Break in Identity: A Case for Dissociative Identity Disorder

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Abstract: **For decades, dissociative identity disorder (DID) has perplexed psychologists worldwide. Since DID was first introduced in the field of psychology, its validity has been in question for decades. Opponents of DID claim that therapists use suggestive practices, such as hypnosis, to influence patients into believing that they have multiple identities. However, advancements in neuroimaging have revealed that within one person, brain scans of one 'alter' can differ from another depending on the alter's physical and mental condition. Furthermore, it has been found that DID is associated with prolonged child abuse. As such, DID patients struggle with autobiographical memory given the individual's primary objective is to protect the the core self from the trauma that they have experienced as a child. In an effort to promote DID education, the International Society for the Study of Trauma & Dissociation has actively worked to promote DID research and has devised a standardized treatment method which is being applied worldwide today. For this literature review, journal articles from the *Journal of Mental Health Counseling*, the *Journal of Abnormal Psychology*, *Psychiatry*, and others were used for a critical analysis and review.**

Keywords: **dissociative identity disorder, mental health, dissociation, prolonged child abuse.**

I. INTRODUCTION

In recent years, modern neuroimaging techniques have proven the existence of dissociative identity disorder (DID) plain and simple. In Germany, one women's brain activity revealed what appeared to be impossible. She embodied both an an alter who is blind and another alter who can see. The brain scans of both personality states revealed that the EEGs of the blind did not reflect brain activity associated with sight while the other alter did. Due to technological advancements in brain imaging, it is now possible to ascertain the validity of DID. Nevertheless, opponents of DID continue to refute DID research questioning the validity of DID as a 'dissociative' disorder rather than as a 'fictitious' disorder as previously categorized in the DSM-IV. Confusing presentation and contradictory accounts have led psychologists and psychiatrists to doubt the truthfulness of the disorder as DID researchers find their arguments to be biased and unfounded. Some people assume that people with DID are malingering, hallucinating, or under the influence of hypnosis; others claim that there is no real evidence to prove that DID is related to perpetual childhood abuse. To verify the validity of DID, it is important to understand both sides of the argument - the reasoning behind iatrogenesis as well as the effects of proper DID treatments - both points which this paper aims to explore.

II. WHAT IS DISSOCIATIVE IDENTITY DISORDER?

According to the DSM-V, Dissociative Identity Disorder (DID) requires the following: a disruption of identity characterized by two or more distinct personality states usually in the case of overwhelming trauma (commonly seen in the form of child abuse). In these dissociated experiences, the person sees the situation from a bird's-eye view, where they are witnesses to their pain and not as direct victims. The brain develops this defense mechanism to protect the person from the trauma, but because the brain is unable to completely dissociate from the body, there exists a discrepancy between a portion of the brain that experienced the trauma and the portion that only witnessed it. The brain compartmentalizes each portion forcing a second personality to be born. In extreme but quite common cases, this divide goes beyond two split personalities, and can extend further, with many DID patients having multiple personalities and some exceeding the

hundreds. The technical term for these "different" personalities are alters, and they each contain varying experiences, memories, feelings, skill sets, and most noticeably, personalities. They can be said to be people who live in seperate apartments within the same building (the building being the person's body), with only a few interconnecting doors between them. The person thus does not function as a whole, as he or she doesn't have access to their full identity, memories, and abilities. (Sachs 66).

III. ONE-OFF TRAUMA VERSUS LONG-TERM TRAUMA

A dissociative experience is very different from dissociative identity disorder in that the first is based on a one-time traumatic experience. It consists of subtypes such as depersonalisation, derealization, and amnesia. An example of a depersonalisation experience is a man who lost his leg in a car crash recollects an "out of body" experience, watching himself in the collison. He does not remember feeling any pain which suggests that the man mentally separated himself from the pain of the trauma. The second being derealisation, meaning the person does not believe what happened was real and the third, amnesia, when the person does not remember the traumatic experience.

In a case of DID, the person is in a constant state of terror, most often, due to abuse in his or her everyday life. In particular, when children frequently dissociate from repeated abuse, the brain can develop a dissociative trait that can deeply affect one's identity and/or personality. It affects the way he or she remembers events as various events, feelings, skills, and stage of life can be controlled by separate personalities. To illustrate, when a 50-year old computer engineer and the mother of two children recollects her childhood abuse, she becomes a frightened 5 year-old who does not remember ever having two children or being a computer engineer. Another part of her personality recollects learning the piano but another alternative personality does not know how to play the piano. These contradictory accounts present a therapeutic challenge.

Previously, the third and fourth edition of the DSM categorized DID under 'fictitious disorders'; in the current DSM-5, DID is now considered to be a 'trauma and stressor-related disorder'. This may be because the number of DID accounts that show similar details in symptomology is most often related to long-term abuse. DID is regarded as an attachment disorder in the sense that parental neglect and abuse defers children from the ability to experience pathological emotions such as love. In therapy, many DID patients describe growing up under sadistic sexual, psychological and physical abuse, usually by multiple perpetrators of whom include family members. The dilemma of trying to maintain a psychological attachment to an abusive caregiver while desperately trying to survive the abuse lead to split motives in an individual, resulting in the compartmentalization of one's memory and thus, personality.

IV. THE CASE OF PAULA

To illustrate why it is so difficult for people to believe DID accounts to be true, the case of Paula is discussed in this section. The story begins with Kim, a mother who continues to meet with her abusive husband. Her younger sister Polly is responsible for making sure the couple does not see each other. One day, as Kim was trying to escape her home, Polly follows Kim outside in an effort to convince her to stay home. Kim's husband, who was waiting outside, leads Kim and Polly into a blue van where they are both raped by Kim's husband. After the attack, Lea, another sister, finds them on the street shaking and crying in terror. Polly, feeling disgusted has a bleach bath while some unknown character bleaches the clothes. Although the bruises on Polly's body show evidence of rape, because both her clothes and body were washed in bleach, the rape account is dismissed by the police under grounds of lack of evidence.

Kim, Polly, Lea, even including the unknown character who bleached the clothes, are all distinct personalities contained within one person, Paula, who claimed she was ironing at home when all of this happened. Paula, who has DID, is unable to corroborate her story as her separate alters contradict one another in their goals and motivations. Because each of her multiple personalities present different accounts of the same situation, it becomes very difficult to determine how to handle the case in court. Paula's case of DID also makes it hard for her to escape her claimed abuse, as she neither has the support to end the abuse, nor chooses to do anything to it, as some of her personalities are quite fond of the claimed rapist, and actively seek to encounter him. Seeing this, critics argue that there isn't substantial proof that the disorder exists at all.

What really happened in the case of Paula? After years of therapy Paula re-explains her story utilizing the multiple angles she has gathered. Because of her deep trauma over her experiences with John, Paula developed amnesia over ever having a baby with him. However, her strong need to see her baby and the boy she loved often broke through her amnesia, and was expressed as her alter Kim. Her longing for her baby often outweighed the fear of John's brutality, creating a case of

split motives, which has been a common contributing factor in many DID cases. She was indeed raped by John, John's brother, and her own 27 year old son. Kim was not consenting sexual activity with John's brother or her own son. Thus she switched alters into Lea, who called for help, and prepared to confront the police. Lea, as the crisis solver, attempted to tell the story to the rest of her alters, but failed given the other alters did not listen or believe the story. One of the few alters who did believe the alters decided to bleach the clothes to protect John from prosecution but also protect Paula from learning the truth, as she was in the state of Kim at the time of the rape.

V. CLAIMING IATROGENESIS

Paula's shocking tale has many inconsistencies that are difficult to follow from both a legal and therapeutic standpoint. And due to a lack of evidence, it is virtually impossible to verify Paula's accounts. Many psychologists, being unfamiliar with DID, could assume Paul's story is completely false. In the case that Paula saw a therapist for DID prior to the rape, some people would claim that her alters were created through suggestive therapy techniques. In the case that she has never seen a therapist for DID, another psychological disorder such as borderline personality disorder may be the cause for her action, and not that she has DID. Although DID has been recategorized from "fictitious disorders" to "dissociative disorders" in the DSM, the general population of psychologists around the world are still divided regarding the validity of the disorder.

In 1999, 301 board-certified U. S. psychiatrists were surveyed about their attitudes toward DSM-IV dissociative disorders diagnoses. The survey showed that 35% held no reservations but were not strong advocates for its legitimacy, 43% remained skeptical, and 15% firmly argued for its exclusion from the DSM. Only 21% believed there was strong evidence for its validity. Some psychiatrists believed that treatment itself can lead to undesired negative effects, and some patients may experience worsening of symptoms and a deterioration of functioning, signifying that they may be treating the wrong disorder, thus leading to a worsening of symptoms. Finally, some people think that a DID diagnosis is both lucrative and provides narcissistic gratification. By diagnosing their patients in a field where there are few experts, being an expert is both financially advantageous and provides self-fulfillment. This incentivizes psychiatrists to diagnose falsely based on only a few matching symptoms.

To be more specific, therapeutically speaking, some critics believe that PTSD, being a symptom of dissociative disorders, can be used to trick a patient into believing that he or she has DID. In other words, by diagnosing a disorder that may not exist, the patient may convince themselves they have the disorder and fake symptoms, whether they fake it consciously or unconsciously. Once the patient is convinced that they have symptoms of DID, it is hard to convince them otherwise, making it difficult to identify if the disorder is a result of PTSD or DID. Some doctors believe that individuals who develop DID often meet the diagnostic criteria for borderline personality disorder, bipolar disorder and other conditions marked by instability. The logic then would be that many individuals prone to DID are bewildered by their unstable moods, self-destructive behavior, impulsivity and erratic relationships, therefore, are seeking an explanation for these disturbances. If psychotherapists or others ask suggestive questions such as "Is it possible that a part of you you're not aware of is making you do and feel these things?" patients may become convinced that their mind houses multiple identities.

VI. OPPOSING IATROGENESIS

On the other side of the spectrum are proponents of DID, such as Bethany L. Brand, Richard J. Loewenstein, and David Spiegel, who are well-known DID researchers. Brand et al. (2014) refute DID opponents claiming that many critics who believe dissociative states are a result of iatrogenesis are often biased in their research. They note how notable DID opponents, Powell and Gee (1999), who are frequently cited in DID research, do not present all the facts in their work. When the two examined a study performed by Ross and Norton (1989), which compared the number of dissociated identity states between patients who have been hypnotized and those who have not been hypnotized, they found that there was no difference in the means. Instead, Powell and Gee focused on the standard deviation of those with dissociated states, saying that they were higher among hypnotized patients than those who were not. Their research concluded that hypnosis can lead to iatrogenic effects.

Furthermore, one important misunderstanding many critics of DID have is that patients with DID can recover new self-states during therapy. DID, being characterised by amnesia, does not mean that DID patients are unable to become aware of lost memories. In fact, what appears to be "getting worse" is the patient coming into consciousness regarding the parts

of themselves that were lost and beyond their control. Treatment, therefore, is focused on recovering one's identity, a process that those without DID training cannot fully comprehend. In fact, DID research has shown that dissociative symptoms, such as hearing voices and the feeling that they are not themselves, have decreased over time. On the other hand, in cases where alters were not properly addressed, this resulted in minimal improvements in dissociation. In addition, many DID patients go through several years of treatment before he or she is properly diagnosed with DID. In these cases, non-DID treatment should have helped alleviate symptoms. However, instead of improved conditions after years of non-DID treatment, many patients were not functional as a result of misdiagnosis and misdirected treatment. Thus, the failure to recognize DID in patients and diagnosing with other conditions is the true iatrogenic harm.

In one study, Vissia et al. (2016) iatrogenic claims by analyzing the psychological test data consisting of two patient groups and two control groups related to the Trauma Model or the Fantasy Model. The objective is to test whether or not the trauma group will have higher scores than the patients with PTSD, the healthy controls group (HC), and the actors posing to have DID (DID-S). The Trauma Model is based on the idea that DID is a severe trauma associated illness, wherein early childhood abuse, disorganized attachment, and chronic neglect are commonly found in these cases. Two prototypical DID personality states were identified, a neutral personality state and a trauma-related personality state. The neutral personality state consists of dissociative amnesia with no emotional or somatic responses and the trauma-related personality state consists of personally experienced trauma with emotional and somatic responses to the trauma questionnaire. The Fantasy Model is a non-trauma model heavily influenced by suggestibility, therefore prone to fantasy, which consists of sociocognitive traits related to enactment, sleep disturbance, suggestive psychotherapy, and sociocultural factors.

The participants included 14 patients with genuine DID, of whom only 3 participants had a neutral personality state since it is difficult to for them to switch between the two personality states. As for the 3 control groups, including PTSD patients, healthy control group, and DID simulating actors, had to meet the necessary criteria on the Dissociative Experiences Scale, the Somatoform Dissociation Questionnaire, and the Traumatic Experience Checklist to participate in the study. The DID simulating participants were recruited from acting schools, coached on how to portray a person with DID, then tested to make sure the DID components were fully understood. PTSD was evaluated using the Clinician-Administered PTSD Scale and finally.

The two main questionnaires were divided as "trauma" and "fantasy". Most of the findings that supported the Fantasy Model, ironically, was interpreted to be in support of the Trauma Model. In regards to the SIMS questionnaire which tested for malingering, the DID-G group had higher scores than the other groups. What appeared to be evidence in support of the Fantasy model, was revealed to support the Trauma Model because affective, psychotic, and neurological symptoms are common in DID, a notion that is supported in current research. The first-rank symptoms of schizophrenia are found in DID patients as well, and given the DID-G group had higher levels than the others, the data is actually in support of the DID diagnosis. Regarding sleep disturbances, both the DID-G and PTSD groups reported higher levels of disturbances which also supports the Fantasy Model. Sleep disturbances can be associated with nightmares, hyperarousal, and sleep avoidance often found in trauma victims, therefore could be explained to support the Trauma Model.

Consistent with the Trauma Model, regarding fantasy measures, the DID-G and PTSD group had higher levels of fantasy when compared to healthy controls. In comparison, no differences were found between the DID-G group, the DID-S group, and the PTSD group. This implies that neither the persons with DID nor persons with PTSD are more prone to fantasy when compared to other groups. The research also revealed that DID-G experienced more difficulty with memory than the DID-S group or the healthy control group. More importantly, there were no group differences in terms of false memory creation, revealing that the findings did not support the Fantasy Model. With these current findings in DID research and advancements in future research, the validity of iatrogenesis harm remains to be seen.

VII. AUTOBIOGRAPHICAL MEMORY

It is true that DID patients share many similarities with PTSD patients in that they both utilize overgeneral memory to cope with their problems. They also share the ability to selectively compartmentalize information linked with negative emotions or traumas. Whether in their normal state or trauma state, for DID patients, these symptoms of memory compartmentalization and overgeneral memory can result in a lack of memory specificity, which shares strong similarities to lack of memory specificity found in PTSD patients. When memories are recalled, both tend to retrieve overgeneral memories instead of specific details. DID persons are typically within their "normal" identity states, the identity state

where the patient is free from relating to the trauma. These normal states concentrate on daily life functioning and avoids the retrieval of his or her traumatic memories. This can lead to the overgeneralization of memory which is linked to dissociative symptoms wherein DID patients will forget or compartmentalize any information that may bring about negative emotions related to past traumatic events. Conversely, in trauma states, the patients will relive the the trauma and defensively react when they feel threatened.

In one study performed by Huntjens et al., the researchers aimed to compare the memory specificity of both the trauma states and the normal states of DID patients by comparing them to PTSD patients as well as DID simulating patients. The study found that DID patients often lack a coherent sense of self due to the lack of autobiographical memory, the first study of its kind in DID research. The participants in the study included 31 healthy individuals, 26 DID simulating participants, 27 patients with PTSD, and 12 DID patients. The Dissociative Experiences Scale (DES) was used to measure dissociation in which scores above 30 suggested pathological dissociation. Regarding trauma history, participants used the Traumatic Experiences Checklist to self-report traumatic events and the PTSD Symptom Scale to answer questions related to their most traumatic event. The the Brief Symptoms Inventory was used to measure depression and the Acceptance and Action Questionnaire-Trauma Specific as well as the Posttraumatic Avoidance Behavior Questionnaire were used to measure avoidance. The Autobiographical Memory Task (AMT) was used to provide participants with memory cures (5 positive words and 5 negative words). The participants memory response to each cue word was categorized either as specific or overgeneral.

Overall, the results of the study showed that DID patients associated memories from their trauma states as trauma-related compared to memories retrieved from their normal state. The researchers speculate that the DID patients were able to refer back to memories more quickly in normal states in order to avoid remembering any trauma-related events. The DID simulating participants retrieved more trauma-related memories in their trauma states as instructed which was not the case for the actual DID patients. Regarding avoidance on the AMT, both DID and PTSD patients struggled with memory specificity when compared to healthy controls providing concrete evidence of overgeneral memory in both patient groups. The memories retrieved were also more trauma-related than the healthy control group. Finally, DID patients struggled with autobiographical memory functioning at a higher rate when compared to PTSD patients. All in all, this study revealed that prolonged trauma is characterized by the lack of memory specificity, an important finding in DID research. Also, a joint diagnostic category which combines DID and PTSD is common when disturbing memories of on-going child abuse are involved. In fact, it is rare to find cases of DID without PTSD providing support that DID stems from severe trauma, not iatrogenesis. Huntjens et al., thus, believe that it is possible for iatrogenically created memories to be a result of the lack of memory specificity given normal states suppress information in order to avoid traumatic memories.

VIII. A NEUROLOGICAL EXPLANATION OF DID

To better understand the impact of trauma on memory, one must draw on a neurological explanation for further insight. Trauma is caused by heightened levels of emotional arousal that is stored in procedural memory systems. Van der Kolk introduced the notion that extreme emotional arousal will not allow for the adequate evaluation of sensory information in the hippocampus. Stress hormones and the sympathetic nervous system are activated prior to contextual understanding as the amygdala, the part of the brain responsible for evaluating the degree of emotional impact received, receives information from the thalamus before it receives information from the cortex. This allows the brain to prepare for danger prior to understanding the context of danger through awareness. The evaluation of the experience occurs out of consciousness in which stress hormones and the sympathetic nervous system are then activated. Before a procedural memory becomes declarative, the greater the hippocampal stimulation the greater the declarative memory, however, only up to a certain switch point. Beyond the switch point, the hippocampus is not fully functioning and becomes partially blocked, meaning the memories do not become declarative memories and remain unintegrated which often appear in the form of a flashback.

Also, continued activation of stress systems will cause hypoarousal instead of hyperarousal. Hypoarousal essentially freezes the central nervous system, lowering heart rate and causing numbing, but most importantly, causing dissociation. Thus for a powerless infant with no other defense capabilities, repeated stress will activate hypoarousal, which is proven to lead to dissociation. An infant's response to trauma is typically hyperarousal and dissociation. Dissociation is likely a result of hyperarousal following hyperarousal, indicating that hyperarousal may be a prerequisite to dissociation. Because hyperarousal as a result of overstress is common between DID patients and non DID patients, and especially in infants, it

is implied all humans have the ability to dissociate upon reaching a certain stress level threshold, but non-DID patients simply have not reached these levels to warrant developing a condition. Because an infant's brain is early in its development stage, it's ability to handle stress is much weaker, making the brain much more sensitive to damage in the earlier years. Although different areas are more sensitive to brain damage depending on age, on the onset of trauma, the volume of the corpus callosum always occur regardless of what brain stage the child is under. Researchers have found that long-term exposure to cortisol released during traumatic experiences, along with repeated activation of stress response systems can seriously damage the function of the brain. In women with DID, studies have found that there was a 19.2% reduction in hippocampal volume. For DID patients, remembering details, thus, become a grave challenge.

IX. THE INTERNATIONAL SOCIETY FOR THE STUDY OF TRAUMA & DISSOCIATION

The most optimal form of treatment for DID has been established by the International Society for the Study of Trauma & Dissociation (ISSTD). For more than 20 years, the organization has been dedicated to the research and education of dissociative disorders as the most academically knowledgeable and experienced with DID, leading and educating therapists regarding proper DID treatment methods. With over 60 years of clinical and research literature, they have developed a consistent treatment model called the tri-phasic process, a standardized care for the treatment of DID. ISSTD believes that iatrogenic harm is more likely to occur from depriving DID patients with appropriate treatment that is consistent with expert consensus and standardized treatment guidelines. Misinformed and poorly educated therapists can cause a worsening of symptoms as inaccurate conclusions over the existence of DID can lead to deprivation of proper treatment for patients.

Failure to focus on the key aspect of the tri-phasic model (stabilization, dealing with traumatic memories later into the treatment process) overwhelmingly leads to complex emotions and exacerbation of PTSD. The tri-phasic model supports that DID symptoms do not substantially improve if dissociated self-states and amnesia are not directly addressed in treatment. In other words, DID cannot be effectively treated in a general psychiatric setting, which means the need for its existence to be acknowledged is further amplified. Especially in chronic cases, the acknowledgement of DID is vital to the patient's well being. In one case, a British woman with DID was misdiagnosed with conditions other than DID for 13 years, which lead to a regressed state that led to frequent hospitalizations. Shortly after being diagnosed and treated under the condition of DID, a drop in psychiatric crises and hospitalizations was noticeable, and in turn led to a reduction in treatment costs annually.

X. COUNSELING DID PATIENTS

Iatrogenesis or not, in the case of Paula, it was through proper treatment that she was able to slowly recover her memories. Although the retrieval of her most painful memories made Paula briefly sink into a severely depressed state leading to extreme suicidal thoughts, she was able to piece together her life one memory at a time and regain a sense of self. Her self-loathing evolved into compassion for the true person within her multiple identities. What many critics of DID fail to understand is that one's break in identity can be mended over time; however, it can be done only by recovering one's memory from childhood, ones that many DID patients try to truncate in order to avoid the intense negative affect that come with specific perceptual- sensory details. In essence, through the help of a caring and supportive therapist, memory retrieval can help improve awareness and thus, bring closure to the trauma experienced.

More often than not, therapists can have an immense impact on the healing process of a DID patient. In fact, positive and negative attributes of counselors were identified in a study performed by Jacobson et al. The study was drafted as a semi-structured interview process and recruited participants nationwide from a conference for survivors of DID. By utilizing a semi-structured interview process, it allowed researchers to use both open and close-ended questioning, allowing for elaboration of information that could not be possible through one specific form of questioning. The questions included the following: 1) What helped you or is helping you recover from being a survivor of DID? 2) What specifically in therapy to this point has been helpful? 3) What characteristics in a therapist were helpful? 4) What specifically in therapy to this point has been least helpful? 5) What characteristics in a therapist were least helpful?

To ensure inter-rater reliability during coding, investigator triangulation was utilized. The results of the study summed up to one factor, whether or not the counselor believed in the disorder. Counselors who accepted the legitimacy of the alters and those who granted clients a sense of validation were described as desirable, with genuineness and transparency going hand in hand with these qualities. On the contrary, counselors who doubted the disorder were seen as dishonest and

unprofessional. Other qualities that DID patients desired were empathy, engaged, transparency, flexible boundaries, experience working with DID patients, and a few others. Regarding effective approaches to therapy, the pacing of session, a secure structure, grounding processes, coping skills development, and boundaries were noted. Given the sensitive nature of persons with DID, without a healthy therapist-patient relationship, it is difficult for the patient to feel safe enough to remember the most traumatic events in their lives. Remembering, being an important part of the healing process and recovering identity, it is pertinent that DID therapists are properly trained to help patients in need.

In other studies, DID patients have stated that simply listening to their counselor's voice on a message system during times of trouble elicited powerful emotions outside of therapy sessions. Others needed to be in contact with familiar aspects of their counselor and thus had recorded meditations created for them that the clients could listen to on their phones. Hearing the therapist's voice helped clients practice systematic visualization that deescalated overpowering emotions between sessions. The goal is to recategorize DID symptoms as challenges rather than a mental sickness, allowing patients to deal with DID more effectively.

XI. CONCLUSION

DID is an area in psychiatric research that requires further study. In particular, neuroimaging studies comparing brain scans of alters may prove especially useful. Also, additional studies that examine the impact of prolonged child abuse on the brain may reveal new information regarding neurological developments. To date, ISSTD remains the leading organization to pave the way in standardized DID treatment, however, it is important for DID research to gain more support from organizations such as the American Psychological Association to gain more clout in the field of psychiatry. Without continued efforts to understand this complex psychological phenomenon, DID patients will continue to be misdiagnosed and the disorder will continued to be seen as 'fictitious' even though it is no longer fictitious in the DSM-V, but until then, researchers must diligently administer studies in order to educate therapists worldwide and the general public at large regarding the validity of DID.

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