

## ***Dissociative Identity Disorder: Hoax or a Reality?***

Dissociation is the disconnection from full awareness of self, time, and/or external circumstances. Researchers and clinicians believe that dissociation is a common, naturally occurring defense against childhood trauma. It is a complex neuropsychological process, and exists along a continuum - from normal everyday experiences, to disorders that interfere with everyday functioning. The most common examples of normal dissociation are highway hypnosis (a trance-like feeling that develops as the miles go by), "getting lost" in a book or a movie so that one loses a sense of passing time and surroundings, and daydreaming (USC: Counseling and Human Development Center). While there are common forms of dissociation such as these, dissociation can also progress into actual disorders. One such disorder has come to be known as dissociative identity disorder (abbreviated as DID).

According to the Diagnostic and Statistical Manual of Mental Disorders (4th Edition, Revised), in order for the diagnosis of DID to be made, an individual must exhibit the symptoms of having at least two different personality states that co-exist within them. These states must continuously take over the individual's behavior - with each exhibiting unique patterns of understanding and communicating. In theory, dissociative identity disorder develops as a result of chronic dissociation, used by children who dissociate as a defense mechanism in response to physical or sexual abuse. Over time, however, for a child who has been repeatedly abused, defensive dissociation becomes reinforced and conditioned. Repeated dissociation may result in a series of separate entities, or mental states, which may eventually take on identities of their own. These entities are essentially made up of chunks of the child's subconscious, weaving in and out of control as the daily abuse continues.

However, many professionals in the field of psychology don't believe that dissociative identity disorder is a valid diagnosis, but that it is dreamed up by therapists who want their patients to have DID. The disorder was once thought to be so rare that Professors in Universities across the country didn't bother covering it in their courses because they assumed their students would never encounter it during their careers. Then, in the early 90's things began to change and suddenly there was a sharp increase in diagnoses being made. This sharp increase over such a short amount of time has greatly contributed to why so many in the psychiatric community consider this development to be nothing more than a hoax (Hockenbury). For instance, Deborah Haddock, author of "The Dissociative Identity Sourcebook", believes that DID affects up to 1% of the population. This would make the cases

of DID equivalent to the percentage of people who are afflicted with schizophrenia. This is a huge jump from the proposed extremely rare and unheard of disorder that DID was once thought to be. But is it enough to support the theory that the diagnoses isn't just rare, but that it is entirely faked by every patient diagnosed?

In an article written by Dr. Paul R. McHugh, the doctor states his belief that the symptoms of DID are comparable to symptoms of hysterical seizures that were recorded in one case study from the early 1800s. In these case studies patients were found to be copying behavior that they'd seen in true epilepsy patients in response to the attention from their doctor who thought he'd discovered a new "hysterical epilepsy" disorder. To illustrate his point, Hughs goes on to quote an introduction to multiple personality disorder, written by the director of the Dissociative Disorders Treatment program at a hospital in North Carolina. The director, Stephen E. Buie, MD, wrote the following instructions for therapists to follow, in order to find personalities in their own patients:

*"It may happen that an alter personality will reveal itself to you during this [assessment] process, but more likely it will not. So you may have to elicit an alter... You can begin by indirect [sic] questioning such as, 'Have you ever felt like another part of you does things that you can't control?' If she gives positive or ambiguous responses ask for specific examples. You are trying to develop a picture of what the alter personality is like...At this point you may ask the host personality, 'Does this set of feelings have a name?'...Often the host [primary] personality will not know. You can then focus upon a particular event or set of behaviors. 'Can I talk to the part of you that is taking those long drives in the country?'"*

Its easy to see, by this example, how Hugh's could come to the conclusion that DID is a created disorder. However, despite this hoax theory, I am in agreement with the more recent studies. These studies have shown that the actual keys to this increase in diagnosis's lays in the enhanced awareness of childhood mistreatment and its consequences, improved diagnostic methods, and the increased awareness of the condition as a whole.

According to Joan A. Turkus, M.D., from the UK Society for the Study of Dissociation, as society has become increasingly aware of the prevalence of child abuse and its serious consequences, there has, likewise, been an explosion of information on dissociative disorders. As an example, we'll look at the diagnosis of depression. With the increased understanding of the biochemical changes in the brain that lead to depression, it has become the most common form of mental illness reported in the United States. Over the past several decades it now has been

found to affect millions of American's each year. With this in mind, as knowledge of childhood abuse, and its widespread affect on society has significantly increased since the early 90's, the likewise increase in the diagnosis of dissociative identity disorder becomes more understandable. Since most clinicians learned little about childhood trauma and its after effects in their training, many are struggling to build their knowledge base and clinical skills to effectively treat survivors of childhood abuse (Turkus).

According to Michael D. DeBellis M.D., developments in the field of Developmental Traumatology have been key to understanding the phenomena of dissociation and, in turn, the nature of DID. DeBellis states that Developmental Traumatology is the scientific study of the mental and psychobiological impact of overwhelming and chronic interpersonal violence on the developing child. Research in the field has indicated that traumatic and normal memories can coexist as parallel sets without ever being mentally combined. In extreme cases of dissociation, such as with DID, different sets of dissociated memories have been known to alter into the sub personalities of dissociative patients. The greatest evidence for the legitimacy dissociative identity disorder has been found in brain imagery studies of subjects that has actually recorded and shown the physical transference between their personality states. Furthermore, according to the American Association of Psychiatry, alter personalities can have differences in prescriptions in eye glasses, different allergies, changes in pain tolerance, and even different levels of blood glucose than that of the primary personality.

Despite these examples, problems in recognizing the disorder in patients still exist. Lack of knowledge and information may lead to misdiagnoses of dissociation, particularly when people are describing symptoms that are common to other mental health problems, such as depression. Because so many mental health professionals have received insufficient training on dissociative disorders, they may not ask the right questions during patient assessments. Current statistics show that the average patient with DID will spend up to an average of 7 years in the mental health system before being correctly diagnosed with dissociative identity disorder (Haddock, 2001). In the UK, professionals often use the ICD10 diagnostic manual. But this manual does not distinguish the disorder as clearly as the Diagnostic and Statistical Manual of Mental Disorders (4th Edition, Revised), which is standard in the United States. The ICD10 uses the out-dated term of multiple personality disorder which DID was known as until 1994. The ICD10 also gives little detail about how to recognize the condition, states that multiple personality disorder is rare, and is skeptical about it's causes. On the other hand, the very nature of the dissociation can make it significantly difficult to detect. For instance, it is standard to ask about any past childhood trauma during patient assessments,

but if the abuse suffered during an individual's childhood has been buried outside of their conscious awareness, then the patient may deny any trauma in their past history, due to dissociative amnesia.

One of the biggest breakthroughs in the study of dissociation came with the development of The Dissociative Experiences Scale. The scale, developed by Eve Bernstein Carlson, PhD. and Frank W. Putnam, M.D., is derived from extensive clinical experience with an understanding of DID. In the initial studies during its development and in all subsequent studies, the DES has discriminated the diagnosis of DID from other diagnostic groups at high levels of significance. The higher a patient's DES score, the more likely it is that they have dissociative identity disorder. The DES is the only dissociative instrument that has been subjected to a number of replication studies by independent investigators. Because of its extensive research base, it is the best self-report instrument for measuring dissociation available. To date, the DES has been translated into nineteen languages other than English. Furthermore, cases of dissociative identity disorder have been found outside the United States. So far, to date, prevalence studies have universally found the presence of DID, with symptom expression very similar in each case (Steele). Prevalence studies have been conducted in countries that include Australia, Czech Republic, Germany, Hungary, India, Japan, Netherlands, New Zealand, Norway, Scotland, Sweden, and Turkey.

In conclusion, as rare as it may be, to say that DID is entirely non-existent is quite a stretch. It is all too understandable that a specific diagnosis is harder to make for a rare disorder that is still so misunderstood. While there is room for error, to say that dissociative identity disorder is nothing more than an invention of doctors who are trying to take advantage of their clients just doesn't add up. With the biological evidence provided by Dr. DeBellis, it is hard to deny the reality of dissociation, including the diagnosis of DID. Especially when taking into account the physical proof of brain imagery studies, and the increasing data that supports the existence of dissociative disorders. In closing, while DID may be overly diagnosed, and perhaps even being created by some professionals, I believe it is still a genuine disorder that exists in a small percentage of individuals. With the increased awareness of child mistreatment and its affect on a child's psyche, as well as with the improvement in methods in properly diagnosing dissociation, it is hard to fathom that the entire diagnosis is nothing more than a sham. In the end, for the small percentage of patients that do suffer from this disorder, to deny their suffering and scoff at their symptoms only causes an elevation in their sense of alienation. In this, I speak of the alienation that comes with being a part of any minority, especially one compacted by the stigma that already surrounds mental illness in itself. In the end, it simply just does them a huge disservice.

## Works Cited

Allison, Ralph B. M.D., Minds in Many Pieces: Revealing the Spiritual Side of Multiple Personality Disorder. Paso Robles: CIE Publishing Inc., 1999.

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.

Baldwin, David. David Baldwin's Trauma Information Pages, <<http://www.trauma-pages.com/links.php>> Sept 25. 2006

Chu, James A. Vol. 4, No. 4, p. 200-204 : "On the misdiagnoses of multiple personality disorder." *Dissociation* : Vol. 4, No. 4 (Dec. 1991) <<http://hdl.handle.net/1794/1466>> Sept 08. 2006

DeBellis, Michael D. M.D., *Developmental Traumatology: Neurobiological Development in Maltreated Children With PTSD*. <<http://psychiatrictimes.com/p990968.html>> Sept 25. 2006

De Bellis, Michael D. M.D., Baum, A., Birmaher, B., et al. (1999a). A. E. Bennett Research Award. "Developmental Traumatology: Part I: Biological Stress Systems". *Biological Psychiatry*, in press.

Haddock, Deborah Bray, M.Ed., The Dissociative Identity Disorder Source book. New York: McGraw-Hill Companies Inc., 2001.

Hockenbury, Don H., Psychology (Second Edition). New York: Worth Publishers, 2000.

McHugh, Paul R. MD., Multiple Personality Disorder (Dissociative Identity Disorder)

<<http://www.psycom.net/mchugh.html>> Sept 8, 2006

National Center for PTSD: Epidemiological Facts about PTSD. National Center for Post-Traumatic Stress Disorder,

<[http://www.ncptsd.va.gov/facts/general/fs\\_epidemiological.html](http://www.ncptsd.va.gov/facts/general/fs_epidemiological.html)> Sept. 25, 2006

Sidran Institute. "What is Dissociative Identity Disorder?" Articles on Trauma and PTSD 2003)

<<http://www.sidran.org.did.br.html>> Sept08. 2006

Steele, Kathy, RN, MN, CS. "Cross Cultural Studies On DID" DID/Trauma/Memory Reference List

<<http://www.sidran.org/refs/ref4.html>> Sept 8, 2006

Turkus, Joan A. M.D. UK Society for the Study of Dissociation <<http://www.ukssd.org/>> Sept 08. 2006

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