

## **Introduction**

Dissociative Identity Disorder (DID) (known in the past as Multiple Personality Disorder-MPD) and other Dissociative Disorders are now understood to be fairly common effects of severe trauma in early childhood. The most common cause is extreme, repeated physical, sexual, and/or emotional abuse.

There is a great deal of overlap of symptoms and experiences among the several Dissociative Disorders, including DID. Some people who may not qualify for a specific diagnosis may, nevertheless, have problems with dissociation. For ease of reading, I use “Dissociative Disorders” as a general term for all of the diagnoses. Individuals should seek help from qualified mental health providers to answer questions about their own particular circumstances and diagnoses.

### **Q: Is DID the same as MPD?**

In 1994, the American Psychiatric Association’s manual that classifies and describes all psychiatric diagnoses changed the name from Multiple Personality Disorder (MPD) to Dissociative Identity Disorder (DID). They felt this better reflected the current professional understanding of the disorder, based on significant recent research.

That said, the term DID recognizes that there is a spectrum of Dissociative Disorders; Whereas, MPD is usually referring to one end of the spectrum.

### **Q: What Does Trauma Have to Do with DID?**

Posttraumatic Stress Disorder (PTSD) is a trauma-related mental illness affecting 8% of Americans. PTSD is closely related to Dissociative Disorders. In fact, most people with a Dissociative Disorder also have PTSD. The cost of trauma disorders is extremely high to individuals, families, and society. Recent research suggests that people with trauma disorders may attempt suicide more often than people who have major depression. Research also shows that people with trauma disorders have more serious medical illnesses, substance use, and self-harming behaviors.

### **Q: What Is Dissociation?**

Dissociation is a disconnection between a person’s thoughts, memories, feelings, actions, or sense of who he or she is. This is a normal process that everyone has experienced. Examples of mild, common dissociation include daydreaming, highway hypnosis, or “getting lost” in a book or movie, all of which involve “losing touch” with awareness of one’s immediate surroundings.

## **Q: When Is Dissociation Helpful?**

During a traumatic experience such as an accident, disaster, or crime victimization, dissociation can help a person tolerate what might otherwise be too difficult to bear. In situations like these, a person may dissociate the memory of the place, circumstances, or feelings about of the overwhelming event, mentally escaping from the fear, pain, and horror. This may make it difficult to later remember the details of the experience, as reported by many disaster and accident survivors.

## **Q: What is a Dissociative Disorder?**

Tragically, ongoing traumatic conditions such as abuse, community violence, war, or painful medical procedures are not one-time events. For people repeatedly exposed to these experiences, especially in childhood, dissociation is an extremely effective coping “skill.” However, it can become a double-edged sword. It can protect them from awareness of the pain in the short-run, but a person who dissociates often may find in the long-run his or her sense of personal history and identity is affected. For some people, dissociation is so frequent it results in serious pathology, relationship difficulties, and inability to function, especially when under stress.

## **Q: Who Gets Dissociative Disorders?**

As many as 99% of people who develop Dissociative Disorders have documented histories of repetitive, overwhelming, and often life-threatening trauma at a sensitive developmental stage of childhood (usually before the age of nine). They may also have inherited a biological predisposition for dissociation. In our culture, the most frequent cause of Dissociative Disorders is extreme physical, emotional, and sexual abuse in childhood. Survivors of other kinds of childhood trauma (such as natural disasters, invasive medical procedures, war, kidnapping, and torture) have also reacted by developing Dissociative Disorders.

## **Q: Is DID a Major Mental Health Problem?**

Current research shows that DID may affect 1% of the general population and as many as 5-20% of people in psychiatric hospitals. The rates are even higher among sexual-abuse survivors and addicts. These statistics put Dissociative Disorders in the same category as schizophrenia, depression, and anxiety, as one of the four major mental health problems today.

## **Q: Does DID Affect Both Women and Men?**

Most current literature shows that Dissociative Disorders are recognized

primarily among women. The latest research, however, indicates that the disorders may be equally prevalent (but less frequently diagnosed) among men. Men with Dissociative Disorders are most likely to be in treatment for other mental illnesses or drug and alcohol abuse, or they may be incarcerated.

### **Q: How Does a Dissociative Disorder Develop?**

When faced with an overwhelming situation from which there is no physical escape, a child may learn to “go away” in his or her head. Children typically use this ability as a defense against physical and emotional pain, or fear of that pain. By dissociating, thoughts, feelings, memories, and perceptions of the trauma can be separated off in the mind. This allows the child to function normally. This often happens when no parent or trusted adult is available to stop the hurt, soothe, and care for the child at the time of traumatic crisis. The parent/caregiver may be the source of the trauma, may neglect the child’s needs, may be a co-victim, or may be unaware of the situation.

### **Q: How Do Dissociative Disorders Help People Survive?**

Dissociative Disorders are often called a self-protection or survival technique because they allow individuals to endure “hopeless” circumstances and preserve some healthy functioning. For a child who has been repeatedly physically and sexually assaulted, however, dissociation becomes a reinforced and conditioned defense.

### **Q: If It’s a Survival Technique, What’s the Down Side?**

Because it is so effective, children who are very practiced at dissociating may automatically use it whenever they feel threatened—even if the anxiety-producing situation is not extreme or abusive. Even after the traumatic circumstances are long past, the left-over pattern of defensive dissociation sometimes remains into adulthood. Habitual defensive dissociation may lead to serious dysfunction in school, work, social, and daily activities.

### **Q: How Do the Identities of DID Develop?**

Until about the age of eight or nine years, children are developmentally primed for fantasy play, such as when they create and interact with imaginary “friends.” When under extreme stress, young children may call on this special ability to develop a “character” or “role” into which they can escape when feeling threatened. One therapist described this as nothing more than a little girl imagining herself on a swing in the sunshine instead of at the hands of her abuser. Repeated dissociation can result in a series of separate entities, or mental states, which may eventually take

on identities of their own. These entities can become the internal “personality states” of DID. Changing between these states of consciousness is often described as “switching.”

### **Q: Do People Actually Have “Multiple Personalities”?**

Yes, and no. One of the reasons for the decision to change the disorder’s name from MPD to DID is that “multiple personalities” is a misleading term. A person with DID feels as if she has within her two or more entities, each with its own way of thinking and remembering about herself and her life. These entities previously were often called “personalities,” even though the term did not accurately reflect the common definition of the word. Other terms often used by therapists and survivors to describe these entities are: “alternate personalities,” “alters,” “parts,” “states of consciousness,” “ego states,” and “identities.” It is important to keep in mind that although these alternate states may feel or appear to be very different, they are all manifestations of a single, whole person.

### **Q: Is it Obvious when a Person Switches Personalities?**

Unlike popular portrayals of dissociation in books and movies, most people with Dissociative Disorders work hard to hide their dissociation. They can often function so well, especially under controlled circumstances, that family members, coworkers, neighbors, and others with whom they interact daily may not know that they are chronically dissociative. People with Dissociative Disorders can hold highly responsible jobs, contributing to society in a variety of professions, the arts, and public service.

### **Q: What Are the Symptoms of a Dissociative Disorder?**

People with Dissociative Disorders may experience any of the following: depression, mood swings, suicidal thoughts or attempts, sleep disorders (insomnia, night terrors, and sleep walking), panic attacks and phobias (flashbacks, reactions to reminders of the trauma), alcohol and drug abuse, compulsions and rituals, psychotic-like symptoms, and eating disorders. In addition, individuals can experience headaches, amnesias, time loss, trances, and “out-of-body experiences.” Some people with Dissociative Disorders have a tendency toward self-persecution, self-sabotage, and even violence (both self-inflicted and outwardly directed).

### **Q: Why Are Dissociative Disorders Often Misdiagnosed?**

Dissociative Disorders survivors often spend years living with the wrong diagnosis. They change from therapist to therapist and from medication to medication, getting treatment for symptoms but making little or no actual progress. Research shows that people with Dissociative Disorders spend

an average of seven years in the mental health system before getting the correct diagnosis. This is common because the symptoms that drive a person with a Dissociative Disorder to treatment are very similar to those of many other psychiatric diagnoses.

### **Q: What Are Some Common Misdiagnoses?**

Common misdiagnoses include attention deficit disorder (especially among children), because of difficulties in concentration and memory; bipolar disorder, because “switching” can look like rapid-cycling mood swings; schizophrenia or psychoses, because flashbacks can cause auditory and visual hallucinations; and addictions, because alcohol and drugs are frequently used to self medicate or to numb the psychic pain.

### **Q: What Other Mental Health Problems Are People with DID Likely to Have?**

In addition, people with Dissociative Disorders can have other diagnosable mental health problems at the same time. Typically these include depression, post traumatic stress disorder, panic attacks, obsessive compulsive symptoms, phobias, and self-harming behavior such as cutting, eating disorders, and high-risk sexual behaviors. Although they may get expert treatment for the more common secondary issue, if the dissociative disorder is not addressed, recovery is generally short lived.

### **Q: Can Dissociative Disorders Be Cured?**

Yes. Dissociative Disorders respond well to individual psychotherapy, or “talk therapy,” and to a range of other treatment modalities, including medications, hypnotherapy, and art or movement therapy. In fact, compared to other severe psychiatric disorders, Dissociative Disorders may carry the best prognosis, if proper treatment is undertaken and completed. The course of treatment is long-term, intensive, and painful, as it generally involves remembering and reclaiming the dissociated traumatic experiences. Ultimately, the “alters” or “parts” can merge into a single whole “personality,” reclaiming the awareness, identity, and history previously held by the individual parts. Individuals with Dissociative Disorders have been successfully treated by therapists of all professional backgrounds, generally with special training, working in a variety of settings.

### **Q: Where Can I Get More Information?**

There are a number of good places to get more information on DID. The best place I found for clinicians is the International Society for the Study of Trauma and Dissociation ([www.isstd.org](http://www.isstd.org)). Another great resource for clinicians, family members and people with DID is the Sidran Institute

([www.sidran.org](http://www.sidran.org)) It helps people understand, recover from, and treat dissociative and traumatic stress conditions. An Infinite Mind ([www.aninfinitemind.com](http://www.aninfinitemind.com)) is another really good resource for people with DID and their supports.