Dissociative Identity Disorder

http://t3.gstatic.com/images?q=tbn:ANd9GcS05wIUdYXVfUNUmMXjqde-jWnoI7IT2RhOCyZ2tnpZtmurRON-

Dissociative identity disorder, formerly called multiple personality disorder, is characterized by ≥ 2 identities (called alters or self-states) that alternate. The disorder includes inability to recall important personal information relating to some of the identities. The cause is almost invariably overwhelming childhood trauma, and the disorder is best viewed as a developmental disorder in which extreme trauma interferes with formation of a single cohesive identity. Diagnosis is based on history, sometimes with hypnosis or drug-facilitated interviews. Treatment is long-term psychotherapy, sometimes with drug therapy.

What is known by one identity may or may not be known by another. Some identities appear to know and interact with others in an elaborate inner world, and some identities do this more than others. The system must be mapped out by the psychiatrist over time.

This disorder may be present in about 1% of the general population.

Etiology

Dissociative identity disorder is attributed to the interaction of the following:

- Overwhelming stress (typically extreme childhood mistreatment)

- Insufficient nurturing and compassion in response to overwhelmingly hurtful experiences during childhood
- Dissociative capacity (ability to uncouple one's memories, perceptions, or identity from conscious awareness)

Children are not born with a sense of a unified identity; it develops from many sources and experiences. In overwhelmed children, many parts of what should have blended together remain separate. Chronic and severe abuse (physical, sexual, or emotional) and neglect during childhood are frequently reported by and documented in patients with dissociative identity disorder. Some patients have not been abused but have experienced an important early loss (such as death of a parent), serious medical illness, or other overwhelmingly stressful events.

In contrast to most children who achieve cohesive, complex appreciation of themselves and others, severely mistreated children may go through phases in which different perceptions, memories, and emotions of their life experiences are kept segregated. Such children may over time develop an increasing ability to escape the mistreatment by "going away" or retreating into their own mind. Each developmental phase or traumatic experience may be used to generate a different self-state.

Symptoms and Signs

Several symptoms are characteristic:

- Fluctuating symptom pictures
- Fluctuating levels of function from highly effective to disabled
- Severe headaches or other pains
- Time distortions, time lapses, and amnesia
- Depersonalization and derealization

Depersonalization refers to feeling unreal, removed from one's self, and detached from one's physical and mental processes. Patients feel like an observer of their life, as if they were watching themselves in a movie. Patients may even feel as if transiently they do not inhabit their bodies. Derealization refers to experiencing familiar people and surroundings as if they were unfamiliar, strange, or unreal.

Patients typically lose time; they experience frequent bouts of amnesia after which they may discover objects or samples of handwriting that they cannot account for or recognize. They may also find themselves in different places from where they last remember being and have no idea why or how they got there. They may refer to themselves in the first person plural (we) or in the third person (he, she, they), sometimes without knowing why.

http://toptenfamous.com/top-10-bizarre-mental-disorders/

The switching of identities and the amnestic barriers between them frequently result in chaotic lives. Because the identities often interact with each other, patients typically report hearing inner conversations between other personalities, which comment on or address them. Thus, patients may be misdiagnosed with a psychotic disorder. Although these voices are experienced as hallucinations, they have a distinctly different quality from the typical hallucinations of psychotic disorders such as schizophrenia.

Patients often have a remarkable array of symptoms that can resemble those of anxiety disorders, mood disorders, posttraumatic stress disorder, personality disorders, eating disorders, bipolar disorder, schizophrenia, and seizure disorders. Suicidal ideation and attempts are common, as are episodes of self-mutilation. Many patients abuse substances.

Diagnosis

- Detailed interviews, sometimes with hypnosis or facilitated by drugs

Patients typically have been diagnosed with at least 3 different mental disorders and have been treated unsuccessfully. On average, these patients are in the mental health system for about 6 to 8 yr before the disorder is accurately diagnosed. The skepticism of some physicians regarding the validity of dissociative identity disorder can contribute to misdiagnosis.

The diagnosis requires knowledge of and specific questions about dissociative phenomena. Prolonged interviews, hypnosis, or drug-facilitated (barbiturate or benzodiazepine) interviews are sometimes used, and patients may be asked to keep a journal between visits. All of

these measures encourage a shift of personality states during the evaluation. The clinician may over time attempt to map out the different self-states and their interrelationships. Specially designed structured interviews and questionnaires can be very helpful, especially for clinicians who have less experience with this disorder.

The clinician may also attempt to directly contact other identities by asking to speak to the part of the mind involved in behaviors for which patients had amnesia or that were experienced in a depersonalized or derealized way.

Prognosis

Symptoms wax and wane spontaneously, but dissociative identity disorder does not resolve spontaneously. Patients can be divided into groups based on their symptoms:

- Symptoms are mainly dissociative and posttraumatic. These patients generally function well and recover completely with treatment.
- Dissociative symptoms are combined with prominent symptoms of other disorders, such as personality disorders, mood disorders, eating disorders, and substance abuse disorders. These patients improve more slowly, and treatment may be less successful or longer and more crisis-ridden.
- Patients not only have severe symptoms due to coexisting mental disorders but may also remain deeply emotionally attached to their abusers. These patients can be challenging to treat, often requiring longer treatments that typically aim to help control symptoms more than to achieve integration.

http://www.pseudoparanormal.com/2010/06/multiple-personality-disorder-real-or.html

Treatment

- Supportive care, including drug treatment as needed for associated symptoms
- Long-term integration of identity states when possible

Integration of the identity states is the most desirable outcome. Drugs are widely used to help manage symptoms of depression, anxiety, impulsivity, and substance abuse but do not relieve dissociation per se; treatment to achieve integration centers on psychotherapy. For patients who cannot or will not strive for integration, treatment aims to facilitate cooperation and collaboration among the identities and to reduce symptoms.

The first priority of psychotherapy is to stabilize patients and ensure safety, before evaluating traumatic experiences and exploring problematic identities. Some patients benefit from hospitalization, during which continuous support and monitoring are provided as painful memories are addressed. Hypnosis may help with accessing the identities, facilitating communication between them, and stabilizing and interpreting them. Modified exposure techniques can be used to gradually desensitize patients to traumatic memories, which are sometimes tolerated only in small fragments.

As the reasons for dissociations are addressed and worked through, therapy can move toward reconnecting, integrating, and rehabilitating the patient's alternate selves, relationships, and social functioning. Some integration occurs spontaneously during treatment. Integration can be encouraged by negotiating with and arranging the unification of the identities or facilitated with imagery and hypnotic suggestion.

Reference: http://www.merckmanuals.com

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