WHEN YOU DO NOT KNOW WHO YOU ARE !

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Introduction

The entire class fell silent as the teacher, Mrs Baldwin, marched across the room. Mrs Baldwin wearily shouted, "Kim Noble, Stand up! I said you stand up!". She shouted grabbing the arm of five-year-old Kim Noble. Mrs Baldwin questioned, "What did you

Fig. 1: Existence of more than one personality within an individual

do that for?". The dress she was wearing was covered in splurges of black paint. Sitting in her drawing room, Kim Noble, now 51, recalls, "Of course, the teacher was exasperated when I denied doing it because she had seen me smear it over myself." But till date, Kim Noble, who now has a daughter, refuses to accept that she had blurred her dress with black paint. But as far as I was concerned, it was somebody else who did it, she says. What Kim could not have known then was that she was suffering from a rare condition called 'Dissociative Identity Disorder' (DID)— colloquially known as 'split personality disorder'— and that over the next four decades her mind would regularly switch from one character to another without warning.

Deborah Bray Haddock in her book *The Dissociative Identity Disorder Sourcebook*, says, "Dissociative Identity Disorder, in short DID, is about survival! As more people begin to appreciate this concept, individuals with DID will start to feel less as though they have to hide in shame. DID develops as a response to extreme trauma that occurs at an early age and usually over an extended period of time."

Dissociative Identity Disorder — The Concept

A person suffering from this ailment adopts one or more distinct identities,

which co-exist within him/her. Each personality is distinct from the other in specific ways. For instance, voice, posture, vocabulary and comprehensive mannerisms — almost everything will be distinct and all these virtues shall mark a separate personality.

There are cases, in which a person may possess as many as 100 or more identities, while some people may exhibit symptoms just of one or two. The psychiatric explicitness of this disease makes it unique to diagnose and study. Doctors consider that persons suffering from DID usually have one main personality that is referred to as the 'host'. This is generally not the person's original personality, but is rather developed along the way. It is usually this personality that seeks psychiatric assistance. Psychiatrists address the other personalities as 'alters' and the phase of transition between alters as the 'switch'. The frequency of alters in

Fig. 2: Three different moods persisting at a time

any given case varies across gender. For example, men can have female alters and women can have male alters. The most baffling aspect of this psychological disorder is the physical changes that occur in a switch between alter. A patient assumes a total new posture, voice, attitude and it seems that a completely different soul resides in a body. One study conducted in 1986 found that in 37 per cent of the total patients, alters demonstrated different handedness compared to the hosts. Eminent psychiatrists described DID as a severe condition, in which two or more distinct identities are present in an individual and alternatively take care of the body. It is a disorder characterised by identity fragmentation, where the patient also experiences extensive memory loss. DID reflects failure to integrate single self of blood and muscles with the same identity, memory and consciousness. Usually , the primary identity carries an individual's prescribed name and is passive, depressed, guilty and dependent. On the contrary, the alters are experienced as if the person has a distinct history, self-image and identity. Certain stressed circumstances can cause a particular alter to emerge, and substantially, the other identities may deny the knowledge of it. The various identities can be critical of each other or appear to be in open conflict.

Etymology and Epidemiology of DID

DID was called Multiple Personality Disorder until 1994, when the name was changed to reflect a concrete understanding of the condition. Since DID is characterised by a splitting of identity rather than by a proliferation of separate identities as considered earlier, the change of name was aptly justified. Some believe that because DID patients are easily hypnotised, their symptoms arise in response to the therapist's suggestions, but actually it is not the case. The high degree of epidemiology of this disorder makes diagnosis difficult. As a consequence, patients with DID are

commonly misdiagnosed with schizophrenia (severe psychiatric ailment) due to common symptoms, like obsessive compulsive disorder, major depression and so on. DID seems to favour mostly females according to several US studies. Cultural and social backgrounds seem to have a strong influence on the disorder and interpretation of the same.

What do the statistics say?

Statistically, sufferers of DID have an average of 15 identities. As stated earlier, women are the favourable victims of this disorder as compared to men with a ratio as high as 9:1. The usual age of its onset is early childhood, generally by four or five years. If untreated, the disorder may last a lifetime, accumulating new identities. There are no reliable statistical figures as to the prevalence of this disorder, although the last few years have experienced a higher frequency. In nearly every case of DID, horrific instances of physical and sexual child abuse were present. It is assumed that juveniles and young children, who faced a routine of torture and neglect, create a hypothetical world of fantasy to escape this brutality. As a sufferer confronts forced sex in adolescence, an identity may emerge that deals with this aspect of life. People with DID tend to suffer from substance abuse, borderline personality disorder, depression, eating disorder, and in this way, DID seems to show its resemblance with post-traumatic stress disorder.

Symptoms

The affected individual experiences two or more distinct identities each with its own enduring pattern of perceiving, relating and judging about the environment and self. The

Fig. 3: Symptoms of Dissociative Identity Disorder

identities recurrently take control of the person's behaviour, exhibiting its own distinct history, self-image, behaviours, physical characteristics and even a separate name. The circumstances determine the identities, and in this way, alternate identities are experienced taking control in sequence, one at the expense of the other and may deny the knowledge of each other. Transitions from one identity to another are often triggered by psychosocial stress. Frequent gaps or lapse of memory are found in personal history, including known people, places and events being washed away from the brain. Different alters may remember different events with passive identities and limited memories and hostile identities with complete memories. The symptoms of depression, anxiety, forgetfulness, dependence are quite evident. In childhood, problem in behaviour and inability to focus on academics are common symptoms. Self-destructive and aggressive behaviour takes place in addition to visual or auditory hallucinations. Patients with DID do not know that their other parts exist because of florid amnesia (pervasive loss of memory). They experience blackouts when another part has taken control of their action and consciousness.

Causes

The reason behind people developing DID is not entirely understood. Frequent reports suggest that patients with DID have more or less experienced severe physical and sexual abuse, especially during the early childhood. Though the accuracy of such accounts is periodically challenged, they are often confirmed by objective evidence. Individuals with DID may also have post-traumatic stress disorder with symptoms, like nightmares, startled responses, etc. Several researches suggest that DID is more common among close biological relatives of persons, who also have the disorder than in the general population. Brain-imaging studies reveal identity transitions as the prime cause of DID. Causes of identity disorder are highly debated and fall under two models. The first is the post-traumatic model, which predicts that there is a correlation between the frequency of DID and childhood trauma and that the incidence of dissociation is a means of dealing with and reviving the trauma experienced. The other is the socio-cognitive model, in which a number of factors, including social cues, cultural aids and the therapist's influence attribute to the occurrence of DID but does not include the possibility of conscious *malingering*. The continual revision of these two models is important as far as the causes of this disorder are concerned. Several physicians argue that DID is actually a survival mechanism. The dissociation protects someone in the moment not only from emotional pain but also the physical pain, acting as endogenous opioids for the brain under high stress. Perhaps a girl child is often abused at night by her father. There she may begin to dissociate herself as soon as she hears the crack of a beer can. It is a type of emotional and physiological response which develops and emerges as a conditioned state. Each time she hears the sound, the child gets triggered and gradually shifts states, so that one state may be aware of the pain and trauma, while in another state, only has a dim recollection of what happened. An extensive research on a rape victim probed out this result when she often described her state as "being out under the lilac tree" as she was being raped there. Rather it was recorded that she disconnected from what was really happening so that she could better endure it. Therefore, scientists and clinicians agree with the concept that trauma is an antecedent that has a causal role in DID. It is painful for an individual to deal with a numb pain, so they begin to dissociate while the experience is happening.

Neuro-anatomical Analysis of DID Patients

(A) Structural Neuro-anatomical Differences

Patients diagnosed with DID exhibit a bilateral reduction in hippocampal and amygdalar volumes in the brain. This reduction in the hippocampal volumes can possibly be explained by the fact that many patients suffering from DID have experienced trauma in their early developmental years of life. The stressful events that occur, while the brain is still undergoing major developmental changes, impair the viability of proliferating hippocampal cells due to excitotoxic levels of CRH (a hormone stimulated during stress). The CRH (Corticotrophin Releasing Hormone) is attenuated at the hippocampus by recurrent episodes of abuse, thus, resulting in a decreased hippocampus. This fact also

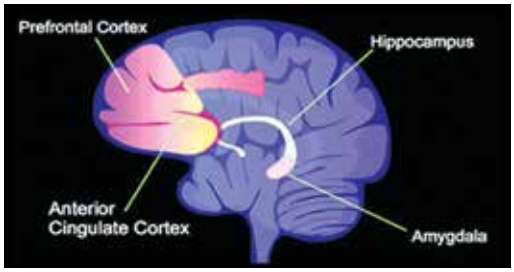

Fig. 4: Brain showing hippocampus and amygdala

puts light on the short memory of patients attributing to the function of hippocampus, an organ which plays a vital role in the formation of long-term memories. The memory loss or memory impairment exhibited by DID patients, thus, explains why they have issues remembering events that take place during the transition of identities.

A similar result was found in order to explain the reduced volume of the amygdalae in response to fear and anxiety. The amygdala (L, corpus amygdaloideum) is an almond-shaped set of neurons located in the brain's medial temporal lobe of higher vertebrates. The amygdala sends projections to the hypothalamus, the dorso-medial thalamus, the nuclei of trigeminal and facial nerve performing notable functions in emotional response. The shrinking of the amygdala implies further degradation of a patient's ability to form long-term memories as well as to regulate emotional relevance. The reduction in the amygdalae relates to the fact that patients with DID have often had some form of traumatic experience (inciting fear, anxiety and stress).

Thus, the bilateral structural reductions in both the hippocampi and the amygdalae can serve as possible biomarkers in those who possess certain risk for developing DID, pointing for preventive clinical measures to be taken.

(B) Functional Neuro–anatomical Differences

Studies on the functional side of the neuroanatomy show promising results for the discovery of the possible biological mechanism of DID. Using SPECT (Single-photon emission computed tomography) imaging techniques, it has been identified that there is a marked decrease in regional cerebral blood flow at the orbital region of the brain. The orbito-frontal region of brain is implicated in many higher order cognitive tasks, such as regulation of emotions, inhibitory control of information, decision-making, and so on. The study also found that blood flow was increased in the medial and frontal lobes as well as the temporal lobes in patients with DID relative to healthy controls. It supports Forrest's orbito-frontal hypothesis for Dissociative Identity Disorder which states that the orbito-frontal region of the brain is the origin from where the distinct mental states of the disorder emanate themselves. This rationale behind this hypothesis leads back to early childhood trauma as the prime cause of DID, due to the fact that the maturation of orbito-frontal region is experience dependent. It creates a huge impact on those brought up in an abusive surrounding. Detached methods of parenting, sexual torments and physical abuse create distinct mental states at the orbito-frontal region, forming a part of the brain's lateral inhibition. The basic idea is that due to vastly different ways in which the patient has been brought up will lead to two completely bifurcated identities that have been created by lateral inhibition. The lack of organisation

of temporal information is the alternative interpretation for the presence of distinct mental states.

(C) General Neuroanatomical Characteristics of DID Patients

In patients with DID, the regional cerebral blood flow in the posterior associative cortices and the medial prefrontal cortex poses an exigent role when changing from one identity to another. This makes sense as the medial pre-frontal cortex is robustly related to holding one's conscious feel of self in the mind. The function of the posterior associative cortices is crucial as they supply conscious information to medial pre-frontal cortex for manifestation and expression of the same. The change in the regional cerebral blood flow during transition of alters stimulates two identities to procure in individuals, one is the neutral identity state (general state the patient is experiencing) and the second is the traumatic identity state (associated with traumatic memories and protection). In provocation studies (where patients read scripts that provoke the switching of identities), it has been noted that the regional cerebral blood flows distinctly in various areas of the brain while changing from neutral identity state to traumatic identity state. When in the traumatic identity state, the PET (Positron Emission Tomography) scan illustrates that there is an increased regional cerebral blood flow in the amygdalae which is involved in the processing of fear as well as the basal ganglia which deals with processing of anxiety.

There is little overlap between the areas that are activated in the neutral identity state and areas activated in the traumatic identity state. More efficient clinical interventions with concrete evidence of neural circuits are paving their way to know the mystery behind this disorder.

Diagnosis and Therapy

There are four criteria for diagnosing someone with Dissociative Identity Disorder. The first being the presence of two or more distinct identities, the second being the regular control of different identities, third the exhibition of amnesia by patients (i.e., forgetting personal information) and finally, the condition must not have been caused by direct physiological effects, such as drug abuse or head trauma. On an average, the time that elapses from the presence of the first symptom to diagnosis is six to seven years. Diagnosis has become controversial as the symptoms are rarely recorded by patients or their relatives. Training in the assessment of DID is important to process structured clinical interviews to distinguish between fake and true disorders. Clinicians need to be diligent enough to interpret the patient's responses in a way which is indispensable to judge the disorder. Diagnosis through fantasy model (the model which says that the trauma is fantasised) should be governed to avoid the wrong notion that overzealous therapists reinforce the patients to believe that they have DID, even though they are unaffected. Even if fantasy model is found accurate for the patients, self report measures should be used, taking help from objective measures of trauma (e.g., police and school reports).

The therapy of this unfathomable psychological disorder is tedious to depict in the form of a doctor's prescription. The primary treatment of this disease is

long-term psychotherapy with the goal of reconstructing the different personalities and uniting them. Cognitive and creative therapies are also taken into consideration. Although there are no specific medications to treat this disorder, anti-depressants, anti-anxiety drugs or tranquilizers may be prescribed to assist patients to have control over their mental health. Sometimes, dissociation of identities is highest right after trauma. In these cases, patients should be immediately hospitalised to recover from the severe trauma to avoid interference with the memory. However, it is also seen that those patients show decreased level of dissociation when persistent mental therapy is bestowed upon them.

This disease is formidable and a debilitating illness for both the patient and others in his/her life. The relatives should try to empathise and listen to the patient. The patient may feel like "left in a dark place" or may report that he/she hears voices calling him/her. The relatives should not accuse him/her of "faking" or "lying" when the alter identities take control of the patient. These are some common complaints from the patient's side. Sometimes, alters express ideas or beliefs that may be completely contradictory to what the person thinks when in dominant personality. The relatives should pay his/her respect to every thought. It should be carefully seen that the information of a person being affected by DID is kept private as this is hurtful for the person when trivialised. Since people with DID have often been through some severe incidents, they may have trouble trusting others and can get scared. The relatives should never argue, rather pacify the patient. Eye Movement Desensitisation and Reprocessing (EMDR), a method that integrates traumatic memories with the patient's own resources, is widely used in the treatment of people with DID. Hypnosis is sometimes used to assert the personality states in the hope of gaining better control. Medications are meant to manage emotional symptoms that occur in addition to DID but caution is exercised in order to avoid re-traumatsation. People with DID can neither maintain a job nor a family. While there is no definite 'cure', long-term treatment, like talk therapy or hypnotherapy or adjunctive therapies, such as art or movement therapy are helpful if the patient stays committed.

Conclusion

Shirley A. Mason (1923–1998) was an American commercial artist who was known to have Dissociative Identity Disorder. Her life was fictionalised in 1973 in the book *Sybil* which was further adapted into films (in 1976 and 2007). Both the book and the films used the name 'Sybil Isabel Dorsetto' to protect Mason's identity. Indian cinema witnessed a Bollywood movie *Bhool Bhulaiya* (2007) and a Tollywood movie *Aparichit* that showed this disorder. Once rarely reported, this disorder has become common nowadays, due to increased physical lust, mental torment, parental anguish, psychological ordeal and social upheaval. Many people mistakenly think and classify trauma patients as a group of liars. A considerable research is paving their way to support patients with DID. The tragedy of being betrayed and sadistically abused makes these people almost equal to 'hell'. Thus, it is the responsibility of every individual close to these patients to emotionally guide them so that they can get out of this situation.

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