

To what extent do environmental factors play a role in causing Dissociative Identity Disorder?

Group 3: Psychology

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Dissociative Identity Disorder (DID) is defined as having two or more distinct identities (*Dissociative Disorders*, n.d.). This disorder has been particularly controversial because there are multiple disorders that present symptoms very similar to DID, and as a result, psychologists and doctors have had trouble discovering a direct cause of Dissociative Identity Disorder. Since the disorder is psychological, researchers have analyzed the brain for causes as well as environmental factors. This essay seeks to discover and construe the different theories involving the varying environmental factors that could possibly be the cause of the disorder. The main focus of the environmental factor is going to be family relations.

This essay will simultaneously explore other aspects, such as biological and cognitive factors that could cause Dissociative Identity Disorder. The biological approach is fixated on the composition of the brain and the cognitive will be concentrated on the patients' thought process and coping mechanisms when dealing with a certain environment. This research paper will also explore the background information of the disorder including, treatments and symptoms.

It will explore each type of disorder that commonly gets confused with Dissociative Identity Disorder, researching the various types will aide in finding the potential cause of the disorder. Various types of treatments will be explored, including invasive and non-invasive, as well as alternative treatments. Researching the various types of treatments will help establish background on the disorder. This research question is worthy of investigation because there has not been a direct cause established for the disorder only speculations that have been theorized.

I. What is dissociative identity disorder?

Dissociative disorders are defined as problems involving memory, personality, perception, and emotion (Wang, 2018). The general symptoms of Dissociative disorder is the feeling of detachment and the loss of memory (Wang, 2018). Dissociative Identity Disorder is more commonly known as DID and previously known as multiple personality disorder, but this changed when the new DSM IV was released. The Diagnostic and Statistical Manual of Mental Disorders is what psychologists and doctors use to diagnose patients with mental illness, the manual is updated every few years with new information about mental disorders ("DSM-5: Frequently," n.d.). When the manual was updated new information was added about Dissociative Identity Disorder causing the change from multiple personality disorder. "People with DID develop one or more alternate personalities that function with or without the awareness of the person's usual personality" (*Dissociative Identity*, 2016). There are multiple different criteria that aid medical professionals in diagnosing patients with DID. The first criterion requires that the patient has two or more distinct identities. The patient switches identities, "when there is a perceived psychosocial threat. The switching allows a distressed alter to retreat while an alter who is more competent to handle the situation emerges" (Gillig, 2009). These identities come with erratic behavior and misconceptions. For instance the demeanor of the person would be contrasting with each one of the identities. Each identity brings a different personality and behavior patterns. This comes with modifications in personal preferences and attitude. "The attitude and personal preferences (for example, about food, activities, clothes) of a person with dissociative identity disorder may suddenly shift and then shift back" (Wang, 2018). The second

criterion requires that the person with the disorder has a transformation in their memory. For instance, there would be gaps in memory dealing with everyday events. The last criterion requires that the disorder causes a significant change in social behavior, such as dealing with jobs, and social life. Psychologists use this specific criteria to confirm that the symptoms presented coincide with the requirements of the Diagnostic and Statistical Manual of Mental Disorders. These criteria are important to the research because presenting the symptoms of Dissociative Identity Disorder aids in understanding the background information of the disorder, which could potentially be beneficial to finding a specific cause of Dissociative Identity Disorder.

It is important to note that sub disorders are commonly confused with Dissociative Identity Disorder. Researching the various sub disorders is important to the research to help understand the complications researchers have when attempting to discover a cause. This problem arises because the multiple sub disorders present analogous symptoms to Dissociative Identity Disorder which complicates finding a specific cause. The first comparison made to DID is depersonalization or derealization. Both of these disorders are recurring or ongoing and a patient could have both or just one disorder (Wang, 2018). Depersonalization can be defined as “experiences of unreality or detachment from one’s mind, self or body. People may feel as if they are outside their bodies and watching events happening to them,” (Wang, 2018). This is frequently mistaken for DID because it has similar symptoms such as the detachment from the mind. Derealization is “experiences of unreality or detachment from one’s surroundings. People may feel as if things and people in the world around them are not real,” (Wang, 2018). Again, this is consistently mistaken for DID because of the element of detachment. Detachment is when the

patient feels in such a way that they are viewing themselves from outside of their body (Wang, 2018). The last disorder is Dissociative Amnesia. “Dissociative amnesia involves not being able to recall information about oneself (not normal forgetting). This amnesia is frequently related to a traumatic or stressful event,”(Wang, 2018). There are three different types of amnesia that are present with Dissociative Amnesia someone can have localized amnesia , selective amnesia , or generalized amnesia . Localized amnesia is losing memory of an event or a period of time (Wang, 2018). For example, the patient may lose memory of being a certain age or traumatic event that happened. Selective amnesia is memory loss pertaining to being, “unable to remember a specific aspect of an event or some events within a period of time”(Wang, 2018). For example, when selective amnesia is present a patient may lose memory of someone being at a certain event. Generalized amnesia is when someone loses all memories about their life history and personality (Wang, 2018). Dissociative Amnesia is commonly inaccurately diagnosed for being Dissociative Identity Disorder. This is because both disorders simultaneously present symptoms dealing with loss of memory. Dissociative Identity Disorder is distinguished from other dissociative disorders by the presence of the multiple personalities. The misdiagnosis happens because dissociative disorders are very similar and Dissociative Identity Disorder and others present the same symptoms. The different types of Dissociative disorders are important to the research to help distinguish why it has been difficult for psychologists and doctors to find a main cause for DID. Distinguishing Dissociative Identity Disorder from various similar disorders helps with the understanding of what DID is and what DID is not which could potentially help find a cause.

II. What are the treatments?

There are numerous treatments for the disorder, but treatments vary from person to person. This is because not everyone has the same psychological needs and there are varying levels of severity related to the disorder. Understanding the treatments of Dissociative Identity Disorder aids in discovering the cause of the disorder. This is because analyzing the benefits of the treatment can help determine the cause. People with Dissociative Identity Disorder have a difficult time trusting people they do not know, which in result makes the treatment aspect difficult. This is because it may be hard for the patient to converse regarding personal issues with an outsider. When patients are being treated the therapy doesn't happen instantaneously. "Therapists who commonly treat patients with DID see them as outpatients weekly or biweekly for years" (Gillig, 2009, p.9). The intention of the therapy is to attempt to combine each of the distinct identities, while still keeping all of the shared experiences. The most prevalent approach to treating DID is cognitive behavioral therapy. This therapy aims to aid the patient in finding new coping strategies to help with the switching their personalities when in distress. This also includes effectively communicating with the multiple identities. Which, "can be enhanced by teaching relaxation exercises, suggesting breaks from the setting for a few minutes, and helping the patient gain control over cognitive distortions of the self and world." (Haddock, 1956). This type of therapy benefits the patient by aiding them in finding new coping mechanisms. Also in a way that is incomparable the therapist attempts to help the patient by changing their own behavior. "The therapist tries to model an appropriate relationship and model appropriate calm

and considered reactions to crises.” (Haddock, 1956). The change in behavior from the therapist helps the patient view how they should act to a crisis when dealing with their own situations. This type of therapy aids in the demonstration that cognitive factors do play some role in the cause of Dissociative Identity Disorder. This is because using a cognitive behavioral approach with therapy results in improved behavior of the patient.

The next type of therapy is psychodynamic therapy, “Psychodynamic theory believes in the influence of the unconscious on behavior and places major importance on the functions of the ego, the self, and social relationships”(Haddock, 1956). With this form of therapy the therapist will “help to bring disowned parts of the self into awareness ...”, “interpret what the client shares...”, and “assist clients in working through the transference relationship”(Haddock, 1956). There are many different disadvantages to psychodynamic therapy including potentially harming the patient. Focusing on the traumas of the patient before the patient is stabilized, the therapist taking an expert stance, and the therapy creates unnecessary distance in the relationship between the patient and the therapist (Haddock, 1956). The psychodynamic approach is important to research because it demonstrates that trauma involving the patient could potentially be a cause to Dissociative Identity Disorder. This is because working through past trauma with the patient may help the patient with switching between the multiple personalities.

The last form of therapy used is the Adlerian therapy. This contains both elements from the psychodynamic and cognitive theory. Adlerian therapy assist patients with DID by addressing client’s misbeliefs, their lifestyle, and also challenging the patient in new ways (Haddock, 1956). Similar to the other forms of therapy this also has disadvantages that are not constructive for the patient . The most prominent disadvantage is the lack of boundaries between

the patient and the therapist. Lack of boundaries happen because the patient is sharing their personal life with the therapist (Haddock, 1956). This may cause the patient to have a lack of trust or feel pressured into certain acts by the therapist. This disadvantage could result in the patient presenting severe symptoms of distrust, in result causing the Dissociative Identity Disorder to be worse. The multiple different forms of therapy is essential to research because it will aid in the understanding of how each patient differs. It further supports with the understanding of the etiology, this is because each form of therapy focuses on one specific aspect that is essential to helping the patient, this could be traced back to a specific cause.

There are various instances when therapy doesn't work for the patient, which is why they also have different types of treatment that the patient can undergo. For instance, art therapy is helpful when the patient feels like they are unable to communicate or when one of their identities is non-verbal. Another form of alternative treatment is mindfulness meditation, which helps “teach the importance of staying in the present moment and the acceptance of yourself without judgement”(Haddock, 1956). One invasive type of treatment is eye movement desensitization and reprocessing which was developed by Francine Shapiro, “is used to process information including traumatic material more quickly than with traditional therapy”(Haddock, 1956). Other treatments include hypnosis and group therapy. Patients with Dissociative Identity Disorder can also be treated using medications such as antidepressants, and anxiety medication. There are many different types of treatments patients can go through whether it is therapy or an alternative method. The non traditional treatment that is the most important is the eye movement desensitization and reprocessing, this is because it focuses on trauma, which seems to be

important when dealing with Dissociative Identity Disorder. This is because the element of trauma is repeated in multiple therapies. Understanding the non traditional form treatment is important to the research because it demonstrates that there are multiple different ways to treat the disorder. It is also important because factors that are being treated could lead to discovering a cause.

III. The biological factors involving Dissociative Identity Disorder

Only one biological factor contributes to Dissociative Identity Disorder and it has to deal with the amygdala and the hippocampus . In one study it was found that people with Dissociative Identity disorder have smaller volumes when dealing with the key components.“The purpose of this study was to compare hippocampal and amygdalar volumes in patients with dissociative identity disorder with those in healthy subjects with no psychopathology”(Vermetten, Schamal, Linder, Loewenstein, & Bremner, 2006). The amygdala and the hippocampus are simultaneously involved in short term memory and detecting fear. The analysts involved in the study hypothesized that there would be a result that the amygdala and the hippocampus have smaller volumes in patients where Dissociative Identity Disorder is present than in patients without the disorder. All of the patients with Dissociative Identity Disorder were tested for symptoms of PTSD using the DSM IV, as result the control patients were tested for having an occurring psychiatric disorder. This is because the researchers needed the participants to have past trauma so that the smaller volumes of the amygdala and the hippocampus could be seen.During the assessment all of the participants underwent an MRI test

to prove the hypothesis of the smaller amygdala and hippocampal volumes, “Volumes were assessed by tracing the outline of the brain (excluding the cerebellum) in all axial slices in which it was visualized”(Vermetten, Schamal, Linder, Loewenstein, & Bremner, 2006). The results concluded that “The mean of the left and right hippocampal volumes of patients with dissociative identity disorder was 19.2% smaller than that of the comparison subjects”(Vermetten, Schamal, Linder, Loewenstein, & Bremner, 2006). It also concluded that “The mean of the left and right amygdalar volumes of the patients with dissociative identity disorder was 31.6% smaller than that of the comparison subjects”(Vermetten, Schamal, Linder, Loewenstein, & Bremner, 2006). The study presented demonstrates that people with Dissociative Identity Disorder had a slight change in brain composition when compared to the patients without any mental disorders. In relation to the research this may be a contributing factor for Dissociative Identity Disorder. This is because the participants in the study that had Dissociative Identity Disorder all had smaller volumes this could be a result of the disorder or the smaller volumes may be a result of another contributing factor.

The smaller volumes of the hippocampus and the amygdala could have been a result of another factor. Many of the participants with Dissociative Identity Disorder were diagnosed with having PTSD prior to starting the study. This could mean that the smaller volumes were caused by traumatic experiences patients have been through. “Consistent with this hypothesis, abused subjects without dissociative identity disorder in the current study had larger hippocampal and amygdalar volumes than nonabused subjects without dissociative identity disorder. Larger hippocampal and/or amygdalar volume may be protective in the face of early

trauma”(Vermetten, Schamal, Linder, Loewenstein, & Bremner, 2006). From the evidence presented it can be inferred that smaller hippocampal and amygdalar volumes have a correlation to having Dissociative Identity Disorder. This is because each of the patients that had smaller volumes also presented symptoms of having DID, but because post traumatic stress disorder is also a factor to be considered as a cause of the smaller volumes it could also be considered as a cause for Dissociative Identity Disorder. This critical biological factor and environmental factor was demonstrated by each of the participant that had Dissociative Identity Disorder followed up by the smaller hippocampal and amygdalar volumes .This is important to the research because it demonstrates that an environmental factor, PTSD, may be the cause of Dissociative Identity Disorder.

IV. The Environmental Factors

As presented in the previous study it can be inferred that people who have experienced severe trauma they are more inclined to have Dissociative Identity Disorder. In this source the etiology of DID is explored using PTSD and early childhood trauma. It has been presented that trauma is very prevalent patients with DID, which resulted in researchers looking into it as a cause. “In most clinical series, childhood abuse and/or neglect is reported by 90–100% of the patients directly during the study examination” (Sar, Dorhay, & Kruger, 2017). The abuse that they go through commonly comes from an attachment figure, such as a mother or father with an authoritative parenting style. This is because the trauma that they experience usually happens during their childhood. This type of trauma is usually constant, severe, and happens over years,

which negatively affects towards the person experiencing the trauma .One source states, “ In general, practitioners who accept the validity of DID as a diagnosis attribute it to the effects of exposure to situations of extreme ambivalence and abuse in early childhood that are coped with by an elaborate form of denial so that the child believes the event to be happening to someone else (perhaps starting out as an imaginary companion)” (Gillig, 2009). This factor is where the multiple identities originate from, in early childhood to cope with the trauma the person mentally creates another identity as a coping mechanism to displace the traumatic events and feelings that they produce. This source significantly demonstrates that environmental surroundings of the patient significantly contributes in the cause of Dissociative identity Disorder.

Various cases of dissociative identity disorder presented are severe, but even the milder cases of DID are consistently linked to the cause of trauma. “Milder presentations of DID are sometimes associated with traumatization that is covert, such as enduring severely dysfunctional communication and relationship styles in family members, including subtle forms of emotional neglect.”(Sar, Dorhay, & Kruger, 2017). With the evidence presented it can be seen that the environment is an attributing factor in people with Dissociative Identity Disorder. Furthermore,if they did not have a stable relationship with their family or if they were emotionally neglected then it could also have an effect on the cause of Dissociative Identity Disorder. “Severe child abuse, a disorganized and disoriented attachment style, and the absence of social and familial support seem to precede the development of DID” (Gillig, 2009). In the family setting the trauma and the abuse stems from the parents. It could come from something

they have experience or the discipline and parenting style they were exposed to. The parents can frequently and erratically switch roles resulting in the child to have confused feelings, “In such a family with subclinical dissociative characteristics, individuals can interchange their social roles over time, alternating between being a victim, abuser, and rescuer” (Sar, Dorhay, & Kruger, 2017). The change of social roles can lead the child or the adult to use a Dissociative tactic, which can occasionally result in Dissociative Identity Disorder. The tactic used could be creating another identity. In result the studies completed and with the extensive research it is prevalent that childhood trauma is a significant factor in causing Dissociative Identity Disorder. This is important to the research because it conveys the evidence that environmental factors could possibly cause the disorder.

V. Discussion

The research completed has demonstrated that environmental factors are the main cause of Dissociative Identity Disorder, which clears the convoluted speculations that have been theorized. This research is an adequate demonstration that environmental factors are the main cause of Dissociative Identity Disorder. It could be proven with more validity by presenting more case studies and research completed on how environmental factors cause and effect the disorder. This would help improve validity because there would be numerous cases that present evidence of the etiology of Dissociative Identity Disorder. In the research completed many questions have arisen. For example, at what level of severity do the environmental factors start to cause Dissociative Identity Disorder? Can the disorder happen at all ages or is the stage of when it develops confined to early childhood? The findings of this research paper can be further

researched using the questions stated below. These questions will further improve the knowledge on the topic of Dissociative Identity Disorder and the environmental causes.

VI. Conclusion

Through the studies presented it can be seen that both cognitive and biological factors play a role in Dissociative Identity Disorder, but the most prominent factor is the environmental factor. This evidence is presented in the trauma, the severe and constant trauma that patients undergo result in them having to use Dissociative coping methods as presented in the research completed, which also includes the environmental factors involving the family and social groups. The evidence presented with the biological factors is that parts of the brain, such as the amygdala and the hippocampus, have smaller volumes in patients with Dissociative Identity Disorder compared to people who have never presented signs of having any psychological disorder. But in the study it is clearly stated that the cause of the smaller volumes was PTSD or experiencing trauma. The common factor between both the cognitive and biological factors is the presence of some form of trauma. This means that the cognitive and biological factors are related. The biological factors are a result of the environmental setting. Because the biological factors are closely related to environmental factors but not a cause it can be concluded that the surrounding environment can directly result in the patient having Dissociative Identity Disorder. So in regards to the research question *To What Extent Do Environmental Factors Play A Role In Causing Dissociative Identity Disorder?*. Environmental factors are the main cause of

Dissociative Identity Disorder as stated previously, this is because of the trauma experienced in early childhood.

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