**ANXIETY AND THE DHARMA**

We live in a culture that is experiencing an “anxiety epidemic”. Usually, the word *epidemic* is a significant outbreak of a disease in a population. The accepted percentage of folks suffering from some sort of anxiety disorder hovers around 18% (National Institutes For Mental Health; statistics compiled in 2007). That certainly qualifies as an epidemic.

As mentioned in a previous article, our culture provides a number of perceived threats, mostly due to conditioning that suggests that loss of money, status, and role identities are dangerous, rather than inconvenient. Our bodies respond to the possibility of being late for an appointment as somehow dangerous, or that seeing a news report of a murder somewhere in the world as a significant sign that our lives are at risk.

Many of these “mini-crises” are barely noticeable, but they add up. I often use the story of “the last straw that broke the camel’s back” to illustrate the cumulative effects of stress. Everyone assumes that the last straw is the problem—what about all the other straws that have accumulated during the day or the week? My suggestion is that mindful attention and the ability to let go of intrusive worrisome thoughts minimizes the accumulated stress from “the camel’s back”, so the last straw is much less likely to fall into place.

Modern research describes two categorical experiences of anxiety: state anxiety and trait anxiety. State anxiety is situational, such as the anxiety one might experience just prior to a final exam in school. When all the “straws” of a sequence of unresolved state anxiety events pile up, a persistent level of hypervigilance and anxiety prevails. Trait anxiety represents one manifestation of “state dependent learning”, that is, one carries around the burden of being easily triggered into producing the symptoms of the various anxiety disorders that are described below.

There is a portion of this population whose vulnerability to anxiety is genetic; their nervous and hormonal triggers for anxiety are lower than most other people (that is, it takes fewer straws to break the camel’s back).

**CHARACTERISTICS OF ANXIETY**

There are several different diagnostic categories regarding anxiety in the discipline of psychology: Generalized Anxiety Disorder (GAD), Phobias, Social Anxiety Disorder (SAD), Post Traumatic Stress Disorder (PTSD), Obsessive-Compulsive Disorder (OCD), and Dissociative Identity Disorder (DID).

Here are what I propose are the common characteristics and symptoms of anxiety which may appear throughout the spectrum of anxiety:

* Physical agitation, which may include muscular tension, headaches, heart palpitations, digestive problems, sleep disturbance and difficulty being still physically or calm mentally.
* Intrusive, negative and worrisome thoughts that are repeated (this is called *rumination*, as in the behavior of cattle regurgitating and chewing grass). The thoughts are either self-critical, or critical of others, or environmental circumstances.
* A tendency to avoid situations that might provoke anxiety. For example, fear of heights means not entering tall buildings, or social anxiety prevents going to crowded situations.
* Hypervigilance-very sensitized to environmental changes, and prone to misinterpret situations as threatening.
* A tendency to actively engage in distracting behaviors or ingest soothing substances (These would be addictive dependence or abuse of drugs, food, tv, computers, etc.)
* Distractibility and forgetfulness, with a tendency to experience “brain lock” in what are perceived to be threatening circumstances, or to “check out” emotionally.
* Irritability and impulsive reactivity to frustration.

**A BUDDHIST PERSPECTIVE OF ANXIETY**

The term *anxiety* didn’t exist in the culture that the Buddha lived in. I suppose it could be characterized as *sankhara dukkha,* that is, the dissatisfaction associated with how the mind has been conditioned by karma. In modern terms, we all suffer from what is called *existential anxiety*, which is the fear of death. That certainly was prevalent in the time of the Buddha, and has been so ever since. My supposition is that, in addition to fear of death (much less pressing in our time than then), we fear loss of property, job, relationship, role identities, and so on. These threats aren’t truly associated with mortality, but the nervous and hormonal systems respond as if this is the case. This is a major environmental contributor to anxiety in this culture.

Regardless of the historical difference between the Buddha’s culture and ours, the same principles apply now as then: distress comes with both seeking pleasure and avoiding pain. The primary cause of distress is the degree to which craving and clinging is the driver of our ever-changing self-states. Relief comes when we can clearly identify craving and clinging and successfully drain the potency of craving and clinging. The conditions that best bring relief include living an ethical life and seeing clearly the emerging formation of craving and clinging and letting go of that process.

To put this in more modern psychological terms relevant to anxiety disorders, here are some considerations:

* Cultivate samadhi/passadhi (stability/tranquility) through the practice of mindfulness of breathing or lovingkindness meditation. When a person focuses persistently on breath awareness or the repetition of the lovingkindness mantra, general levels of anxiety are reduced. In effect, this constitutes reducing the number of straws on the camel’s back. We know from contemporary research that regular practice of either of those two meditations reduces general anxiety levels, and, over time changes the structures in the brain associated with generating anxiety (the amygdala and the hippocampus, primarily) in beneficial ways, mostly through increasing the capacity of the prefrontal cortex to moderate the stress reactivity of the brain.
* Investigation of the sensations associated with breathing in and out increases inner awareness and makes it possible to note the emergence of negative rumination and disregard it sooner rather than later. Since most of what we regard as “ego” is internal narrative, when we can effectively monitor internal self-talk, substituting more realistic and stress-moderating narratives for stress-reinforcing narratives. The degree to which we have accumulated samadhi/passadhi through daily meditation enhances the ability to disregard the “magnetic pull” of craving and clinging to the anxiety reinforcing narratives.
* The skillful application of mindfulness and lovingkindness practices builds more positive associations in the mind, thereby creating more self-confidence and stress resilience.

There has been much research in the field of neuroscience about the effectiveness of mindfulness-based interventions for a variety of emotionally potentiated conditions, such as anxiety. In 2013 a research paper was published by the Oxford University Press entitled “Neural Correlates Of Mindfulness Meditation-Related Anxiety Relief”, by Zeidan, et.al. Here are some relevant quotes:

Meditation-related anxiety relief was associated with greater activation in the vmPFC, [ventromedial prefrontal cortex], ACC, [anterior cingulate cortex], perigenual ACC (pgACC), bilateral anterior insula and SII [secondary somatic projection area, in the posterior insula],….

…Consistent with the instructions of mindfulness-based mental training, meditation activated brain areas associated with the mindfulness practice of Shamatha and Vipassana (Lutz et al., 2008; Manna et al., 2010). Our findings confirm that mindfulness meditation modulates state anxiety by engaging a network of brain regions including the ACC, anterior insula and vmPFC.

We postulate that the engagement of these regions by mindfulness meditation regulates anxiety through multiple potential mechanisms. **Meditation-related anxiety relief was associated with greater activity in a distinct network of brain regions involved in cognitive reappraisal processes** (Ochsner and Gross, 2005; Eippert et al., 2007; Wager et al., 2008). **Greater reductions in anxiety during meditation were associated with increased vmPFC activity. Furthermore, the vmPFC is crucially involved in successfully down regulating negative emotions and is associated with enhanced cognitive control, working memory processing and modifying appraisals of sensory events** (Teasdale et al., 1999; Urry et al., 2006; Hermann et al., 2009; Kompus et al., 2009; McRae et al., 2009).

The relationship between the vmPFC and meditation-related anxiety relief is consistent with the act of monitoring and reappraising cognitive and affective states. Creswell et al. (2007) found that greater activity in the vmPFC was directly associated with higher levels of dispositional mindfulness as well as down regulation of amygdala activity during an affect-labeling paradigm (Creswell et al., 2007).….

Mindfulness meditation also reduced brain activity in areas associated with ruminative thought processes (i.e. default mode). Mind wandering has been associated with negative disposition (Smallwood et al., 2009; Smallwood and O’Connor, 2011).

**We postulate that mindfulness meditation-related improvements in anxiety may be related to acknowledging discursive thought processes accompanied by the intention to sustain a present focused, non-reactive mental stance.** These mechanisms are remarkably consistent with the premise that mindfulness meditation involves enhanced awareness in the present moment and the cognitive reappraisal of emotionally salient sensory events (Wallace, 2006; Lutz et al., 2008; Garland et al., 2009; Grant et al., 2010; Zeidan et al., 2011). **It has also been postulated that mindfulness meditation produces a sense of emotional detachment from experienced sensory events** (Kabat-Zinn et al., 1992; Gunaratana, 2002; Farb et al., 2007; Grant et al., 2011; Taylor et al., 2011).

**Mindfulness meditation practitioners can decouple transitory appraisals of ‘self’ with corresponding sensory**

**events** (Kabat-Zinn, 1982; Astin, 1997; Farb et al., 2007; Zeidan et al., 2011).

To this extent, the present findings provide support for this hypothesis, evidenced by meditation-related anxiety relief and activation in brain areas associated with sensory processing (i.e. posterior insula, SII), cognitive control (ACC) and higher-order evaluation

(vmPFC, anterior insula;.

There are many books available about mindful approaches to reducing anxiety. On the Amazon website, here is the URL for their offerings:

[https://www.amazon.com/s/ref=nb\_sb\_ss\_i\_1\_18?url=search-alias%3Dstripbooks&field-keywords=mindfulness+and+anxiety&sprefix=mindfulness+and+an%2Caps%2C261&crid=2ARO342JP3PGO](https://www.amazon.com/s/ref%3Dnb_sb_ss_i_1_18?url=search-alias%3Dstripbooks&field-keywords=mindfulness+and+anxiety&sprefix=mindfulness+and+an%2Caps%2C261&crid=2ARO342JP3PGO)

**CATEGORIES OF VARIOUS ANXIETY DISORDERS AND THEIR SYMPTOMS**

As a mental health professional, I have been trained to clinically identify various psychological problems. I believe it is in the best interest of the general public to have some idea of how various anxiety disorders are described. A person is diagnosable if there are a majority, but not all, of the listed symptoms, and that the person’s sense of well-being and degree of functionality is impaired.

**Generalized anxiety disorder** (**GAD**) is an [anxiety disorder](http://en.wikipedia.org/wiki/Anxiety_disorder) characterized by excessive, uncontrollable and often irrational worry, that is, apprehensive expectation about events or activities. This excessive worry often interferes with daily functioning, as individuals with GAD typically anticipate disaster, and are overly concerned about everyday matters such as health issues, money, death, family problems, friendship problems, interpersonal relationship problems, or work difficulties. Individuals often exhibit a variety of physical symptoms, including [fatigue](http://en.wikipedia.org/wiki/Fatigue_%28medical%29), fidgeting, headaches, [nausea](http://en.wikipedia.org/wiki/Nausea), [numbness](http://en.wikipedia.org/wiki/Numbness) in hands and feet, [muscle tension](http://en.wikipedia.org/wiki/Muscle_tension), [muscle aches](http://en.wikipedia.org/wiki/Myalgia), difficulty swallowing, bouts of breathing difficulty, difficulty concentrating, [trembling](http://en.wikipedia.org/wiki/Tremor), [twitching](http://en.wikipedia.org/wiki/Muscle_contraction), irritability, [agitation](http://en.wikipedia.org/wiki/Psychomotor_agitation), sweating, restlessness, [insomnia](http://en.wikipedia.org/wiki/Insomnia), [hot flashes](http://en.wikipedia.org/wiki/Hot_flashes), [rashes](http://en.wikipedia.org/wiki/Rashes), and inability to fully control the anxiety. These symptoms must be consistent and ongoing, persisting at least six months, for a formal diagnosis of GAD.

In a given year, approximately 6.8 million [American](http://en.wikipedia.org/wiki/United_States) adults and two percent of European adults experience GAD. GAD is seen in women twice as much as men. GAD is also common in individuals with a history of substance abuse and a family history of the disorder. Once GAD develops, it may become chronic, but can be managed or eliminated with proper treatment.

**Diagnostic criteria:**

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
B. The individual finds it difficult to control the worry.
C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):
Note: Only one item is required in children.

1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating or mind going blank.
4. Irritability.
5. Muscle tension.
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).
F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia](http://en.wikipedia.org/wiki/Social_phobia), contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).[[1]](http://en.wikipedia.org/wiki/Generalized_anxiety_disorder#cite_note-DSM-5-1) No major changes to Generalized Anxiety Disorder (GAD) have occurred since publication of the [Diagnostic and Statistical Manual of Mental Disorders](http://en.wikipedia.org/wiki/DSM-IV-TR) (2004); minor changes include wording of diagnostic criterion.

**Phobias:** Phobias are a common form of [anxiety disorders](http://en.wikipedia.org/wiki/Anxiety_disorder) and distributions are heterogeneous by age and gender. An [American](http://en.wikipedia.org/wiki/United_States) study by the [National Institute of Mental Health](http://en.wikipedia.org/wiki/National_Institute_of_Mental_Health) (NIMH) found that between 8.7 percent and 18.1 percent of Americans suffer from phobias,[]](http://en.wikipedia.org/wiki/Phobia#cite_note-37) making it the most common [mental illness](http://en.wikipedia.org/wiki/Mental_illness) among women in all age groups and the second most common illness among men older than 25. Between 4 percent and 10 percent of all children experience specific phobias during their lives.

Most phobias are classified into two categories and, according to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* ([DSM-V](http://en.wikipedia.org/wiki/DSM-V)), such phobias are considered to be sub-types of anxiety disorder. The two categories are:

1. [Specific phobias](http://en.wikipedia.org/wiki/Specific_phobia): Fear of particular objects or social situations that immediately results in anxiety and can sometimes lead to panic attacks. Specific phobia may be further subdivided into five categories: animal type, natural environment type, situational type, blood-injection-injury type, and other.[[3]](http://en.wikipedia.org/wiki/Phobia#cite_note-3)

2. [Agoraphobia](http://en.wikipedia.org/wiki/Agoraphobia): a generalized fear of leaving home or a small familiar 'safe' area, and of possible [panic attacks](http://en.wikipedia.org/wiki/Panic_attack) that might follow. It may also be caused by various specific phobias such as fear of open spaces, social embarrassment (social agoraphobia), fear of contamination (fear of germs, possibly complicated by [obsessive-compulsive disorder](http://en.wikipedia.org/wiki/Obsessive-compulsive_disorder)) or [PTSD](http://en.wikipedia.org/wiki/PTSD) ([post traumatic stress disorder](http://en.wikipedia.org/wiki/Post_traumatic_stress_disorder%22%20%5Co%20%22Post%20traumatic%20stress%20disorder)) related to a trauma that occurred out of doors.

Phobias vary in severity among individuals. Some individuals can simply avoid the subject of their fear and suffer relatively mild anxiety over that fear. Others suffer full-fledged panic attacks with all the associated disabling symptoms. Most individuals understand that they are suffering from an irrational fear, but are powerless to override their panic reaction.

**Specific phobias**

A specific phobia is a marked and persistent fear of an object or situation which brings about an excessive or unreasonable fear when in the presence of, or anticipating, a specific object; the specific phobias may also include concerns with losing control, panicking, and fainting which is the direct result of an encounter with the phobia.[[4]](http://en.wikipedia.org/wiki/Phobia#cite_note-4) Specific phobias are defined in relation to objects or situations whereas social phobias emphasize social fear and the evaluations that might accompany them.

The DSM breaks specific phobias into five subtypes: animal, natural environment, blood-injection-injury, situational, and other.[[5]](http://en.wikipedia.org/wiki/Phobia#cite_note-5) In children, phobias involving animals, natural environment (darkness), and blood-injection-injury usually develop between the ages of 7 and 9, and these are reflective of normal development. Additionally, specific phobias are most prevalent in children between ages 10 and 13.[[6]](http://en.wikipedia.org/wiki/Phobia#cite_note-Bolton.2C_D._2006-6)

**Social anxiety disorder** (**SAD**), also known as **social phobia**, is an [anxiety disorder](http://en.wikipedia.org/wiki/Anxiety_disorder) characterised by an intense fear in one or more social situations causing considerable distress and impaired ability to function in at least some parts of daily life. These fears can be triggered by perceived or actual scrutiny from others. It is the most common [anxiety disorder](http://en.wikipedia.org/wiki/Anxiety_disorder) and one of the most common psychiatric disorders, with 12% of American adults having experienced it.

Physical symptoms often accompanying social anxiety disorder include excessive [blushing](http://en.wikipedia.org/wiki/Blushing), [excess sweating](http://en.wikipedia.org/wiki/Hyperhidrosis), [trembling](http://en.wikipedia.org/wiki/Tremor), [palpitations](http://en.wikipedia.org/wiki/Palpitations) and [nausea](http://en.wikipedia.org/wiki/Nausea). [Stammering](http://en.wikipedia.org/wiki/Stutter) may be present, along with rapid speech. [Panic attacks](http://en.wikipedia.org/wiki/Panic_attack) can also occur under intense fear and discomfort. Some sufferers may use [alcohol](http://en.wikipedia.org/wiki/Ethanol) or other [drugs](http://en.wikipedia.org/wiki/Psychoactive_drug) to reduce fears and inhibitions at social events. It is common for sufferers of social phobia to [self-medicate](http://en.wikipedia.org/wiki/Self-medication) in this fashion, especially if they are undiagnosed, untreated, or both; this can lead to [alcoholism](http://en.wikipedia.org/wiki/Alcoholism), [eating disorders](http://en.wikipedia.org/wiki/Eating_disorders) or other kinds of substance abuse. SAD is sometimes referred to as an 'illness of lost opportunities' where 'individuals make major life choices to accommodate their illness.'

(Downloaded from Wikipedia June 7, 2015)

**Panic Disorder**

Panic is an intrusive, overwhelming feeling of dread and fear that seems like one’s life is threatened. In my view, a person with panic disorder has accumulated so much anxiety that their nervous and hormonal system is persistently dealing with “the last straw”, and often what precipitates the episode seems to “come out of nowhere”. Here is a quote from the National Institute Of Mental Health pamphlet regarding panic disorder:

“People with panic disorder may have: Sudden and repeated attacks of fear, a feeling of being out of control during a panic attack, an intense worry about when the next attack will happen, a fear or avoidance of places where panic attacks have occurred in the past, physical symptoms during an attack, such as a pounding or racing heart, sweating, breathing problems, weakness or dizziness, feeling hot or a cold chill, tingly or numb hands, chest pain, or stomach pain.” Downloaded June 10, 2015

**Post Traumatic Stress Disorder (PTSD)**

Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and, the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition.

Two specifications are noted including delayed expression and a [dissociative subtype of PTSD](http://www.ptsd.va.gov/professional/PTSD-overview/Dissociative_Subtype_of_PTSD.asp), the latter of which is new to DSM-5. In both specifications, the full diagnostic criteria for PTSD must be met for application to be warranted.

**Criterion A: stressor**

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (one required)

1. Direct exposure.
2. Witnessing, in person.
3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

**Criterion B: intrusion symptoms**

The traumatic event is persistently re-experienced in the following way(s): (one required)

1. Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play.
2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
4. Intense or prolonged distress after exposure to traumatic reminders.
5. Marked physiologic reactivity after exposure to trauma-related stimuli.

**Criterion C: avoidance**

Persistent effortful avoidance of distressing trauma-related stimuli after the event: (one required)

1. Trauma-related thoughts or feelings.
2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

**Criterion D: negative alterations in cognitions and mood**

Negative alterations in cognitions and mood that began or worsened after the traumatic event: (two required)

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous").
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.

**Criterion E: alterations in arousal and reactivity**

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (two required)

1. Irritable or aggressive behavior
2. Self-destructive or reckless behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems in concentration
6. Sleep disturbance

**Criterion F: duration**

Persistence of symptoms (in Criteria B, C, D, and E) for more than one month.

**Criterion G: functional significance**

Significant symptom-related distress or functional impairment (e.g., social, occupational).

**Criterion H: exclusion**

Disturbance is not due to medication, substance use, or other illness.

**Specify if: With dissociative symptoms.**

In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

1. Depersonalization: experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
2. Derealization: experience of unreality, distance, or distortion (e.g., "things are not real").

**Specify if: With delayed expression.**

Full diagnosis is not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

**References**

1. American Psychiatric Association. (2013) Diagnostic and statistical manual of mental disorders, (5th ed.). Washington, DC: Author.

**DISSOCIATIVE IDENTITY DISORDER (DID)**

This anxiety disorder has been controversial, likely due to the extraordinary features associated with this condition. My wife had significant therapeutic interactions with a friend from her youth with DID, and his behavior was congruent with the diagnostic criteria. He was successfully treated by a psychologist close to where he lived.

Here are the current criteria, as documented through Wikipedia (downloaded June 10, 2015):

According to the fifth [Diagnostic and Statistical Manual of Mental Disorders](http://en.wikipedia.org/wiki/Diagnostic_and_Statistical_Manual_of_Mental_Disorders) (DSM), DID includes "the presence of two or more distinct identities or personality states" that alternate control of the individual's behavior, accompanied by the inability to recall personal information beyond what is expected through normal forgetfulness. In each individual, the clinical presentation varies and the level of functioning can change from severely impaired to adequate. The symptoms of [dissociative amnesia](http://en.wikipedia.org/wiki/Dissociative_amnesia), [dissociative fugue](http://en.wikipedia.org/wiki/Dissociative_fugue) and [depersonalization disorder](http://en.wikipedia.org/wiki/Depersonalization_disorder) are subsumed under the DID diagnosis and are not diagnosed separately. Individuals with DID may experience distress from both the symptoms of DID (intrusive thoughts or emotions) and the consequences of the accompanying symptoms (dissociation rendering them unable to remember specific information). The majority of patients with DID report childhood [sexual](http://en.wikipedia.org/wiki/Sexual_abuse) and/or [physical abuse](http://en.wikipedia.org/wiki/Physical_abuse), though the accuracy of these reports is controversial. Identities may be unaware of each other and compartmentalize knowledge and memories, resulting in chaotic personal lives. Individuals with DID may be reluctant to discuss symptoms due to associations with abuse, shame and fear. DID patients may also frequently and intensely experience time disturbances.

The number of alters varies widely, with most patients identifying fewer than ten, though as many as 4,500 have been reported. The average number of alters has increased over the past few decades, from two or three to now an average of approximately 16. However it is unclear whether this is due to an actual increase in alters, or simply that the psychiatric community has become more accepting of a high number of alters. The primary identity, which often has the patient's [given name](http://en.wikipedia.org/wiki/Given_name), tends to be "passive, dependent, guilty and depressed" with other personalities or "alters" being more active, aggressive or hostile, and often containing more complete memories. Most identities are of ordinary people, though fictional, mythical, celebrity and animal alters have also been reported.