DISSOCIATIVE IDENTITY DISORDER

Dissociative identity disorder (DID) is a psychiatric condition that was formerly known as multiple personality disorder (MPD). DID is viewed as the most complex and severe of the dissociative disorders, a category that also includes dissociative amnesia, dissociative fugue, and depersonalization disorder (see Cardeña & Gleaves, 2007 for a discussion of other dissociative disorders). Although it is controversial and long regarded as exotic and rare, a wealth of research has been conducted on DID in recent years, particularly since the 1980s.

Description

According to the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association, 2000), DID is defined by the presence of two or more distinct identities or personality states that recurrently take control of the individual. The other essential diagnostic criterion is some degree of psychogenic or psychological amnesia. Although the DSM focuses on the issue of alternate identities, a core set of features of DID has also appeared in research and may be as essential as the diagnostic criteria. These features include severe depersonalization and derealization (feeling as if the self or surroundings are unreal in some way), a variety of memory problems (typically apparent amnesia for childhood or even ongoing events), identity alteration and confusion, and experiences of auditory hallucinations perceived as coming from inside the individual's head. Some researchers (e.g., Dell, 2006) have argued that the DSM criteria should be revised to focus on these features. In fact, the current focus on the issue of alternate identities has probably only fueled controversies about the disorder with respect to its causes, diagnostic validity, prevalence, and treatment.

Etiology/Causes

The central controversy is about the cause of DID; the remaining issues are directly or indirectly related to that controversy. There are two general theories regarding the causes of DID. One is the iatrogenesis or sociocognitive theory (Spanos, 1994). The term *iatrogenic* literally means of physician origin, but it is used more broadly in this context to mean of therapist origin. In other words, proponents of this theory consider DID to be a product of therapy. Because some people with DID have never been in therapy, proponents of the theory may also blame the popular media and use terms such as *mediagenic*. The term *sociocognitive* is adapted from the similar theory of hypnosis, which regards a hypnotic state as a strategic role enactment. Thus, according to this theory DID is something similar to the notion of hypnotic strategic role enactment, and it is caused by therapists suggesting the concept of DID to their patients and inadvertently teaching them how to behave. Such clients are allegedly not lying or purposefully role-playing but have come to believe what they have learned from the therapist.

Although the sociocognitive model seems to be commonly accepted by a subset of the health field and the general population, there are several problems with it, most critically a lack of empirical support. In a review, Brown, Frischolz, and Scheflin (1999) concluded that "these sparse data fail to meet a minimal standard of scientific evidence justifying the claim that a major psychiatric diagnosis like dissociative identity disorder *per se* can be produced through suggestive influences in therapy" (p. 549). It also appears that the model is based on numerous misconceptions regarding the psychopathology, assessment, and treatment of DID (Gleaves, 1996). The model focuses almost exclusively on the concept of multiple identity enactment, which involves behaving as if one had more than one identity, but it does not thoroughly explain the complex dissociative symptomatology described previously.

The second etiological perspective is that DID develops from severe and ongoing childhood trauma. It is thus considered a form of childhood onset posttraumatic stress disorder (PTSD; Spiegel, 1991). According to this perspective, however, it is not trauma alone that causes DID. Kluft (1996) proposed that four factors may be required for DID to develop: (1) the capacity or ability to dissociate (possibly genetic); (2) experiences that overwhelm the child (usually severe trauma but broader than childhood sexual abuse); (3) secondary structuring of the DID alternate identities (typically based on the child's culture); and (4) a lack of soothing and restorative experiences. The last factor implies that, if the child had the resources to help him or her cope with the trauma at the time, the DID would be unlikely to develop. However, the trauma reported by persons with DID is all too often at the hands of their own caregivers.

At least four pieces of information support the posttraumatic model of DID: (1) the vast majority (if not all) of persons with DID report histories of childhood trauma (and the trauma can often be corroborated; Lewis, Yeager, Swica, Pincus, & Lewis, 1997); (2) dissociative symptoms in general are reliably associated with trauma; (3) the vast majority of DID patients also have diagnosable PTSD; and (4) some symptoms of PTSD (flashbacks, emotional numbing, inability to recall) are actually dissociative in nature. Overall, although more research is needed, there is more empirical and logical support for the posttraumatic theory than for competing theories.

Diagnostic Validity

A second area of controversy concerns the diagnostic validity of DID. That is, some authors (e.g., North, Ryall,

The Corsini Encyclopedia of Psychology, edited by Irving B. Weiner and W. Edward Craighead.

Ricci, & Wetzel, 1993) argue that DID is not a valid psychiatric disorder, but rather a symptom of another disorder (such as somatization disorder or a personality disorder). A review of the empirical evidence (Gleaves, May, & Cardeña, 2001) suggests otherwise. Although there is no definitive set of criteria for determining if a disorder is valid, DID seems to meet a variety of different criteria fairly well, perhaps more so than do many other disorders whose validity is rarely questioned. Research suggests that the disorder can be reliably diagnosed using structured interviews and that it can be discriminated from other disorders (Gleaves, et al., 2001). The disorder with the most overlap seems to be PTSD, which is not surprising given that DID is considered by many to be a variant of PTSD.

Prevalence

The controversy regarding prevalence is closely tied to the issues regarding its causes. DID was once believed to be extremely rare. Chris Sizemore, the original Eve of the *Three Faces of Eve,* was apparently told that she was perhaps the only person in the world with the condition. As recently as 1980, it was estimated that approximately 200 cases had been reported in the world literature. Now, more recent research suggests that DID may be approximately as common as schizophrenia and more common than anorexia nervosa. Studies in nonclinical samples have found prevalence rates of around 1%, and estimates in clinical samples are in the range of 6% to 10% (see Foote, Smolin, Kaplan, Legatt, & Lipschitz, 2006).

There are two general explanations for this change in the apparent prevalence of the disorder. The first is that the increase is artificial and that most new cases are not real (i.e., are iatrogenic). However, this argument rests on the assumption that the disorder was, in fact, previously rare, when we really do not have any clear evidence that it was, because prevalence studies of DID were not conducted until recently. We only know for sure that the disorder was rarely, if ever, diagnosed. The other explanation of the apparent increased prevalence is that there has simply been an increased recognition of the problem. Although this interpretation is rejected by many skeptics of the disorder, it is noteworthy that the same pattern has been observed for child sexual abuse and incest. That is, as recently as 1975, some psychiatric textbooks stated that incest occurred in one in one million families. We now know that it is much more common and was previously unrecognized (rather than extremely rare). If DID is a secretive condition (related to the abuse itself), it is clearly conceivable that it was previously unrecognized (or perhaps misdiagnosed). There are also many other reasons why an increased recognition of DID is quite plausible, including the inclusion (in 1980) of DID in the DSM, the Vietnam War and subsequent interest in PTSD, the feminist movement and the subsequent recognition of the reality of sexual trauma, and developments in the field of cognitive psychology (e.g., network models of memory and information processing), that may be analogous to the memory subsystems seen in DID (Gleaves, 1996).

Related to concern that the prevalence of DID is artificially increasing is the argument that it is culture bound and restricted to North America. However, this argument is not based on empirical research but rather simply the expressed opinions of clinicians who say they have never encountered cases. There is, in fact, now a growing body of research on the cross-cultural occurrences of dissociative disorders (Şar, 2006). Prevalence studies from clinical samples have come not only from North America, but also from Norway, Turkey, Switzerland, the Netherlands, and Germany. It appears that wherever prevalence studies are done, DID is found to be approximately as common as it is in North America.

Treatment

There are two general approaches to the treatment of DID, each of which is consistent with the theoretical view regarding the nature and causes of the disorder. Proponents of the iatrogenesis model suggest that the dissociative symptomatology should not be actively addressed (North et al., 1993). They believe that doing so shapes and creates the disorder. There is no published empirical research on this approach to treatment, and in the case studies reported by North et al., the clients remained chronic or even worsened. There is also consistent evidence that persons diagnosed with DID have typically spent 7–12 years in the mental health system, without evidence of improvement, prior to receiving the diagnosis. This finding is interpreted by many as *prima facie* evidence that failure to diagnosis and directly treat the disorder is an ineffective overall intervention strategy.

The second general approach, based on the posttraumatic model, involves actively targeting the dissociation and other posttraumatic symptomatology. The treatment is conceptually similar to those designed for treatment of PTSD (e.g., Leskin, Kaloupek, & Keane, 1998), but it takes into consideration the client's perception of separate selves and more severe history of trauma. Treatment guidelines for this approach are published by the International Society for the Study of Trauma & Dissociation (http://www.isst-d.org/). These guidelines refer to a three-phase approach: (1) "Establishing Safety Stabilization and Symptom Reduction"; (2) "Focused Work on Traumatic Memories"; and (3) "Integration and Rehabilitation." Overall, these imply that stability is important before processing trauma memories and that integration, (the bringing together of what were the separated identities) is not an initial goal; rather, it is something that typically only occurs after years of treatment.

Although the treatment for DID is described in these guidelines, empirical research is needed. The evidence that exists comes from several large-case series by clinical researchers and two uncontrolled studies by Ross and colleagues (see Ellason & Ross, 1997). Collectively, the data suggest that persons with DID can make substantial improvements when the disorder is actively treated and that such persons are unlikely to improve when the disorder is not addressed in treatment. However, larger controlled outcome studies are clearly needed, particularly those in which this approach is compared with other active treatments.

In conclusion, what we know about DID has changed dramatically over the last 20–30 years. Evidence now suggests that it is a relatively common although clandestine disorder of posttraumatic origin that does not remit if untreated. Well-established methods of assessment exist and treatment guidelines exist but the treatments need to be better studied.

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SUGGESTED READINGS

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See also: **Dissociative Disorders; Posttraumatic Stress Disorder; Stress Consequences**