Dissociative identity disorder: Fact, fantasy or invalid?

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ABSTRACT

Dissociative identity disorder (DID) is a rare, complex and controversial mental health presentation, characterised by two or more distinct personality states and recurrent gaps in memory. Mental health practitioners currently rely on their own assessment of the available literature to conceptualise the presentation of DID as a result of lack of guidelines from the National Institute of Health and Care Excellence. This article presents the key findings of a systematic literature search and narrative synthesis of the conceptualisations of DID. This aims to offer an overview of current thought to support practitioners in their understanding, assessment, formulation and approach to working with this population. Three key approaches to the conceptualisation of DID were identified as dominant discourses in the literature: trauma-based models, sociocognitive models and invalid diagnosis theories. This review identified the need for a more collaborative approach to research between the different schools of thought and for more flexibility in approach from those working in the field.

Dissociation is defined by the *Diagnostic and Statistical Manual for Mental Disorders* (DSM) (American Psychiatric Association [APA], 2013) as a 'disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment' and defined by the *ICD-10* (World Health Organization, 1991) as a 'partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements'. Dissociation is believed to occur to reduce subjective distress experienced as a result of stressful and traumatic events (Huntjens and Dorahy, 2015).

Janet (1889) originally conceptualised pathological dissociation as a discontinuous phenomenon that was only seen in individuals with a mental health disorder to cope with the experience of trauma. Later investigators conceptualised dissociation as functioning along a continuum from normal everyday experiences, such as daydreaming, to the most severe clinically dissociative states represented by the dissociative disorders (e.g. Ross, 1997).

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Dissociative identity disorder

Dissociative identity disorder (DID) is conceptualised as falling at the furthest point along this continuum, defined by the DSM (APA, 2013) as a disruption of identity characterised by two or more distinct personality states (self-states) and recurrent gaps in the recall of everyday events resulting in significant distress or impairment in functioning. DID is an exceptionally rare presentation with estimated rates of 0.01% (Coons, 1984) to 1% in the general population and 0.5 to 1% in psychiatric settings (Maldonado et al, 2002). Due to its rarity, it is unlikely that most mental health practitioners will have much direct experience of working with this population, and therefore, access to information and understanding is important for effective intervention.

Method

This review focuses on systematically identifying current literature describing or reviewing theories or models of the causal and maintenance mechanisms of DID on which case-formulation of DID could be developed. Electronic databases (MEDLINE, EMBASE, PsycINFO) were searched for studies published in English between 2000 and 2015 that describe theories or models for understanding DID. Search terms were based on a modified search criteria from the Boysen and VanBergen (2013) study, and included 'dissociative identity disorder', 'multiple personality disorder' and 'dissociative disorders'. These key search

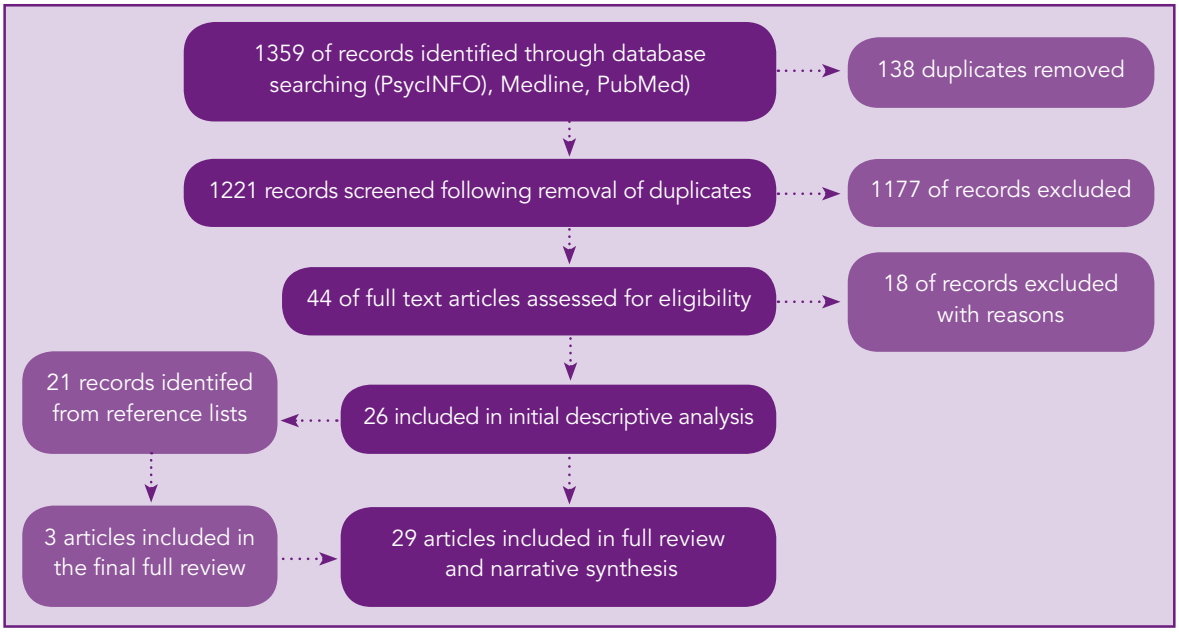

Figure 1. Flowchart of the systematic literature search

terms were combined with the terms 'model', 'theory', 'framework', 'formulation', 'structure', 'etiology' and 'conceptualisation'.

The initial search resulted in 1359 articles (see *Figure 1*) that were reviewed by title and abstract against the inclusion criteria. Initial inspection found 1177 articles did not address the research question or did not meet the inclusion criteria. Following removal of duplicates, 44 articles were potentially relevant.

Studies were included if they were published journal articles. All accepted articles focused on describing or examining theories or models to enhance understanding of the causative and maintenance factors (conceptualisation) of DID in adult mental health. Methodological quality criteria were applied; studies were excluded if they were based on case studies or self-reports, commentaries or correspondence, focused on children, or were population- or gender-specific. Uncertainties about whether a study met the inclusion criteria were resolved through discussions between the authors.

Twenty six papers identified through the electronic searches were included in the final review. Examination of these articles' reference lists highlighted a further 21 potential articles, of which three met the inclusion criteria, resulting in a total of 29 papers (see *Table 1*).

Synthesis

The broad nature and aims of the review question pointed to a narrative synthesis of the data (e.g. Popay et al, 2006). Articles were listed by theory or model and grouped together into overarching thematically related categories (see *Table 2*).

Results

The systematic literature review found 25 papers describing three core approaches to understanding DID: trauma-based models, sociocognitive models and validity approaches. In addition, there were three stand-alone theories that were not replicated in other articles.

Trauma-based models of DID

Twenty four articles described a foundation of trauma leading to the development of DID. Trauma-based models regard DID as an internal coping mechanism developed by infants to distance themselves from overwhelming and intolerable trauma (such as physical and sexual abuse) through dissociative processes. They suggest the infant is forced to turn to internal mechanisms of escape when all external sources of relief have failed (e.g. running away and seeking help from an adult) (Nijenhuis et al, 2010). As a result of the repetition of the internal escape mechanisms, there is an interruption to normal developmental personality integration. These processes are hypothesised to occur during early critical developmental periods leading to fragmentation of the personality into a number of different and often separate self-states (International Society for the Study of Trauma and Dissociation [ISSTD], 2011).

The trauma-based models grouped together into two key themes—attachment theory and structural models.

Attachment theory

Attachment theories of trauma suggest that children who experience significant trauma to early attachment

Table 1. List of articles included in the full article review

Reference	Date	Dissociation or DID	Model/theory
1. Huntjens and Dorahy	2015	Dissociation and DID	Trauma (TM)
2. Lynn et al	2015	Dissociation	Trauma (TM), sociocognitive and sleep-model
3. Dorahy et al	2014	DID	Trauma (TM), validity model, socio-cognitive
4. Lynn et al	2014	DID	Trauma (TM) , fantasy (SCM)
5. Boysen and VanBergen	2013	DID	Overview (SCM) (TM) (V)
6. Macintosh	2013	Dissociation	Integration model: trauma (TM) and relational (TM)
7. Dalenberg et al	2012	Dissociation	Trauma (TM) and fantasy models (SCM)
8. Lynn et al	2012	Dissociation	Sociocognitive model (SCM)
9. Paris	2012	DID	Invalid diagnosis model (V)
10. Harper	2011	DID	Structural dissociation model (TM)
11. Nijenhuis et al	2010	Dissociation	Structural dissociation model (TM)
12. Brenner	2009	DID	Attachment perspective (TM)
13. Dell	2008	DID	Validity model (V)
14. Korol	2008	DID	Attachment perspective (TM)
15. Selligman and Kirmayer	2008	DID	Spirits/trance/possession
16. Lester	2007	Dissociation	Subself theory
17. Ryle and Fawkes	2007	DID	Trauma model (TM)
18. Sar and Ozturk	2007	Dissociation	Trauma model (TM)
19. Liotti	2006	Dissociation	Attachment perspective (TM)
20. Lyons-Ruth et al	2006	Dissociation	Attachment perspective (TM)
21. Shaffer et al	2005	DID	Trauma model (TM)
22. Liotti	2004	Dissociation	Trauma (TM) and attachment models (TM)
23. Kennedy et al	2004	Dissociation	Cognitive model (TM)
24. Piper and Merskey	2004	DID	Iatrogenesis theory (SCM)
25. Blizard	2003	DID	Attachment perspective (TM)
26. Thomas	2003	Dissociation	Trauma model (TM)
27. Rieber	2002	DID	Psychoanalytic conceptualisation (TM)
28. Forest	2001	DID	Discrete behavioural states model
29. Gleaves et al	2001	DID	Valid diagnosis model (V)

Key: SCM – Sociocognitive Model; TM – Trauma Model; V – Valid diagnosis model;

Table 2. Table outlining the key models and theories of DID identified

Theory/model	Number of papers theory discussed in	Theory/model grouped by theme
Attachment/relational perspective	8	Trauma: attachment basis
Cognitive behavioural model	1	Trauma: structural dissociation of the mind
Discrete behavioural states model	1	Psychobiological model
Fantasy model	2	Sociocognitive model
Iatrogensis model	1	Sociocognitive model
Invalidity of diagnosis theory	4	Invalidity of DID model
Possession/trance/spirits	1	Spiritual model
Social constructionist/constructivist	1	Sociocognitive model
Sociocognitive model	2	Sociocognitive model
Structural dissociation model	4	Trauma: structural dissociation of the mind
Subself theory	1	Subself theory
Trauma model	11	Trauma model
Theory clusters	**TOTALS**	
Trauma models	24	
Sociocognitive model	8	
Invalidity of DID model	4	
Psychobiological model	1	
Spiritual model	1	
Subself theory	1	

relationships are likely to engage in detached behaviours, such as dissociation as a method of tolerating the distress caused (Barach, 1991). Attachment theory hypothesises that disorganised attachment (DA) develops as a result of these early traumas to attachment. A child with DA is unable to develop a coherent strategy for maintaining attachment to a primary caregiver due to the caregiver offering both a source of protection, as well as a source of threat to wellbeing. This ultimately results in the pervasive lack of behavioural and mental integration witnessed in infant disorganisation and dissociation (Liotti, 2006; Korol, 2008).

Blizard (2003) discussed the role of the 'double-bind' scenario on attachment and in the development of DA and DID:

> *'…the victim is repeatedly placed under a negative injunction, which is contradicted by a second injunction, both of which are enforced by punishment or signals that threaten survival. A third injunction prohibits the victim from escaping' (Blizard, 2003: 29).*

The key contextual element to the double-bind is the conflicting messages (e.g. the message spoken is not the message demonstrated). For example, 'I'm doing this because I love you' is followed by an experience that causes pain and distress. An important additional context to the double-bind is that the child is powerless to escape. As a result of these mixed messages and an inability to escape, a coherent attachment system cannot be formed but instead, two or more segregated models of attachment are developed. Here, the child is faced with ongoing relational dilemmas—the need to adapt to be attached for survival and the conflict with the need to self-protect. In response, a number of separate attachment models are developed—it is these that are believed to account for multiple self-states or personalities observed in people with DID.

Structural compartmentalisation models

The fundamental premise of these models is that early

childhood trauma provokes a structural dissociation/disconnection in the personality (in the mind) that results in the development of multiple self-states (DID) in an attempt to survive. They suggest that during critical periods of infant brain development, there can be a structural split in the personality when under extreme, chronic and intolerable threat or actual harm. These self-states display definable differences in their presentation, including differences in their in psychobiological responses and sense of self (Reinders et al, 2003; Nijenhuis et al, 2010).

These hypotheses suggest that the chronic experience of intolerable trauma happens in the earliest developmental years when either attachment relationships are being formed (Ainsworth et al, 1972) and/or when the brain still has the level of plasticity to support structural changes resulting in compartmentalisation (Mundkur, 2005).

Although interesting hypotheses, the available empirical research to support this understanding is lacking. As described by Lyons et al (2006), this population are under-represented in research and so research in this area remains sparse. To establish the links between trauma, attachment, dissociation and DID, ideally requires prospective and objective research that could measure variables, such as: attachment; seen as well as hidden trauma (i.e. emotional or psychological neglect); and environmental, physical, genetic and familial factors to track the development of dissociation and DID over time.

The sociocognitive model

Eight articles described the sociocognitive model (SCM) of DID. In contrast to trauma-based models, the SCM suggests that DID is constructed by popular culture, the individual themselves (fantasy) or imposed by an external person e.g. a therapist (iatrogenesis).

The SCM posits that some people unconsciously act as if they have two or more self-states when in reality this is the result of cultural roles created in relation to others rather than the result of a complex internal defence to overwhelming childhood trauma (Lilienfeld et al, 1999). Self-states therefore result from a process of socialisation reinforced over time.

Fantasy

Fantasy models (FM) propose that patients who are more suggestible and prone to fantasy are more likely to dissociate and report the symptomology of DID (Lilienfeld et al, 1999; Lynn et al, 2014). It suggests that these individuals have this proneness in the context of a culture or relationship that encourages this presentation. They effectively turn the trauma-dissociation relationship on its head, putting forward that it is dissociation, proneness to fantasy, cognitive distortion and suggestibility that result in reports of childhood trauma.

This theory particularly refutes the reality of trauma memories, believing these to be fantasies rather than factual. This hypothesis therefore interprets the evidence showing a relationship between trauma and dissociation as equally supporting this contention but with the belief that the relationship is in the opposite direction.

Iatrogenesis

Some researchers argue that DID may only 'be seen' by therapists who believe in DID (Coons, 1984). They suggest DID is co-created by the therapist with the client (iatrogenesis) through a combination of suggestion and the client's eagerness to please or proneness to suggestion and fantasy (Piper and Merskey, 2004). Piper and Merskey make a powerful statement about the reliability and validity of DID;

> *'Consistent evidence of blatant iatrogenesis appears in the practices of some of the disorder's proponents' (Piper and Merskey, 2004: 592).*

Invalid diagnosis perspectives

Models of validity include those challenging the very concept of DID as a distinct and separate diagnosis—suggesting that it is simply a constellation of symptoms that could be better explained by other diagnoses (Paris, 2012) and argue in favour of it being removed from the DSM. Four articles discussed the issue of diagnostic validity with one in support and two against the validity of the DID diagnosis.

Gleaves et al (2001) acknowledge that DID has been a controversial diagnosis to which there have been two main challenges. First, that DID is a construction and not 'real', and second, that DID does not represent a distinct valid diagnosis, but is simply a variant of other disorders. In response to these arguments, they present a convincing case to support the validity of DID, using three comprehensive validity frameworks. They completed a systematic comparison of the validity criteria set out by Robins and Guze (1970), Spitzer and Williams (1985) and Blashfield et al (1990), in addition to their own taxometric research. Taxanomic procedures (Meehl, 1995) aim to distinguish between psychological types as opposed to variations along the same continuum. Where a construct is found to be typological, this approach aims to determine a set of indicators for that taxon.

Dorahay et al (2014) found that DID met the validity criteria for content validity (i.e. a consistent detailed clinical presentation found across cultures and

independent researchers), criterion validity (i.e. data from research and tests is consistent with the clinical presentation) and construct validity (i.e. DID can be distinguished from other disorders and simulation).

The findings of these studies demonstrate that DID has strong evidence in support of its' validity. For some criteria the authors were unable to present evidence to either support or contend it. For example, Gleaves et al (2001) were unable to support the criteria showing there is no diagnostic bias and argue that nearly all DSM diagnoses would not be able to demonstrate evidence for this. Diagnoses such as anorexia nervosa and borderline personality disorder (Tadic et al, 2009) are predominantly found in females. In their conclusion, the authors point out that DID is one of only a few disorders that has been exposed to this type of validity research.

Dell (2008) suggests that DID should not be a stand-alone diagnosis but would be better captured under the umbrella of major dissociative disorder. Rather than a denial of the disorder itself, Dell argues that the restrictive nature of the diagnostic criteria leads to under-diagnosis and misdiagnosis that may occur less frequently with a more flexible diagnostic criteria. Dell is concerned with diagnostic criteria being user friendly and accessible rather than refuting the existence of the disorder altogether.

By comparison, Paris (2012) published a strongly worded piece about the 'fad' of DID as an invalid and potentially harmful 'diagnosis'.

> *'This is a trajectory of a medical fad… The problem continues, given that the DSM-5 includes DID and accords dissociative disorders a separate chapter in its manual' (Paris, 2012; 1076).*

Paris argues that the presenting symptoms of DID could be equally well accounted for by other less controversial diagnoses in the DSM-IV-TR, (APA, 2000). Although a valid hypotheses and one that all diagnoses should be tested against, he does not provide evidence to support this statement and apparently ignores the previous evidence provided in the validity study by Gleaves et al (2001). Gleaves et al provide evidence to differentiate DID from the key comparative diagnoses in the literature including schizophrenia, borderline personality disorder, post-traumatic stress disorder, somatisation disorder and complex partial seizures/neurological condition.

Paris goes on to explain that the experience of dissociation is quite normal and gives examples such as dissociating whilst driving long distances 'dissociative symptoms do not necessarily constitute a disorder' (Paris, 2012: 1076).

However a mental health disorder, as defined by the DSM-V, is:

> *'A mental disorder is a syndrome characterised by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.'*

There is also a dysfunction reflecting an abnormal process—i.e. not a normal process experienced by the average person. For example, feeling sad is a normal human experience that does not necessarily constitute clinical depression. Similarly, mild forms of dissociative experience are normal but severe dissociative symptomology observed in individuals with DID are not and constitute a mental health disorder.

What had been lacking—despite powerful arguments for both sides—was a comprehensive, unbiased systematic review of the empirical evidence for the validity of DID. This was answered by Dorahy et al (2014) who published a systematic review of the empirical literature and concluded that:

> *'Existing data show DID as a complex, valid and not uncommon disorder, associated with developmental and cultural variables, that is amenable to psychotherapeutic intervention' (Dorahy et al, 2014: 1).*

Integration of understandings

In the past, the trauma and SCM models have been entirely opposed, but more recently there has been a shift towards finding common ground. Dalenberg et al (2012) point out that the two models are not necessarily mutually exclusive. Both models propose a relationship between trauma and dissociation, but account for this relationship in different ways. It may be the case that trauma results in dissociation for some individuals, but also that fantasy proneness may lead to inaccurate trauma reports in others or at the same time. Both models recognise that fantasy proneness may be an aspect of dissociation caused

Despite the dominance of the trauma-based models… there continues to be a controversy around the diagnosis

by childhood trauma, where fantasy and imagination serve as an important coping strategy to escape from intolerable experiences (Dalenberg et al, 2012). This highlights the importance of mental health practitioners' skills for individually formulating difficulties. There is no one conceptualisation or remedy that can be generically applied to all.

Lynn et al (2014) highlight the need for a more integrative approach to making sense of DID that does not try to simplify it to single causative and maintenance factors.

> *'Accordingly, we conclude that the field should now abandon the simple trauma–dissociation model and embrace multifactorial models that accommodate the diversity of causes of dissociation and dissociative disorders' (Lynn et al, 2014: 896).*

Limitations

This review only included English-language journals, which may have limited the results to Western cultural interpretations of this presentation. In addition, this may have implications for understanding the hypothesis related to cultural clustering of DID and the idea that self-states are created in response to cultural expectations. Although a limitation, it also offers a potential area for further research that will be particularly beneficial for area of research such as DID.

Conclusions

As highlighted above, despite the dominance of the trauma-based models in the discourse of the literature, there continues to be a controversy around this diagnosis. It is important for therapists and researchers alike to hold an open and flexible mind. It is possible that some clients will present to services displaying imagined and created presentations, while others suffer from the long-term structural or attachment difficulties inflicted by previous overwhelming trauma. Others may present with a combination of factors including both trauma and fantasy proponents not captured in this article. The role of the practitioner is to collaboratively make sense of these experiences and difficulties to work towards relieving distress and in the direction of a life worth living.

What is clear from the literature is that DID provokes strong responses from those interested in the presentation. For example, Paris writes

> *'DID is only one of many fads that have afflicted psychiatry during the last century …Among the best known in the past have been frontal lobotomy…' (Paris, 2012: 1078).*

Researchers in the field tend to align themselves with a particular school of thought, which leaves the research area open to claims of bias. In an area of such contention and controversy, the influence of bias is particularly important to consider. It would be a powerful step forward for researchers from these opposing camps could come together to explore this area together in future research endeavours.

Above all else, it is important to hold in mind that there are a number of individuals diagnosed with DID and regardless of the 'how and why', these difficulties developed, and these individuals present to services looking for support and help to manage and change their lives for the better. BJMHN

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