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The Scientific Status of Childhood Dissociative Identity Disorder: A Review of Published Research

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Key Words

Dissociative identity disorder, posttraumatic · Dissociative identity disorder, sociocognitive · Mental disorder · Etiology · Child · Adolescent

Abstract

Background: Dissociative identity disorder (DID) remains a controversial diagnosis due to conflicting views on its etiology. Some attribute DID to childhood trauma and others attribute it to iatrogenesis. The purpose of this article is to review the published cases of childhood DID in order to evaluate its scientific status, and to answer research questions related to the etiological models. ***Methods:*** I searched MEDLINE and PsycINFO records for studies published since 1980 on DID/multiple personality disorder in children. For each study I coded information regarding the origin of samples and diagnostic methods. ***Results:*** The review produced a total of 255 cases of childhood DID reported as individual case studies (44) or aggregated into empirical studies (211). Nearly all cases (93%) emerged from samples of children in treatment, and multiple personalities was the presenting problem in 23% of the case studies. Four US research groups accounted for 65% of all 255 cases. Diagnostic methods typically included clinical evaluation based on Diagnostic and Statistical Manual of Mental Disorder criteria, but hypnosis, structured interviews, and multiple raters were rarely used in diagnoses. ***Conclusion:*** Despite continuing research on the related concepts of trauma and dissociation, childhood DID itself appears to be an extremely rare phenomenon that few researchers have studied in depth. Nearly all of the research that does exist on childhood DID is from the 1980s and 1990s and does not resolve the ongoing controversies surrounding the disorder.

Introduction

Dissociative identity disorder (DID), commonly referred to as multiple personalities, is a mental disorder in which a person's consciousness, memory and identity appear fractured. Alternate personalities emerge and take control of a person's actions and consciousness without his or her knowledge. Although it is officially listed in the Diagnostic and Statistical Manual of Mental Disorders

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(DSM) [1], DID is a highly polarizing diagnosis that remains a source of disagreement in the field of psychopathology [2–4]. One specific area of contention is the status of DID among children. Advocates of a posttraumatic explanation of DID claim that it is the sequela of severe childhood abuse [5], but this etiological explanation has been the subject of intense criticism [6–8]. Skeptics find numerous reasons to doubt the validity of DID, but an often-repeated problem with the diagnosis is that childhood cases are rare [6, 7]. Despite strong claims about childhood DID on both sides of the issue, no systematic review of childhood DID cases exists in the literature. Such a review is particularly relevant given recent research suggesting that the dissociative disorders were merely a scientific fad [9] and given the current process of DSM revision.

Etiology is the main source of controversy surrounding DID because of the two conflicting explanations for the disorder. The posttraumatic model (PTM) posits that DID develops as a strategy for dealing with trauma [10]. Specifically, the most commonly cited trauma is severe childhood abuse. As a coping strategy, abused children with a capacity for dissociation create alternate personalities to experience trauma. Self-reports of childhood abuse are a core feature among individuals diagnosed with DID, and this constitutes the crucial evidence supporting the PTM [11].

An alternative etiological approach, the sociocognitive model (SCM), is built around skepticism toward the validity of DID [7, 8]. According to the SCM, DID is explained by individuals enacting a social role. Cultures have specific rules and expectations associated with having multiple selves. As members of a culture, people learn about what it means to have multiple personalities, and some individuals begin to fulfill that role. Role enactments are influenced by both conscious and unconscious factors, and the SCM does not imply that people with multiple selves are consciously faking. Rather, the SCM posits that memory, identity and psychopathology are shaped into DID through exposure to the concept in the culture and specific social experiences such as psychotherapy. Supporters of the SCM argue that treatment can elicit the presentation of multiple personalities through such practices as suggestion, leading questions, and hypnosis.

A resolution between the etiological models has not emerged in the literature – in fact both sides appear to have declared victory [5, 7] – but research on childhood DID could provide answers to research questions stemming from the etiological debate. For example, Lilienfeld et al. [6] stated that cases of childhood DID occurring before treatment and before the possibility of learning the role of multiple personality would critically harm the validity of the SCM. Conversely, they pointed out that the validity of the trauma model would be harmed by the discovery that symptoms of DID only emerged after treatment had started. Although the literature is unlikely to provide information on learning the social role of DID from general culture, it should provide evidence concerning the relation of treatment and childhood DID. To illustrate, case studies should indicate if DID was a presenting problem or if it emerged in treatment, and studies of larger samples of children should indicate if recruitment occurred from a treatment or nontreatment population.

Another area of disagreement between proponents of the SCM and the PTM is assessment and diagnosis. There is good reason to carefully evaluate the diagnostic practices for DID; bipolar disorder, borderline personality disorder, schizophrenia, malingering, fluctuations in normal behavior, and other dissociative disorders all have the potential for misdiagnosis as DID, and this may even be exacerbated among children [12–14]. Generally, supporters of the PTM and SCM hold confident and skeptical views, respectively, on the reliability and validity of diagnostic practices for DID. According to the SCM, certain subjective and leading practices are associated with increased rates of DID. For example, the use of hypnosis for 'facilitating access to dissociated personalities', 'age regression' and 'memory retrieval' – practices still endorsed by the American Psychiatric Association [15, p. 688] – may facilitate enactment of the DID role [8]. If specific therapeutic practices caused DID, the SCM would predict that a small number of clinicians accounted for a disproportionately large number of DID cases due to their use of those methods [6, 8]. Another contributor to uneven distribution of cases might be the use of subjective diagnostic practices; some clinicians may be especially likely to interpret behaviors as signs of DID, which would lead to a high rate of false-positive diagnoses. Proponents of the PTM deny that hypnosis is prevalent in the treatment of DID [8]. Rather, they emphasize the assessment and diagnosis of DID by objective means such as diagnostic interviews [10, 16]. Unfortunately, the use of objective measures does not provide direct evidence for the etiology of childhood DID because a reliably diagnosed case of DID indicates nothing about its cause. Nonetheless, an examination of the literature will help to determine if the standard assessment and diagnostic practices for childhood DID are predominantly

objective or subjective, and if cases tend to cluster around a few clinicians.

A final topic of interest in the childhood DID literature is the existence of cases across cultures. Supporters of the SCM claim that DID is a culture-bound syndrome. Because cultural influences are central to the etiology of DID, supporters of the SCM predict that DID is heavily influenced by culture. For example, DID may be more prevalent in Western cultures than non-Western cultures. In contrast, arguing that the disorder is not simply a product of culture, supporters of the PTM would expect researchers to identify cases of DID across cultures with similar frequency.

DID remains a controversial topic with more unanswered questions than scientifically established facts. As such, the purpose of the current study is to evaluate its scientific status. Specifically, I reviewed the childhood DID literature in order to address the following research questions related to (a) the prevalence of cases outside of treatment, (b) diagnostic methods, and (c) the prevalence of cases across cultures: (1) How frequently do cases of childhood DID emerge independently of treatment? (2) How frequently are hypnosis and objective diagnostic measures used to identify cases? (3) Are cases of childhood DID evenly distributed across clinicians? (4) Are cases of childhood DID more prevalent in Western than non-Western countries?

The answers to these questions may offer support for a specific etiological model of childhood DID. Generally, the PTM would be supported by similar prevalence rates in and out of therapy, frequent use of objective diagnostic methods, and similar prevalence rates across cultures. In contrast, the SCM would be supported by differing prevalence rates in and out of therapy, frequent use of hypnosis, uneven distribution of cases across clinicians, and differing prevalence rates across cultures.

Methods

In order to identify articles, I searched MEDLINE and PsycINFO using the terms 'dissociation', 'dissociative identity disorder' and 'multiple personality' with the limiters set to include age groups from birth to 18 years. In addition, I examined the references of identified articles. To be included in the review, a study had to be published and contain at least 1 case of DID/multiple personality disorder in an individual who was less than 18 years old; other dissociative disorders, dissociation, or high scores on dissociation scales were not sufficient for inclusion. In addition, because there are questions related to diagnosis, I only included research that was published after 1980 when the DSM first included diagnostic criteria for multiple personalities [17].

Results

The review led to the identification of 19 articles presenting case studies [18–36] and 13 empirical articles containing data on 15 samples of aggregate cases [37–49]. The case study articles included 44 individual cases, and the empirical studies included approximately 211 participants diagnosed with DID. Unfortunately, the number of cases from the empirical studies must remain somewhat tentative because in one study the author only reported an approximate number of cases seen in treatment [44], and in another study only a range of ages was provided [47]. Thus, the childhood DID literature includes published data on about 255 cases.

Prevalence Outside of Treatment

The first research question focused on the frequency with which cases of childhood DID emerged outside of treatment. In 10 of 44 case studies (23%), the author clearly indicated that the existence of multiple personalities was the initial reason for the child's treatment [18, 22, 25, 33, 34, 36]. However, there are two caveats to this result. The first caveat is that 8 of 10 cases initially presenting with DID symptoms appeared to have strong sociocultural influences. Specifically, 4 of the 10 children initially presenting with symptoms of multiple personalities were identified by mothers who were diagnosed with DID themselves [25, 34], and another child, who self-diagnosed, reported that both her parents and 3 siblings were diagnosed with DID [33]. As such, it is not clear if these children would have presented with DID without the influence of their families. An additional 3 of the 10 children initially presenting with symptoms of multiple personalities were identified by Indian doctors who specifically cited Hindi cinema as a potential influence on their atypical presentations of DID [18]. The second caveat is that the reason for treatment among 10 of the children not initially presenting with DID included psychotic symptoms, most frequently hearing voices [24, 25, 27, 33, 34, 36]; supporters of the PTM argue that hearing voices is a key indicator of childhood DID [50].

The results of the empirical studies with regard to the existence of childhood DID outside of treatment were much clearer. No studies have documented the prevalence of childhood DID in the general population. In fact, only 1 sample was recruited outside of treatment [49]. The sample consisted of siblings of children diagnosed with DID who were in treatment; however, the treatment history of these siblings was not clear, and they underwent an average of 4 sessions to determine if they had DID,

which is a substantial amount of time in a treatment-like setting.

Diagnostic Methods

Two additional research questions focused on (a) the utilization of hypnosis and objective diagnostic measures and (b) the distribution of cases across clinicians. In terms of diagnostic methods, 3 of the 44 individual cases included assessment by the Structured Clinical Interview for DSM Dissociative Disorders [32, 33], 2 mentioned the use of a diagnostic manual [22, 30], 1 included assessment by an unpublished interview schedule [27], and 6 mentioned the use of hypnosis at some point during treatment [20, 25, 34–36]. The distribution of cases did not cluster around a limited number of clinicians; most of the articles presented a small series of cases.

Several different methods of diagnosis were used in the 15 empirical studies. In 6 studies, diagnosis occurred using DSM criteria and an additional criterion that actual switches in personality be witnessed by the diagnostician [38, 40, 43, 46, 48, 49], 4 studies included diagnoses based on DSM criteria only [37, 39, 41, 47], 3 studies included diagnoses based on the Dissociative Disorder Interview Schedule [44, 45], and 2 studies did not include information on their diagnostic methods [42, 45]. Only 1 study included independent diagnosis by multiple researchers [46]. Hypnosis was not reported as part of the assessment or diagnosis in any study. Examination of the number of cases of childhood DID identified by specific research groups clearly showed an uneven distribution. Researchers responsible for more than 1 study – essentially 4 research groups – accounted for 165 out of the 255 total cases [40, 41, 43–45, 48, 49].

Prevalence across Cultures

A final research question concerned the prevalence of childhood DID across cultures. There was some evidence for DID in non-Western cultures because case studies originating from India and Turkey exist [18, 22, 28, 36], and empirical studies have included samples from Israel, Japan and Turkey [39, 42, 46]. However, it should be noted that all of these international researchers published their work in English-language journals and cited Western literature on DID. As such, the non-Western cases of DID did not occur in isolation from Western influence.

Discussion

This study consisted of a review of the childhood DID literature as it related to four research questions. One, how often does childhood DID emerge independently of treatment? Childhood DID appears to be extremely rare outside of treatment. Although some children do come to treatment with symptoms that meet the criteria for DID, its prevalence in the general population has never been documented. Two, how frequently are hypnosis and objective diagnostic measures used to identify cases? Researchers infrequently report using hypnosis or objective diagnostic measures, and neither method seems to be standard in the literature. Three, are cases of childhood DID evenly distributed across clinicians? A severe skew in the distribution of cases emerged in the literature. In fact, just 4 research groups accounted for 65% of all reported cases of childhood DID. Four, is childhood DID more prevalent in Western than non-Western countries? Although non-Western cases exist in the literature, most cases of childhood DID have emerged from Western countries. Overall, the answers to the research questions provided more support for the SCM than the PTM; childhood DID is extremely rare outside of therapy, it is unevenly distributed across clinicians, and it is mostly a Western phenomenon.

The results of this review illustrate that the PTM and SCM are difficult to confirm or refute because the models offer contradictory interpretations of the same evidence. For example, lack of symptoms before treatment is interpreted by the PTM as a typical developmental pattern of DID, and it is interpreted by the SCM as evidence for iatrogenesis. Also, clustering of cases among a limited number of researchers is considered further evidence for iatrogenesis from the SCM perspective, but supporters of the PTM contend that clustering is the result of clinical expertise and referrals. Finally, existence of childhood DID in other countries is support for the universality of DID according to the PTM, but the fact that nearly all cases are found in the USA is evidence of learned cultural roles from the perspective of the SCM. Furthermore, it is possible that patients, therapists and researchers based in other countries are influenced by Western conceptualizations of DID. Given the contradictory evidence and interpretations, the most logical way to account for childhood DID is probably an integrative model, i.e. DID exists in childhood, but it is extremely rare. Furthermore, the upsurge in reported cases in the 1980s and 1990s likely represents concomitant increases in diagnostic recognition of real cases, misdiagnosis and iatrogenic prac-

tices. Unfortunately, a definitive test of any etiological model is beyond the reach of extant research.

Scientific questions surrounding childhood DID remain largely answered in the research literature. Although there has been continued growth in theory and research on trauma and dissociation [51, 52], scientific work on the dissociative disorders per se has declined abruptly since the 1990s [9]. Consequently, little convincing evidence exists concerning the prevalence, etiology or diagnostic validity of childhood DID. Considering the results of this review, more research is needed before DID in childhood can be considered anything other than an extremely rare and poorly understood phenomenon that was briefly the object of intense scientific interest and speculation.

Disclosure Statement

This research was unfunded, and the author has no conflicts of interest to declare.

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