

Dissociative Identity Disorder: A Controversial Diagnosis

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ABSTRACT

A brief description of the controversies surrounding the diagnosis of dissociative identity disorder is presented, followed by a discussion of the proposed similarities and differences between dissociative identity disorder and borderline personality disorder. The phenomenon of autohypnosis in the context of early childhood sexual trauma and disordered attachment is discussed, as is the meaning of *alters* or *alternate personalities*. The author describes recent neurosciences research that may relate the symptoms of dissociative identity disorder to demonstrable disordered attention and memory processes. A clinical description of a typical patient presentation is included, plus some recommendations for approaches to treatment.

CASE EXAMPLE: MARY (AS MARY, EDITH, “BABY”)

Mary was a quiet 30-year-old woman who was meek and reticent and had many avoidant traits. She was talking about some of the events of her past, which included severe sexual abuse starting at the age of 20 months. She began to tell the psychiatrist about a crying voice she heard constantly:

Mary: Baby cries all the time—

Baby—I hear her. She is sad all the time. She can't talk, but she cries all the time. (Mary stops speaking. Her demeanor and



EDITOR'S NOTE: All cases presented in the series “Psychotherapy Rounds” are composites constructed to illustrate teaching and learning points and are not meant to represent actual persons in treatment.

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posture were now so different the psychiatrist was startled. It really felt as though a different person was in the room.)

Mary (now Edith): She is a wimp. I would never put up with any of that sh--. I'll kill him. I'll kill him. I'll kill you too and she deserves to die.

Psychiatrist: Who? Baby?

Mary (now Edith): Mary. She's a wimp.

Psychiatrist: What about Baby?

Mary (now Edith): What are you talking about?

Psychiatrist: May I speak to Mary?

Mary (now Edith): She doesn't have the guts to come here.

A CONTROVERSIAL DIAGNOSIS

In 1988, Dell¹ surveyed clinicians to assess the reactions they had encountered from others as a result of their interest in dissociative identity disorder (DID), previously called multiple personality disorder. Of 62 respondents who had treated patients with DID, more than 80 percent said they had experienced "moderate to extreme" reactions from colleagues, including attempts to refuse their patients' admissions to hospitals or to force discharge of their patients, even patients that the respondents felt represented a serious suicidal risk. Dell speculated that the emotional reactions to the diagnosis of DID stemmed from anxiety evoked by the disorder's "bizarre, unsettling clinical presentation,"¹ similar to some clinicians' emotional reactions to psychiatric emergency patients.² Another reason for the heated controversy surrounding the diagnosis of DID is the dispute over the meaning of observed symptoms: Is DID a disorder with a unique and subtle set of core symptoms and behaviors that some clinicians do not see when it is before their eyes?³ Or is it willful malingering and/or iatrogenically caused symptoms created by the other clinicians who think something is there that is not?⁴⁻⁶ A third and very important reason for the controversy is the fear that criminals will "get off" without

being punished by a gullible justice system, which attributes behavior to another personality⁷ and does not hold the perpetrator responsible.

The diagnosis of DID is controversial. Reported cases of DID by Frankel,⁸ Ganaway,⁹ and McHugh,^{10,11} among others, have been attributed instead to social contagion, hypnotic suggestion, and misdiagnosis. These authors have argued that the patients described as having DID are highly hypnotizable, and therefore are very suggestible. They argue that these patients likely would be prone to follow direct or implicit hypnotic suggestions, and that the majority of diagnoses of DID are made by a few specialist psychiatrists.

DID VERSUS BORDERLINE PERSONALITY DISORDER

In 1993, Lauer, Black, and Keen¹² concluded that DID was an epiphenomenon of borderline personality disorder, finding few differences in symptoms between the two diagnoses. They described, rather, a "syndrome" of symptoms that occurs in persons with disturbed personalities, particularly borderline personality disorder. They concluded that DID had "no unique clinical picture, no reliable laboratory tests, could not be successfully delimited from other disorders, had no unique natural history and no familial pattern." That same year, after yeomans' efforts to answer this question by empirically reviewing the literature, North et al¹³ concluded that the diagnosis has not been "truly" validated,¹⁴ but yet they "came to believe in (its) existence." They stated, "Current knowledge does not at this time sufficiently justify the validity of DID as a separate diagnosis," but this also does not disprove the concept. Subsequently, Spira¹⁵ edited a book by proponents of the existence of DID, describing treatment options.

Loewenstein¹⁶ and Bliss¹⁷ concluded that DID existed and spontaneous autohypnotic symptoms were basic to the phenomenology of DID. Gelinis¹⁸ described

autohypnotic and posttraumatic stress disorder (PTSD) symptoms in DID patients that likely were a response to childhood sexual abuse. Spiegel and Rosenfeld¹⁹ attributed the "spontaneous age regression" (to a younger alter) seen in DID patients to early trauma and also believed that PTSD symptoms related to trauma were central to DID.

Horevitz and Braun²⁰ found that 70 percent of patients who had been diagnosed with "multiple personality disorder (DID)" would just as likely, by chart review, meet the criteria for borderline personality disorder. However, they also found other patients that could not be so characterized, and they concluded that DID was in fact a distinct entity, but overdiagnosed.

Coons et al²¹ performed assessments with the Structured Clinical Interview for DSM Disorders (SCID) and Structured Interview for DSM-III-R Personality Disorders (SIDP-R), Dissociative Disorder Interview Schedule (DDIS), the Beck Depression, Beck Hopelessness, and Dissociative Experiences Scale (DES) and Shipley Institute of Living Scales on patients who had been diagnosed with DID. They found that 64 percent of patients diagnosed with DID met criteria for borderline personality disorder, but of those who did not, they met many of the criteria for borderline personality. However, as found by Horevitz and Braun,²⁰ one third of persons previously diagnosed with DID on Axis I on the basis of the above-mentioned assessment scales did not meet criteria for any Axis II disorder. Of special note was that the DES was higher in DID-diagnosed subjects than in other subjects. Coons et al²¹ concluded that DID was a "syndrome" that occurred in persons with disturbed personalities, particularly borderline personality disorder, and that both borderline personality disorder and DID were on the same character disorder spectrum, with DID representing its more severe end. They argued that DID arises from a substrate of borderline traits. The authors argued

that the multiplicity of symptoms associated with DID, including insomnia, sexual dysfunction, anger, suicidality, self mutilation, drug and alcohol abuse, anxiety, paranoia, somatization, dissociation, mood changes, and pathologic changes in relationships, supported their view. Herman²² has characterized DID as a disorder of extreme stress, possibly a form of complex PTSD, due to prolonged repeated trauma.

THE MEANING OF ALTERS, OR ALTERNATES

Although the alters described in DID are sometimes referred to as *ego states*, Watkins and Watkins²³ draw a distinction between the two concepts. They define *ego state* as an “organized system of behavior and experience whose elements are bound together by some common principle but that is separated from other such states by boundaries that are more or less permeable.” Watkins and Watkins and others differentiate the concept of *alters* from that of *ego states* because the alters in DID have “their own identities, involving a center of initiative and experience, they have a characteristic self representation, which may be different from how the patient is generally seen or perceived, have their own autobiographic memory, and distinguish what they understand to be their own actions and experiences from those done and experienced by other alters, and they have a sense of ownership of their own experiences, actions, and thoughts, and may lack a sense of ownership of and a sense of responsibility for the action, experiences, and thoughts of other alters.”²³

TRAUMA, ATTACHMENT, AND DID

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).²³ Because of the stage of life a child is in when imaginary companions “exist,” the “solution” to severe trauma at that stage may be a dissociated identity. In contrast, PTSD symptoms would more likely occur when trauma is experienced later in childhood or during adult life.²⁴

Severe child abuse, a disorganized and disoriented attachment style,^{25,26} and the absence of social and familial support seem to precede the development of DID. The tendency to dissociate seems to be related as much to a pathogenic family structure and attachment disorder acquired early in the life of the child as to original temperament or genetics. Parenting style toward these patients was usually authoritarian and rigid, but paradoxically with an inversion of the parent-child relationship.²⁷ Blizard²⁸ speculated that children who display a disorganized/disoriented pattern of attachment²⁹ might be in the process of dissociating their representations of contradictory parent behavior and that, in DID, distinct patterns of attachment may have been incorporated into the various personalities. The disorganization that is observed in the DID patient's attachment pattern is particularly interesting in view of some of the recent neurosciences findings about this disorder.

RECENT NEUROSCIENCES RESEARCH ON DISSOCIATIVE IDENTITY DISORDER: ATTENTION AND MEMORY

Attention. In one study, a subsample of DID patients manifested abnormal interest scatter on the Wechsler Adult Intelligence Scale-Revised (WAIS-R) verbal subtests, and this variability was attributed to subtle neuropsychological deficits on the memory/distractibility factor similar to what is seen in attention deficit disorder.³⁰ In another study, when compared with other dissociative disorder patients, DID patients

showed a prepulse inhibition (PPI) of the acoustic startle reflex, suggesting maladaptive attentional processes when functioning at a controlled level, but not at a preattentive automatic level. DID patients showed increased vigilance, resulting in reduced habituation of startle reflexes and increased PPI. This response is a voluntary process that directs attention away from unpleasant or threatening stimuli. The authors concluded that aberrant voluntary attentional processes may thus be a defining characteristic of DID.³¹ In a third study, regional cerebral blood flow (rCBF) in patients diagnosed with DID was decreased in the orbitofrontal cortex regions bilaterally (similar to what is seen in attention deficit disorder), and increased in median and superior frontal regions and occipital regions bilaterally.³²

Memory. In a study of memory in subjects who were diagnosed with DID, Nissen et al³³ found that the degree of apparent compartmentalization of learned items depended on the extent to which the information was interpreted and stored in ways that conveyed a unique meaning to the alter or “personality state.” They concluded that “implicit” memories could be best stored and retrieved mainly during discrete behavioral states of consciousness. By contrast, one identity could recognize neutral words learned by the other identity.³⁴ Also, memories of presumably neutral words,³⁵ which were presented via auditory input but retrieved visually, showed interidentity memory transfer. Huntjens et al³⁶ recommend that clinical models of amnesia in DID should exclude impairments for emotionally neutral material.

In one study of patients with DID that did not exclude patients also suffering from PTSD symptoms, hippocampal volume was 19.2-percent smaller and amygdala volume was 31.6-percent smaller compared to healthy subjects.³⁷ In another study, when compared with controls, trauma-exposed subjects

with PTSD symptoms but without DID had significantly reduced amygdalae and hippocampi and significantly impaired cognition in comparison to trauma-exposed patients with DID symptoms but without PTSD, who had normal amygdalae and hippocampi and normal cognition.³⁸

Further research is needed to clarify whether or not the symptoms of DID actually perform a protective, defensive function neurologically by creating a neuroprotective environment that ameliorates the neurotoxic effects of traumatic stress. This would be predicted by the adaptive hypothesis described by Stankiewicz and Golczynska.³⁹

MAKING THE DIAGNOSIS: CLINICAL DESCRIPTION

The typical patient who is diagnosed with DID is a woman, about age 30. A retrospective review of that patient's history typically will reveal onset of dissociative symptoms at ages 5 to 10, with emergence of alters at about the age of 6. Typically by the time they are adults, DID patients report up to 16 alters (adolescents report about 24), but most of these will fade quickly once treatment is begun. There generally is a reported history of childhood abuse, with the frequency of sexual abuse being higher than the frequency of physical abuse. Patients who have been diagnosed with DID frequently report chronic suicidal feelings with some attempts. Sexual promiscuity is frequent but patients usually report decreased libido and an inability to have an orgasm. Some patients report that they dress in clothing of the opposite gender or that they, themselves, are of the opposite gender. Patients often report "extrasensory experiences" related to dissociative symptoms, sometimes called hallucinations. They report hearing voices, periods of amnesia, periods of depersonalization, and may use the plural ("we" instead of "I") when referring to the self. These patients experience so much dissociation and also many somatic symptoms (some

cases resemble Briquet syndrome or somatization disorder)⁴⁰ that they have a very inconsistent work history.⁴¹ Patients usually have periods of time for which they cannot account, may meet people who know them but whom they do not recognize, and find clothes in their possession that they do not recall purchasing and normally would not wear.

Most DID patients come into treatment because of affective, psychotic-like or somatic symptoms. However, in an emergency situation with a new patient who does not know his or her name, it is important to consider that the patient may have a true psychosis, because most "Jane and John Does" who present in psychiatric emergency settings have turned out to be psychotic, rather than in a dissociated state⁴² or to have an associated functional or organic psychosis.⁴³ Although DID patients often describe hearing voices, North et al¹³ found that in DID, the reported hallucinations often also had a complex visual quality.

APPROACHES TO TREATMENT

Patients who have been diagnosed with DID tend to possess extreme sensitivity to interpersonal trust and rejection issues, and this makes brief treatment in a managed care setting difficult.¹⁴ Therapists who commonly treat patients with DID see them as outpatients weekly or biweekly for years, with the goal of fusion of the personality states while retaining the entire range of experiences contained in all of the alters.

Patients tend to switch personality states when there is a perceived psychosocial threat. This switching allows a distressed alter to retreat while an alter who is more competent to handle the situation emerges. The alter system may replicate the DID patient's experience of the relationships and circumstances that prevailed in the family of origin.³ In Kluff's view,³ alternate identities or personality states are the core phenomena of DID. Kluff does not view the alters as

obstacles, distractions, or artifacts to be bypassed or suppressed. In fact, he argues that he has found no evidence of improvement if the therapist does not work with these alternate personality states.

A cognitive behavioral therapy (CBT) approach is often recommended that incorporates communicating effectively with the alters and helping the patient find more adaptive coping strategies than "switching" when distressed. This 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. The therapist tries to model an appropriate relationship and model appropriate, calm, and considered reactions to crises.

According to Kluff, large systems of alters usually collapse as the treatment moves forward and so it is not necessary to be overly concerned if the patient experiences a large number of personality states. It is important to get to know the prominent personality states, however, because sometimes one assumes that the host personality constitutes the patient's true identity, but this may not be the case.³

One of the most important issues to deal with in treatment is the fear on the part of an acting-out or antisocial personality state that he or she will be obliterated by therapy—that the psychiatrist's goal is to "get rid" of an "alter" who may have committed illegal, even violent, acts. This would not be an appropriate goal of treatment. The personality state was created to defend the self against abuse and injury and can become a strong and important element when integrated more adaptively into the overall personality structure.²³

CASE EXAMPLE (CONTINUED): MARY

Psychiatrist (to Mary, now Edith):
It sounds like you think Mary should handle things differently. If Mary feels anxious about coming

to her appointments, what are some things she can do to feel more at ease? Is there anything that I can do to help her more?

Mary as Edith: Tell her to have more guts. She can get along without you if you leave her.

Psychiatrist (to Mary, now Edith):

I am not going to leave. I will be here.

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