# Integrative Research Paper:

# Dissociative Identity Disorder

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Few psychological disorders in the Diagnostic Statistical Manual have generated as much controversy as Dissociative Identity Disorder (DID). For the past 35 years diagnoses of DID, previously referred to as Multiple Personality Disorder (MPD), have increased exponentially, causing various psychological researchers and clinicians to question the validity of this disorder. DID is, however, currently recognized by the DSM-IV-TR as a true psychological disorder that emerges, most commonly, as a result of early childhood sexual abuse (DSM-IV-TR, 1994; Haddock, 2001; Zimbardo, Johnson, & Weber, 2006; Comer, 2007; Lev-Wiesel, 2005). In this essay I will first provide background information on DID, and identify and define the terminology commonly associated with the disorder. Second, I will discuss treatment modality, in addition to options for health insurance coverage. Third, I will discuss the argument of Dr. August Piper and Harold Merskey that contradicts the validity of DID. And lastly, I will address the ethical importance of recognizing DID as a severe and complicated disorder that continues to defy a mechanistic definition.

*Background*

Evidence for Dissociative Identity Disorder dates back to the Paleolithic era, however, it was not until the late eighteenth century that recorded cases of "exchanged personalities" began to emerge (as cited in Cohen, Berzoff, & Elin, 1995, p. 28). In 1791, a 20-year-old woman from southern Germany adopted the personality of a French aristocrat and even began speaking fluent French. The woman seemingly developed two

different nationalistic personalities (French and German) that, when told of the other, denied any recollection or awareness of it.

More recently, the case of Sybil Isabel Dorsett has come to be considered "the most important clinical case of multiple personality" which linked the disorder to early childhood abuse (as cited in Cohen et al., 1995, p. 362; Lev-Wiesel, 2005). Combined, Sybil developed sixteen different personalities—all of which she was unaware of—to help her cope with the emotional trauma that was caused by early childhood abuse. Sybil's case was important for the understanding and early acceptance of DID because it gave psychologists a standard measure with which to assess and diagnose other people showing similar symptoms. By 1980 the criteria for diagnosing MPD became solidified in the publication of the DSM-III. In 1994, MPD was renamed Dissociative Identity Disorder and an increasing amount of information concerning assessment and diagnosis was made available to clinicians and therapists (as cited in Cohen et al., 1995, p. 353). Although DID is widely accepted as a true psychological disorder, clinicians such as Piper and Merskey (2004) maintain that it is an illegitimate construct that is imposed upon the patient, by the therapist (p. 676).

Currently DID is defined as "the presence of two or more distinct identities or personality states that recurrently take control of the individual's behavior, accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness…a disorder characterized by identity fragmentation rather than a proliferation of separate personalities" (DSM-IV-TR, 1994, p. 528; Zimbardo et al., 2006, p. 504; Comer, 2007, p. 208). The identity of the dominant, or "host personality," breaks off sub categorically, and identities begin to develop with

separate and distinct sets of memories, behavioral patterns, historical and familial backgrounds, differing physiological characteristics, and cognitive function (Comer, 2007, p. 208). Comer (2007) refers to the separate and distinct personalities of the individual as “sub personalities or alternate personalities” (p. 208). The transference from one identity to the next is referred to as “switching,” commonly triggered by a negative or stressful event or experience although, at times, occurring without noticeable indication (Comer, 2007, p. 208; Thomas, n.d.).

Interaction between the sub personalities can vary greatly, however, there are three primary relationships that commonly develop. One, “mutually amnesic relationships” are defined as personalities that have no awareness of the others. Two, the “mutually cognizant pattern” is defined as the sub personalities being aware and in-tune with the other personalities, often having discussions with one another. And three, “one-way amnesic relationships” in which various sub personalities are aware of the others, yet, some personalities maintain no connection or awareness of the others (as cited in Comer, 2007, p. 209).

*Causes of DID*

From the psychodynamic perspective DID is generally recognized as a developmental disorder that emerges due to early childhood sexual abuse or trauma (Haddock, 2001; Zimbardo et al., 2006; Comer, 2007; Lev-Wiesel, 2005). The dissociation from one's true self is essentially a coping mechanism to protect the individual from fearful emotions or situations. As Haddock (2001) demonstrates, "if an individual is traumatized in early childhood and the experience is so overwhelming that he is unable to process it, the child may dissociate to survive" (p. 28). What separates the

severe form of dissociation from normal, everyday dissociation, such as daydreaming, is the brains biological response to overwhelming and extended experiences with traumatic stimuli. Because most cases of DID are linked to early childhood abuse, experienced at age nine or before (Lev-Wiesel, 2005), it is easy to understand how an individual finds solace in dissociating from their dominant personality by allowing sub personalities to emerge and confront difficult situations or emotions.

From the behavioral perspective DID is understood as the result of a cyclical method of dissociation from everyday memory processes learned over time (Comer, 2007, p. 211). More simply, the individual learns through operant conditioning that "reinforced acts of forgetting...help them escape anxiety" (Comer, p. 211). Over time, an individuals' learned "escapist behavior" causes them to dissociate more often, and to a greater degree of intensity from their dominant personality.

It is important to note that DID is not recognized as a psychotic disorder, commonly mis-referred to as a "split personality" disorder (Zimbardo et al., 2006, p. 505). Additionally, it is important to note the difference between DID and post traumatic stress disorder (PTSD), as DID closely resembles, and is often misdiagnosed as PTSD. DID is an organization of negative emotions that are assigned to different sub personalities (Haddock, 2001, p. 30). While DID can be involuntary acts of mental escape in order to help alleviate negative emotions, PTSD is a more direct, and voluntary form of emotional repression.

*Diagnosing DID*

As mentioned previously, the DSM-IV-TR has outlined the criterion for DID to be accurately diagnosed. Despite new techniques for diagnosing and treating DID, the

disorder remains relatively elusive to detection in early childhood (Lev-Wiesel, 2005). The symptoms of DID closely resemble the symptoms of other disorders, such as, "attention deficit disorder, oppositional or conduct disorders, anxiety and panic disorders, post traumatic stress disorders, depression and suicidal ideation, and substance abuse," making the disorder difficult to diagnose (Lev-Wiesel, 2005). Unfortunately, many individuals suffering from DID spend a great deal of their time in search of relief prior to receiving an accurate diagnosis (Petersen, 2003, p. 1; Lev-Wiesel, 2005).

Nevertheless, it is important to recognize the *primary* symptoms of DID prior to discussing treatment modality. Dr. Gary Peterson (2003) of the University of South Florida outlines five of the primary dissociative symptoms that are indicative of DID. First, "inconsistent consciousness may be reflected in symptoms of fluctuating attention, such as trance states or 'black outs'" (p. 2). Second, "autobiographical forgetfulness and fluctuations in access to knowledge" may be indicative of a disruption in memory processes in early childhood development (p. 2). Third, "fluctuating moods and behavior...may reflect difficulties in self-regulation" (p. 2). Fourth, a "belief in alternate selves or imaginary friends…may reflect disorganization in the development of a cohesive self" (p. 2). And fifth, "depersonalization and derealization may reflect a subjective sense of dissociation from normal body sensation and perception" (p. 2). Peterson's model demonstrates how indications of detachment from the primary personality, and the emergence of sub personalities, contribute to a plausible diagnosis of DID.

*Treatment*

Treatment through artistic expression is one method for both therapy and assessment of DID. Lev-Wiesel (2005) conducted a study based on a technique known as the Draw-A-Person (DAP) test "to examine to what extent dissociative identity disorder is reflected in human figure drawings." In the study, Lev-Wiesel (2005) found that individuals who are diagnosed with DID "reveal their emotional states," by creating drawings that reflect the individuals' sub personalities. This is important for the therapist because it identifies the various sub personalities (that emerge in the drawings) which may be the first step towards, "establish(ing) a greater integration between" all personalities (Lev-Wiesel, 2005). The DAP is also an invaluable form of self-expression for an individual with DID because it creates an emotional and expressionistic outlet that may otherwise emerge, and switch to replace the dominant personality. Additionally, Lev-Wiesel's study demonstrates how the DAP test is beneficial for assessment of DID which, as mentioned previously, may be difficult. If an individual is issued the DAP test and their drawings reflect, "multiplicity or part of the whole body...it seems worthwhile for clinicians to further inquire (about) the client's dissociative mechanisms" (Lev-Wiesel, 2005).

It is important to note that Lev-Wiesel's study demonstrates how art therapy is merely one part of the holistic treatment and assessment of DID. To assume that an individual may be diagnosed and/or fully treated using the DAP test would be implausible and highly unsubstantial.

Dr. Peterson of the Dissociative Disorders Psychotherapy Program, has outlined a four-part model for treatment of DID. Peterson’s (2003) treatment focuses primarily on

the integration of the sub personalities with the dominant personality. In his model, the therapist should begin by assisting the individual in being made aware of the behaviors and cognitions of the sub personalities, helping them to “accept responsibility" for their actions (Peterson, 2003, p. 7). Although this may be a frustrating process, Peterson (2003) claims, "frustration...stimulates the internal awareness that leads to change" (p. 7). Second, Peterson demonstrates the importance of confronting basic conflicts. Because dissociative “switching” is a defense mechanism against negative stimuli, it is important to recognize, confront, and examine the "conflicts between internal voices, imaginary friends, or conflicting identities" (Peterson, 2003, p. 8). Once conflict is recognized, the therapist should provide integrative solutions as a step towards alleviating the need for "dissociative escape" (p. 8). Third, it is important to confront and discuss traumatic memories and previous negative experiences as a step towards integration. In my personal belief, dissociation seems to be a learned response to dealing with an overwhelming or traumatic experience. This learned response compounds over time, making dissociation a habitual and responsive behavior that occurs unconsciously to alleviate anxiety. As Peterson (2003) demonstrates, talking about the potential reasons for *why* the dissociation occurs will introduce the individual to dealing with the negative events through talk therapy, and thereby avoiding the dissociative process they have grown accustomed to. Lastly, and most importantly, Peterson recommends the promotion of autonomy to "regulate and express affects and to self-regulate state changes" (p. 8). This last part of treatment methodology is two-part. Self-monitoring promotes the idea of verbal expression of feelings and emotions as a way of proactive and conscious expression through words, not dissociation. Additionally, friends and

family should be cognizant of any physiological warning signs that the individual may display prior to dissociation. In this way, those who consistently interact with the dissociative individual may interrupt the emergence of sub personalities, helping the dominant personality remain within the present. (pp. 8-9).

*Health Insurance Coverage*

Health coverage for DID is problematic in various ways. While DID may be covered under certain PPO plans (Blue Shield, 2007), it must be diagnosed based on patient pathology in order for it to be covered by insurance (Haddock, 2001, p. 79). This poses a problem because few therapists are trained in the treatment and diagnosis of DID (Haddock, 2001, p. 80). As well, patient pathology is accessible (upon written consent) by a patient's future employer if requested (Haddock, 2001, p. 80). This may create problems for the patient, supposing that they are uneasy about having people know that they are, or have been, diagnosed with a mental health disorder. Additionally, treatment of DID requires long-term care, yet, health insurance plans such as Blue Shield PPO plans 500, 750, 1500, and 2000 only cover up to twenty sessions if the mental disorder is deemed by the therapist as, "non-severe" (Blue Shield, 2007; Haddock, 2001). As Haddock (2001) demonstrates it is best "for clients to use insurance until the coverage runs out then pay for services on their own" (p. 80). This is seemingly the best method for health coverage of DID due to the potential for the disorder to grow worse over time if not treated.

*Criticism of DID*

Despite recognition in the DSM-IV-TR as a true psychological disorder, various psychologists maintain that DID is an iatrogenic disorder (Comer, 2007, p. 210; Piper &

Merskey, 2004, p. 678). Piper and Merskey are perhaps two of the most outspoken critics of DID who, in their paper, *The Persistence of Folly,* examine how a DID diagnosis, "reify(s) the alters and thereby iatrogenically encourage(s) patients to behave as if they have multiple selves" (Piper & Merskey, 2004, p. 678). The basis of their argument looks at the vagueness of the DID diagnosis in the Diagnostic and Statistic Manual, stating how the, "diagnostic criteria allow(s) the concept of an alter personality to be defined in virtually any way imaginable" (Piper & Merskey, 2004, p. 679). It is easy to question the validity of a diagnosis of DID for the simple reason that the "the basic claims of the disorder...appear to be founded on beliefs and not on facts or logic" (p. 681). I, however, would like to argue for the importance of biological research to support the existence of DID, despite its vague definition.

While DID is considered complex and elusive to diagnose, one should not lose sight of the biological evidence that supports the existence of DID. Researchers have found that each sub personality displays involuntary physiological differences, such as, variations in autonomic nervous system activity, blood pressure levels, and allergies (as cited in Comer, 2007, p. 210). Additionally, as Muller (1998) describes, those who display the indicative symptomatology, "have frequent exacerbations of their symptoms, and they often come to the emergency room in crisis." The variance of these physiological differences across sub and dominant personalities, as well as the critical effects of DID, provides supportive evidence that neither the patient nor therapist is responsible for the imposition of multiple personalities.

*Discussion*

It is evident that Dissociative Identity Disorder is a highly complex, and troublesome disorder. An overwhelming growth in the number of diagnoses over the past 35 years (as cited in Comer, 2007, p. 209), a general lack of knowledge and understanding, and outspoken critics, such as the aforementioned Piper and Merskey, demonstrate how DID is not wholly understood, explained, and in some cases, accepted. The critical arguments raised against the disorder are understandable considering the subjectivity of the definition of DID in the DSM-IV-TR. After all, how much personal information should a person *not* be able to recall to be diagnosed with DID? Has the individual truly dissociated from the dominant personality, or are they simply responding to a negative emotion or situation in a manner that is outwardly different from their normal behaviors? Does therapist suggestion "encourage and reinforce displays of multiplicity?" (Piper & Merskey, 2004, p. 679). Questions such as these remain valid, numerous, and, for this research, unanswerable. However, what is important is the acceptance of the fact that people who have received diagnoses of DID are suffering from a disorder that has interrupted their abilities to function normally. These individuals seek relief from their psychological burdens, looking to therapists and clinicians to help them understand and comprehend their dysfunction. Is it therefore "ethically sound" to question these individuals' responsive behaviors? In my personal opinion it is not ethically sound. Contradicting the ways in which people have learned to cope with psychological or physical trauma is highly unethical.

Despite the criticism, DID remains to be an infinitely fascinating disorder to analyze and comprehend. While there is a vast amount of literature on diagnostic and

treatment modality, the full understanding of DID remains to be in constant flux. There may never be a standardized method for understanding *why* people respond to psychological trauma by dissociating from their dominant personality. Nevertheless, for a nerd like me, the evolving understanding and study of DID, and the ways in which one may be alleviated of it, continues intriguingly into the future of psychological research.

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