Dissociative Identity Disorder:

A Diagnostic Puzzle

Literature Review

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Abstract

Over the last two decades, the diagnosis of dissociative identity disorder has evoked polarized contention in both research and clinical arenas. The level of emotion elicited in the proponents and sceptics of the diagnosis appears to transcend the content of the debate. When a concern commands such potent reactions, perhaps there are underlying agendas which warrant further investigation. The present work seeks to review historical evidence, the evolving nosological criteria, an alternative dissociation construct, the etiological and epidemiological controversy, the forensic psychiatric ramifications, and the supernatural element. In the process, the writer wishes a) to demonstrate the quality and quantity of scientific investigation completed, to date, in validation of the diagnosis; b) to stress the need for a paradigm shift in the official North American nosological schema; c) and to promote future dissociation screening studies in the prison population.
Historical Evidence

Dissociative identity disorder was first granted official North American diagnostic status under the label multiple personality disorder (MPD) in the 1980 *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association) (2nd ed.). However, that was not the historical inception of MPD. Fragmentation of self is central to the Egyptian Osiris complex; the outcome of the myth is perpetuated by way of persisting child abuse through future generations. A similar focus on transformation of identity was prevalent in the North American Haida Indian tribe, years before the arrival of the first white settlers. A third illustration rests in the dissociation and trance states of circumpolar Shamanism (Ross, 1989). Fragmentation of self, transformation of identity, dissociation and trance states are components of the MPD diagnosis. Historians have, in addition, underscored the evolution from demon possession to MPD (Oesterreich, 1974; Rogo, 1987; Ross, 1989; Russell, 1981), as applied in Adityanjee, Raju & Khandelwal's 1989 examination of possession syndrome and MPD epidemiology in East India. The last century is especially prominent in the historical unfolding of MPD.

A strong team of dissociation clinical investigators, including Bernheim, Binet, Charcot, James, Janet, Jung, Freud and Prince, recorded cases of MPD, hereafter termed dissociative identity disorder (DID), between the late 19th and early 20th century (North, Ryall, Ricci & Wetzel, 1993; Ross, 1989). Their clinical and therapeutic models of dissociation, in the opinion of contemporary dissociation proponents, were flawed; Janet focused on concepts such as "mental degeneration" leading to an ultimate diagnosis of schizophrenia (Rosenbaum, 1980; Ross, 1989), Prince supported the ascendancy of one primary alter in therapy (Coons, 1980). The greatest credit for scientific theoretical constructs, clinical observation and experimental evidence of DID was awarded to Alfred Binet (Ross, 1989).

Goff and Simms (1993) disagreed with the correlation between 19th and 20th century DID case accounts. They contested that statistically significant differences exist in the mean number of
personalities, age of onset, proportion of males, and in the prevalence of childhood abuse histories across the two historically and culturally detached samples. This work was rebutted directly by Armstrong (1993), and indirectly by an extensive study of the subjects (North et al., 1993). Out of the entire 20th century collection of clinical DID accounts, the studies by Sigmund Freud generated the greatest respect.

In 1896, Freud presented a paper to the Society for Psychiatry and Neurology in Vienna (as cited in Powell & Boer, 1994). The Aetiology of Hysteria depicted the "seduction theory" in which patients, upon recalling previously forgotten events of childhood sexual abuse, suffered abreacts of traumatic effect followed by alleviation of symptoms. In his clinical diaries, Freud recorded the phenomenon of dissociation or double consciousness; he even noted an appearance of superior intelligence outside the patients' consciousness (Ross, 1989). Later Freudian theory, however, negated the trauma-driven etiology of dissociative disorders; his previous constructs were usurped by a set of ancillary metapsychological interpretations for his patients' symptoms. Freud's repudiation of the seduction theory was instrumental in the discreditation of DID (Coons, 1980; Gutowski, 1993; Kluft, 1987a; North et al., 1993; Putnam, 1989; Ross, 1989).

Despite their reciprocal disdain, Freudian and biological psychiatry have, for much of this century, enjoyed a mutually propitious homeostasis. The biologists of classical psychiatry inspired the biologically-driven mental illness model; Axis I clinical disorders of the DSM-IV (1994) testify to their success. Today, support of pure Freudian psychoanalysis is fading. Simultaneously, psychiatric and psychological validation of DID, and its primary construct of dissociation, a strategy employed for coping with severe trauma, is flourishing despite the raging dispute. Increasingly, the contribution of dissociation to the psychopathology of other Axis I and II disorders is being recognized (Bernstein & Putnam, 1986; DiTomasso & Routh, 1993). How, then, have the DSM editors rewarded the polydiagnostic DID classification?
Evolving Nosological Criteria

DID was unobtrusively introduced in the DSM-II (American Psychiatric Association, 1968, p. 40) under the division, "hysterical neurosis; dissociative type." By 1980, the disorder achieved status as a dissociative disorder in the DSM-III (American Psychiatric Association, 1980). The third edition also narrowed the diagnostic criteria for schizophrenia, possibly enhancing recognition of DID (Rosenbaum, 1980; Ross, 1989). The criteria modifications in the DSM-III-R (American Psychiatric Association, 1987) rendered that distinct personalities or personality states (otherwise known as “alters”) with separate social relationships are not necessarily present in all DID cases. Nor is there invariably a distinct differentiation of which alter personality is in control at any given time.

The DSM-IV (American Psychiatric Association, 1994) lists the following criteria:

A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

B. At least two of these identities or personality states recurrently take control of the person's behaviour.

C. Inability to recall important personal information that is too extensive to be unexplained by ordinary forgetfulness.

D. The disturbance is not due to the direct psychological effects of a substance (e.g., blackouts or chaotic behaviour during alcohol intoxication) or a general medical condition (e.g., complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

The key modification in the latest edition is the presence of amnesia. Clearly, differential diagnosis is not a pure science.
Upon receiving diagnostic status two decades ago, DID has been diagnosed by an increasing number of North American mental health care workers (Amstutz, 1992; Coons, 1994; Cozolino, 1990; Friesen, 1991, 1992; Gutowski, 1993; Kluft, 1984; Loewenstein, 1994; Putnam, 1989, 1992; Putnam & Loewenstein, 1993; Rogo, 1987; Ryder, 1992; Wells, 1990). Sceptics of DID argue for false positive diagnosis; proponents stress possible underdiagnosis. DID is as complex to assess as it is a diagnostic disorder. Perhaps a new theoretical construct is warranted.

Trauma Disorders, A New Dissociative Construct

Unfortunately many DSM disorders, of which DID is only one, are not purely biomedical illnesses; for many the natural history and prognosis remain uncertain, as do known effective treatments (Maxmen & Ward, 1994; Ross, 1989). The emotional controversy is partly fuelled by the fact that DID does not fit into the DSM-IV (1994) paradigm, nor into its hierarchical and parsimonious diagnostic constructs. A DID patient often satisfies numerous DSM-IV diagnoses; a more discerning single diagnosis which encompasses all of the symptomology is required.

Intense study of dissociation may demand a paradigm shift. Scientists and clinicians could be forced to modify the established diagnostic scheme, their comprehension of phenomenology, and their therapeutics. For example, recent work indicates that schneiderian first-rank symptoms are more common in DID than schizophrenic patients (Kluft, 1987b; Ross, 1989; Ross, Heber, Norton & Anderson, 1989; Ross, Miller, Reagor, Bjornson, Fraser & Anderson, 1990). Curiously, the schneiderian symptoms are also trauma-driven and treatable with psychotherapy (Ross, 1989). Due to the prevailing political leverage of biological psychiatry, it is imperative that DID be investigated with clinical objectivity. Experiments and observations employing reliable and valid instruments must generate scientific data. Otherwise, the debate is open to unsubstantiated contentions and highly temperament reasoning.

The maturing link between dissociative symptoms and traumatic experiences led Ross (1989) to propose an alternative diagnostic category. Under the inclusive category of trauma disorders, DID is considered the most severe and therefore supraordinate in terms of treatment focus. Time of onset further classifies disorders within this model. For example, chronic trauma with childhood onset leads to DID, acute or chronic trauma whereas trauma with adult onset may lead to a diagnosis of PTSD. This alternative is both impressive and encouraging. Authors of future DSM editions would, however, have to agree with Ross' etiological model of DID.

Etiological & Epidemiological Controversy

Most proponents envision DID as a subtype of chronic trauma disorder; they contend that such a classification is consistent with available laboratory and scientific evidence (Bliss, 1988; Coons, 1980, 1994; Friesen, 1991, 1992; Gutowski, 1993; Kluft, 1985a, North et al., 1993; Putnam, 1989; Ross, 1989, 1990, 1991; Saxe et al., 1993; Stolzenburg, 1990). The etiology helps to explain the comorbidity quandary. For example, Putnam & Loewenstein (1993) suggest that the increase in diagnosis results
from a reformulation of DID as a "chronic form of childhood-onset posttraumatic dissociative disorder."

Kemp, Gilbertson, & Torem (1988) examined the seriously abusive background shared by DID and borderline personality disorder (BPD) clients, concluding that, where multiples employ dissociation to cope, borderlines do not.

The disorder begins early in life; children as young as three have been treated for DID (Confer & Ables, 1983; Coons, 1994; Gutowski, 1993; North et al., 1993; Schaffer & Cozolino, 1992). In 1992, Kluft presented what is now commonly termed the four-factor theory of etiology. It entails a) biological capacity for dissociation; b) a history of trauma or abuse; c) specific psychological structures or contents which can be employed in the creation of alternate personalities; and d) lack of adequate nurturing or opportunities to recover from abuse.

The sceptics counter with two leading, yet related, etiological constructs. Some suggest iatrogenesis, unnaturally manufactured through misdiagnosis, suggestion and hypnosis, explains the exponential diagnostic increase (Baker, 1992; Ganaway, 1989; Merskey, 1992; Ofshe & Waters, 1993; Orne, Soskis, Dinges, Orne & Tonry, 1985; Spanos, Weekes & Bertrand, 1985; Toland, Hoffman & Lofuts, 1991). Warnings to therapists with respect to possible countertransference needs, which unwittingly contribute to the overdiagnosis of DID, have been published by at least three DID proponents (Coons, 1991; Ross, 1991; Rosik, 1995). Others propose that wilful malingering or misguided patients seeking out underwriting therapists are the culprits (Fahy, 1988; Piper, 1994a, 1994b; Sarbin, 1995; Spanos et al., 1985; Spanos, 1994; Spiegel, 1988).

Regarding iatrogenesis, Ross (1990, p. 350) responds, "There is not a single reported case of alleged, let alone confirmed, iatrogenic MPD reported in the world literature." Ross challenges the scientific reasoning behind the "pseudo-databased" work of researchers such as Harriman, Kampman, Levitt or Spanos who have claimed to artificially manufacture multiple personalities. This point elicits
discussion of hypnosis and suggestion, and the often cited 1986 simulation study of Spanos and his colleagues in which non-MPD college students displayed MPD-like symptomology following hypnotic interview treatments (Spanos, Weekes, Menary & Bertrand, 1986).

One could dedicate an entire literature review to the issue of hypnosis and the retrieval of memory (Kluft, 1985b), not to mention False Memory Syndrome. Ganaway (1989), Orne et al. (1985) and Spanos et al. (1985) contend, and I happen to agree, that DID patients are easy candidates for memory contamination at the hands of therapists. Memory contamination may be occurring on a limited basis; but, it is an error to generalise the supposition to a substantial, and ever growing, portion of the mental health community. The overgeneralised conjecture has been refuted; tests have shown that artificially created alters differ significantly in symptomology from genuine DID alters (Coons & Milstein, 1994; Kluft, 1987a; Ross, 1989, 1990). Over a century ago, Alfred Binet created alters experimentally; he concluded that they could be called out only by the persons who created them. Autohypnotic alters could, alternately, be called out by anyone (Ross, 1989). Memory retrieval is a complex subject.

Van der Kolk and his colleagues, of the Trauma Clinic at Harvard Medical School/Massachusetts General Hospital, have contributed a significant body of work in the field of traumatic memory recovery. Van der Kolk contends that traumatic memory must be differentiated from normal or explicit memory. Normal memories are organised by category in the hippocampus of the brain and later data may indeed contaminate earlier memories. With severe trauma, however, particularly when it occurs early in life, the stress of the event may overload the circuitry of the brain's limbic system, thus barring the information from reaching the hippocampus. Rather, it remains engraved in the sensorimotor processes and it is dissociated from the person's conscious awareness (Van der Hart & Witztum, 1993; van der Kolk, 1994;

Other sceptics have appropriately challenged the validity of research designs, specifically self-report procedures, and have demanded supporting corroborative evidence (Spanos et al., 1985; Tillman, Nash, & Lerner, 1994; Wakefield & Underwager, 1992). This controversy was addressed by Coons (1994) in which he contends, "this study provides documentation through collateral reports from numerous sources that the abuse actually did occur." In addition to the Minnesota Multiphasic Personality Inventory (MMPI), the last ten years has seen the design of a variety of dissociative diagnostic scales and psychometric tests to facilitate scientific collaboration.

The leading tests, with sound psychometric properties, employed in programmatic research of dissociative disorders include: a) Dissociative Experiences Scale (DES) (Bernstein & Putnam, 1986), b) the Dissociative Disorders Interview Schedule (DDIS) (Ross, Heber, Norton & Anderson, 1989), and c) the Structured Clinical Interview for DSM-III-R-Dissociative Disorders (SCID-D) (Steinberg, Rounsaville & Cichetti, 1990). Multicentred studies and reports have supported the validity and reliability of these scales (Carlson, Putnam, Ross, Torem, Coons, Dill, Loewenstein & Braun, 1993; Ellason & Ross, 1994; Frischholz, Braun, Sachs, Hopkins, Shaeffer, Lewis, Leavitt, Pasquotto & Schwartz, 1990; Hall & Steinberg, 1994; Ross, Heber et al., 1989; Ross, Miller et al., 1990; Steinberg et al., 1990, 1991).

With respect to children, Sanders & Giolas (1991) have conducted psychometric examination of dissociation related to child abuse/trauma scales; Putnam, Helmers & Trickett (1993) have focused on the development, reliability, and validity of a child dissociation scale. Psychological testing of dissociative disorders has also invoked interest (Armstrong & Loewenstein, 1990; Wagner, Allison & Wagner, 1983; Wagner & Heise, 1974).
A further argument regarding accurate prevalence rate relates to the sociocultural bias of a positive DID diagnosis. Aldridge-Morris of Britain (1989) alleges that DID is an almost exclusively North American curiosity. Perhaps the significant rift in British and American treatment of DID relates to Britain's hesitancy to adopt the DSM-III (1980) modifications of both DID and schizophrenia criteria. Merskey (1992) warns that when the diagnostic occurrence of a psychological disorder, namely DID, which is not an infectious disease, increases at such a rate; psychiatrists should consider that social effects may be the cause. This contention can be rebutted by the works of epidemiological researchers in India, New Zealand and Australia, the Netherlands, and Switzerland, respectively (Adityanjee et al., 1989; Atchinson & McFarlane, 1994; Boon & Draijer, 1993; Modestin, 1992). Historical study also refutes Merskey's caution.

Forensic Psychiatry, The DID Defence

Between 1973 and 1993, at least 18 cases employing DID as a defence have reached the public eye: two were acquitted on an insanity plea, two were found incompetent to stand trial, two verdicts were unconfirmed, and the remaining offenders were found guilty (North et al. 1993). While Bianchi, the infamous Hillside Strangler, ultimately failed diagnostic DID tests conducted by Orne and seven others, Ross (1989, p. 73) considered that "Perhaps both malingering and genuine MPD were coexistent in Bianchi." Clearly, this diagnosis, and the possible associated secondary gain courtesy of the insanity plea, is a judicial and political hot potato.

Realistically, no battery of tests can prove scientifically, beyond reasonable doubt, that a criminal is or is not multiple (Appelbaum & Greer, 1994; Saks, 1995; Watkins, 1984). Coons (1991) presented an excellent journal with guidelines to enable the clinician to discern between genuine and malingered DID in the forensic setting. In 1994, Coons & Milstein designed a study to contrast genuine DID subjects with DID simulators, and to test for the presence of symptoms characteristic of either malingering or
factitious disorder. I argue that antisocial personality disorder (ASPD) individuals, a large majority of whom are not present in the psychiatric populace due to incarceration, represent another group who warrant dissociative screening. I propose three chief grounds.

The first driving rationale behind further investigation of dissociation in an ASPD population is of an epidemiological nature. The sex ratio of DID is one male to approximately eight females (Ross, Norton et al., 1989); it is proposed that the balance of seven men are likely serving sentences resulting from their abusive tendencies (North et al., 1993; Gutowski, 1993; Kluft, 1987; Ross, 1989; van der Kolk, 1994). Waxmen & Ward (1994) state, "In psychiatric populations, multiple personality is reputed to affect four times as many women as men, but if prison populations were included, the sex differential would narrow." Second, considerable overlap in DID and ASPD symptomology is well documented (Fink, 1991; Kluft, 1987a; North et al., 1993; Ross, 1989). Third, literature indicates that a large proportion of ASPD patients have childhood histories of neglect and abuse (Benjamin, 1993; Cline, 1995; Frick & Lahey, 1992; Hodge, 1992; Lahey & Rolf, 1995; Lewis & Bucholz, 1993; Luntz, & Widom, 1994).

Specifically, Lahey & Piacentini (1988) conclude that conduct disorder, a precursor to ASPD, is clearly linked to parental psychopathology. In their 1993 work, in which over 2,500 men and women were surveyed, Lewis & Bucholz reported a strong relationship between alcoholism, antisocial behaviour and negative family histories. Hodge (1992) proposed that ASPD has its origins in PTSD as a result of childhood and sexual abuse. He conceptualised ASPD persons as suffering from an addiction to violence resulting from developmentally mediated PTSD.

Dissociation screening of the prison populace would enhance understanding of the comorbidity issue between ASPD and DID subjects. The ramifications of the DID diagnosis to forensic psychiatry are beyond description and clearly of political import. If dissociative disorders are discovered in the
prison population, alternative therapeutic applications would warrant research investigation (Modlin, 1992). Piper (1994b) and his colleagues advise that the treatment of DID is an unjustified economical burden to society. What of the price paid by individuals and mankind in general when one individual is jailed for life on a murder conviction? The writer's philosophical rhetoric leads to the last aspect of the present work.

The Supernatural Element

Prasad (1985, p. 301) eloquently introduces the supernatural element, "The concept that more than one person may exist within one body is so alien to common sense that it borders on the supernatural." I wonder if one can equally tolerate the concept of genuine, pathological evil in today's cultural milieu? Pure scientific inquiry, particularly in the field of social sciences, must acknowledge historical constancy. It is illogical to "scientifically" deny the reality of mankind's history of cruelty.

Perhaps the most fascinating facet of DID is that it has, without intention, drawn together both Christian and non-Christian scientists/therapists who are dedicated to working with, or on behalf of, DID individuals. For those in this field, and I speak from experience, the discussion of ritualistic abuse is often sadly unavoidable (Cozolino, 1990; Friesen, 1992; Gutowski, 1993; Hilgard, 1986; McCulley, 1995; Shaffer & Cozolino, 1992). This is very dangerous, for the arguments against satanic ritual abuse seem to parallel those against the veracity of DID as a diagnosis (Mulhern, 1992; Gardner, 1992; Rogers, 1992; Spanos, 1994). A number of proponents have been accused of dualistic mind sets which advocate belief in the diagnosis; evangelical Christians often fall within this category (Rosik, 1995; Ross, 1989). As a caution to overenthusiastic Christian therapists, Rosik produced an excellent paper designed to aid one in avoiding the traps which lead to this type of accusation.

Spanos (1994) boldly alleges that satanism is a myth. He described a book, Michelle Remembers, (Smith & Pazder, 1980) as "propaganda used by the evangelical Christian movement that
became increasingly prominent in many facets of American social and political life during the 1980s."

Dr. Pazder, the therapist and co-author, was not a Christian at the time of writing, and the victim was of Roman Catholic heritage. Spanos further purports that law enforcement agencies have failed to substantiate the reports of ritualistic abuse. This is clearly false (Crowley, 1974; Frattorola, 1986; Johnson, 1989; LaVey, 1969; Marron, 1988; Morgan & Zedner, 1992; Ryder, 1992). A copious quantity of evidence is available from agencies such as a) the Office of Criminal Justice Planning; b) the Los Angeles Ritual Abuse Task Force, which annually updates a Ritual Abuse handbook; or c) Minister of Supply and Services Canada, which also publishes Canada's law on child sex abuse: A handbook (Wells, 1990). Wells directly compares the signs of satanic ritualistic abuse with those of non-ritualistic sexual or physical abuse observed in victimised children. Marron (1988) stages a compelling case for the existence of ritualistic abuse in the context of Canada's most infamous trial on child abuse.

Generational cults play a major role in familial incidence of ritualistically abused DID survivors (Bryant, Kessler & Shirar, 1992; Friesen, 1991; Gutowski, 1993; McCulley; 1995; Wells, 1990). The family of origin confesses rigid, false, religious or mystical beliefs. Though the unit may present a united front to the community, it is internally fraught with conflict. Often the family is isolated from the community which creates strong resistance against intervention and/or assistance from external sources (Frattorola, 1986; Gutowski, 1993; Johnson, 1989; Wells, 1990). Generally, at least one caretaker demonstrates severe pathology and the child is subject to contradictory communications from his/her significant others during childhood (Wells, 1990).

For those who present DID as a sociocognitive phenomenon (Spanos & Burgess, 1994), Ross (1989), a non-Christian, retorts that the evolution of this disorder is not without historical explanation. He outlines a four step progression stemming from the early 1800s to our modern world a) classical demon possession, b) early transitional demon possession, c) late transitional demon possession, and d)
postdemonic demon possession (see also Kenny, 1981). In today's postdemonic demon possession civilization, Christianity no longer functions as the guiding authority of society. DID is therefore subject to scientific scrutiny. Unfortunately, science, is not immune to political or economical influence.

With regard to memory recovery and ritualistic abuse, the writer agrees that a) memories are not necessarily accurate and can be false, as components of the False Memory Syndrome camp would propose; b) cases exist in which the therapist has influenced the patient in retrieval of questionable memories of ritualistic abuse; and c) it is extremely difficult to forensically corroborate retrospective traumatic events which may have occurred over two decades ago in the patient's life. It is for the foregoing reasons that both proponents and sceptics of DID must remain rationally balanced, and be exceedingly careful not to diagnose from a partisan perspective.

Conclusion

The writer has sought to present both angles of this dispute, though each appears immersed in today's plethora of cultural doctrines. Whether debating historical, diagnostic, etiological, epidemiological, forensic or supernatural facets of this controversy, each facet tends to rest in the overarching philosophy of the debater.

As DID does not appear to be an infectious illness, it is the responsibility of the proponents to satisfy the scientific requirements of current biomedical psychiatry. If they are successful, dissociation could challenge the existing nosologies and metatheories of psychopathology. A true correlation, scientifically demonstrated, between dissociation and other Axis I and II disorders, could force a major change in the DSM-V or VI (Kihlstrom, Glisky & Angiulo, 1994; Ross, 1989; Saxe et al., 1993). Even then, if the proponents fail to meet the fashionable philosophical requirements of the day, DID may again achieve obscurity.
Having observed the destruction of self in clients dear to me, I personally hope that the scientific proponents meet the task ahead, regardless of the opposition. Perhaps there are indeed men in jail whose broken hearts and minds have been shattered by childhood abuse. If this were the case of even 1% of the prison populace, imagine the benefit to society, not to speak of the misdiagnosed ASPD convicts. It is a diagnostic puzzle worth solving.
References


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