

Dissociative Identity Disorder: A Literature Review

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Abstract

Dissociative Identity Disorder (DID) is a disorder that has a big burden in the everyday life of the patient, and it's not well-known because of the often-wrong idea portrayed by the media. To better understand this disorder, in this review we looked at four important questions. First, we looked at the prevalence of DID to have an idea of how many people have it, and we found it is not as rare as it is believed. Second, we looked at how it develops and we found three possibilities: Trauma Model, Fantasy Model, and a severe symptom of Borderline Personality Disorder. Third, we looked at the existent treatments and found that the trauma-focused psychotherapy is the preferred way of treatment, but we also found that quetiapine helps, as well as the use of relational psychoanalytic treatment. Lastly, we concluded that there is not a lot of research done in any area of DID and that is where we should focus on doing more research so we can know more about a forgotten disorder that affects the lives of so many people.

Key Words:

Dissociative identity disorder, trauma, prevalence, development, treatment

Dissociative Identity Disorder (DID) is the disruption of the identity by the presence of two or more identities, or personality states, which are present and may take control of the individual. The symptoms include a severe form of dissociation from the self, sense of agency, alterations in behavior, consciousness, memory, perception, cognition and/or sensory motor-functioning. The individual may have recurrent gaps in their memory about everyday situations, important personal information and/or traumatic events (American Psychiatric Association, 2013).

The impact of DID is significant, including distress for the individual, his or her family and friends, and

society. The outcomes may include comorbid depression, anxiety, substance abuse, self-injury, and non-epileptic seizures; not to mention that 70% of the outpatients have attempted suicides multiple times as well as self-injuries (American Psychiatric Association, 2013). Because they may not be aware of their condition, they may experience disruptions in consciousness and amnesia without realizing they may suffer from this disorder, considering DID is not well-known. There is a controversy over whether DID is a real disorder, as well as controversy over the reasons it develops.

The media has portrayed DID, but the way it is portrayed is often not accurate and it may be shown

as just a media tactic to get the attention of the public and make the story more interesting. As Robert T. Muller said (2013), fiction tends to overgeneralize and exaggerate the disorder, sending a wrong idea and concept to the public about the existence and diagnosis of it. For example, in films such as *Raising Cain* (1992), *Fight Club* (1999), and *Secret Window* (2004), the main character develops sort of an evil personality to help them fulfil their darkest desires. This is fiction; most of those who suffer from DID do not develop an “evil alter” (Muller, 2013). One of the things to consider is how help be possible to someone when the problem or the way to solve it is not available.

Considering the burden of the disorder and the inaccurate idea portrayed by the media, in this literature review we will be focusing on investigating four topics: (1) the prevalence and the existence of DID, (2) how it develops, (3) existing treatments and (4) directions for future research.

Prevalence and Existence

The question of whether DID is a true disorder has been circulating for decades. According to the American Psychiatric Association, the 12-month prevalence of DID among adults in the US is 1.5%, with 1.6% of that percentage being male and 1.4% being female. Sar, Önder, Kilincaslan, Zoroglu and Alyanak (2014) performed a study in Turkey among 116 adolescents (11-17 years) psychiatric outpatients and found out that among 73 participants, 33 (45.2%) had a dissociative disorder, 12 (16.4%) had DID and 21 (28.8%) had a dissociative disorder not otherwise specified. There another study made in Puerto Rico that showed that 4.9% of the youth were experiencing pathological dissociative symptoms; and another study in Swedish showed 2.3% of nonclinical and 50% of clinical adolescents had dissociative symptoms. These numbers suggest that DID may not be as rare or nonexistent as was previously thought, and that DID may be more prevalent in adolescents than in adults. One of the challenges in screening dissociative disorders among adolescents is the fact that it is normal for the individual around that age to suffer from an “identity crisis”. So, it will seem more prevalent in those years, but later, they may

find out that it was not actual DID and it was wrongly diagnosed.

How it develops

There is a controversy over the reasons why DID develops. One argument claims it is because of childhood trauma, such as chronic neglect or physical and/or sexual abuse, while the other argument claims DID to be fantasy based, or in other words, stimulated by high suggestibility, fantasy proneness, and sociocultural influences (Vissia et al., 2016). Yet another argument believes DID is a symptom of Borderline Personality Disorder (BPD), rather than a distinct pathology (Suetanie & Markwick, 2014).

The Trauma Model explains that DID is caused by traumatic experiences which usually happen during childhood. A healthy relationship at home as well as the way parents raise and treat their children has a big effect in the child’s life. Research shows that growing up and living in an abusive and neglectful environment interferes with the capacity to integrate, self-regulate and develop a sense of trust and safety; and in extreme cases, it affects the sense of the self. Dissociation of identity being the first route of defense the victim takes; it is called “the escape when there is no escape”, and in severe cases, victims of abuse develop DID (Baker, 2010).

Baker (2010) mentioned that DID is not a disorder of many personalities, but rather, it is a disorder of not enough of one personality. Personalities arise, because of the traumatic events in the patients’ lives, to try to help and deal with the outcome of those experiences.

To figure out if trauma is a big reason in DID development, there was a study done among delinquent adolescents with dissociative disorders and 96.8% had a history of trauma (Sa et al., 2014). Abused patients manifest symptoms such as PTSD, panic disorder, social and simple phobia, agoraphobia, major depression, and substance abuse (Ellason, Ross & Fuchs, 1996).

There have been different studies done to see if the Trauma Model is correct, and one of those studies

which helps illustrate this model was a case study conducted by Baker (2010). Baker was working with a patient named Jackie who had suffered from extreme childhood trauma, including sexual, physical and emotional abuse. Jackie created a new alter ego to deal with each of the traumatic experiences and she had convinced herself that those things never happened to her, but to her alter egos. Baker (2010) worked with her and one of her alter egos so she could come to realize that the trauma she experienced was real and that she had to understand that it happened to her.

The other model explaining the reason DID may develop is the Fantasy Model. This model refers to DID as a sociocognitive or non-trauma-related model, and says that DID is related to enactment, sleep disturbances, suggestive psychotherapy and/or sociocultural influences. One of the limitations of this model is that it has been shown in studies that healthy people can imitate some of the most obvious and well-known symptoms of DID, such as psychoform dissociation, amnesia, loss of control, and identity confusion; but fail to present the subtle and less well-known symptoms, which as mentioned in the American Psychiatric Association (2013), DID tends to be comorbid with depression, anxiety, substance abuse, self-injury, or non-epileptic seizures. Also, some of the constructs of both models can overlap. Dissociative phenomena related to trauma and dissociative phenomena related to fantasy are not separate categories; for example, traumatized individuals will use fantasy to deal with the traumatizing events and the aftermath of trauma (Vissia et al., 2016).

An example to help illustrate the Fantasy Model would be the case of Sybil. This case is about a woman with 16 personalities who could, with the help of her psychiatrist over time, start to live a normal life with the integration of her alter egos. Rieber (1999) did a study on the case about the relationship between hypnosis, false memory and DID. He concluded that Wilbur, the psychoanalyst which took care of Sybil, suggested the existence of multiple personalities to her when there were none.

These two models are the most well-known ones so to figure out which side is correct, Vissia et. al

(2016) performed a study where they compared individuals with DID, post-traumatic stress disorder (PTSD), individuals simulating DID and healthy participants. They used self-report questionnaires, where they measured trauma and fantasies variables, while dividing the participants into two groups. The participants with DID had the highest scores in the trauma measures and they were not more fantasy-prone, suggestible or generating more false memories. The evidence of this experiment supported the Trauma Model of DID and challenged the hypothesis of the Fantasy Model.

The last hypothesis of why DID develops claims that it is a severe symptom of BPD. BPD is “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity” (American Psychiatric Association, 2013, pg.663). Patients with BPD suffer from an unhealthy fear of abandonment, real or imagined, they have an unstable pattern of interpersonal relationships, and impulsivity in at least two areas that could be self-damaging, as well as other symptoms. BPD is also characterized by identity disturbance and transient, stress-related paranoid ideation or severe dissociative symptoms; thus, it is believed that DID is one of these symptoms.

There was a study done by Laddis, Dell and Korzekwa (2017) where they compared DID and BPD symptoms and mechanisms of dissociation. There were 75 patients diagnosed with DID and 100 patients diagnosed with BPD in the study. The core symptoms of DID patients (the presence of alters, identity confusion, and memory problems) and BPD patients (flashbacks, identity confusion, and memory problems) were similar but there were considered to be produced by different circumstances. Alter identities seemed to be generated most -even though not all- of the time in patients with DID, while only 24% of BPD patients manifested alter-driven dissociative experiences. The study showed that even though there are a lot of similarities between these two disorders, this does not mean that they are the same. Each one has different symptoms and characteristics which makes it its own disorder.

Existing Treatments

There had been different treatments created and tested over time. The current standard of care for DID treatment is described in the International Society for the Study of Trauma and Dissociation Treatment Guidelines for Dissociative Identity Disorder in Adults (Brand et al., 2016). In these guidelines, the DID experts recommend a tri-phasic, trauma-focused psychotherapy. “In the first stage, clinicians focus on safety issues, symptom stabilization, and establishment of a therapeutic alliance. Failure to stabilize the patient or a premature focus on a detailed exploration of traumatic memories usually results in deterioration in functioning and a diminished sense of safety. In the second stage of treatment, following the ability to regulate affect and manage their symptoms, patients begin processing, grieving, and resolving trauma. In the third and final stage of treatment, patients work to integrate their dissociative identities and become more socially engaged.” (Brand et al., 2016, pg.264).

There was a study done by Kluft (1996) where he believed the approach for DID treatment was to treat and emphasize the traumatic memories of the patients. He mentions that it is a difficult method because patients may not want to remember those traumatic moments and realize that those memories are theirs; but, with an empathic approach and the adequate therapist’s training, this approach allows the processing of the traumatic events of the patient’s life and reduces the likelihood of disruptive events and crises. The study concluded that the treatment of traumatic material with more efficiency and compassion, shows fewer possibilities of misadventure, as how it was in the past.

Apart from the trauma-based treatment, there are other possibilities shown in different studies. For example, another study worked with a 13-year-old female with a 2-year history of auditory hallucinations. The patient had a history of trauma and it was reported that in the past year, she had had losses in time continuity and emotional liability; as well as interactions with others while calling herself by different names and showing different

personalities. They worked with different medicines to see if she showed any improvement, which did not work, until they prescribed her with quetiapine. The patient showed a dramatic improvement with quetiapine, also mentioning how other studies have used quetiapine in patients who have had traumatic events. They concluded that quetiapine should be considered a useful alternative while treating DID (Perales-Blum, Ibarra-Yruegas, & Cuellar-Barboza, 2016). This is still the only study done in a DID patient using quetiapine. Some of the limitations with this study may be that it was only done once and with just one patient, that is around teenager years and may be experiencing an identity crisis instead of DID.

There is also the relational psychoanalytic process that emphasizes the safety and clarity of the treatment. The therapeutic relationship is highlighted as one of the most important aspects in the treatment process and the impact of early trauma on attachment is emphasized. They work towards the engagement and acceptance of all parts of the patient’s self, with the goal that the patients know that, in that relationship -therapist and patient- they are welcome to express themselves and tell their truth (MacIntosh, 2014). Evidence shows that “this approach of treatment assists patients in developing the capacity for affect regulation and intersubjectivity and can restore connections between dissociated self-states so that the patient becomes able to hold their own mind” (MacIntosh, 2014, pg.522). These model access alter self-states through the unconscious communication of dreams and enactments in the therapeutic relationship (MacIntosh, 2014).

There may be more treatments created in the future. There are different ways of approaches when treating DID, because it is still a disorder in “discovery”, one can say. Even though there is a standard treatment for it, each therapist may find their own preferred way to treat DID patients and it may work for them.

Directions for Future Research

As was mentioned before, DID is still not a well-known disorder, and if people do know about

it, this might be from what the media shows and they may have a mistaken idea of what exactly DID is. There is not a lot of research done either, so finding real information is currently difficult. There should be more research done about DID and that way we may not be deceived into believing something that is not a reality. Research needs to be done in the areas of DID -such as prevalence, treatments, and different aspects of the disorders- and different people from different backgrounds and ages need to be studied so we have a better understanding of what DID is and how we can help those who suffer from it.

Conclusion

DID is a disorder that burdens the life and relationships the patient diagnosed with it has. The media has portrayed a mistaken idea of what DID actually is and how it develops. The purpose of this review was to show the prevalence of DID to understand how many people have it, the reasons it may develop to know what exactly are we looking for, the existing treatments to see the modern ways of helping and treating this disorder, and the directions for future research because DID is still a mystery to most of us.

Looking at the prevalence showed that DID may not be as rare, or nonexistent, as it is thought to be. DID is usually more prevalent in adolescents than in adults; however, a limitation of these numbers is that during adolescent years, teenagers tend to suffer from a “identity crisis” and they might not have DID at all.

When we look at how it develops, we notice there are different possibilities that are claimed. The first one is the “Trauma Model” that claims DID develops because of a severe trauma, usually during childhood, and it is an escape from reality. The second model is the “Fantasy Model” that claims DID is stimulated by society, fantasy proneness and high suggestibility. The last model claims DID is a severe symptom of BPD, instead of its own separate pathology.

The existent treatments could be many, but the most used would be the trauma-focused psychotherapy.

As the name says, this way of treatment focuses on dealing with the traumatic experiences in the patients’ lives so they can later integrate their alter-egos and become aware of their own mind and persona. There was, as well, a study done which showed that quetiapine worked in the treatment of a 13-year-old female diagnosed with DID. And the other existing treatment found was the relational psychoanalytic that focuses on the relationship between the therapist and the patient. This model works towards the understanding of the patient’s life using the unconscious communication of dreams and the enactments in the therapeutic relationship.

In conclusion, we noticed that DID is not as rare as it is believed, that the reason why it develops is still in controversy but the Trauma Model is the one who is most believed to be true, that there are different treatments that can be done to help with DID, the trauma-focused psychotherapy being the preferred and most accepted way in these times. We can conclude that there is not a lot of research done about DID, because some people do not believe in the existence of DID and it is left to the side. DID affects the lives of a lot of people and it destroys relationships. We need to keep investigating to find out more about this disorder. We need to study the people who suffer from DID, test hypotheses, and take good care of the ones who are diagnosed with DID. Instead of thinking it is not real or it is not a big problem, we need to start thinking as how our lives would be if we were in the position of a DID patient. By having an empathic attitude towards DID patients and DID in general, we will reach an understanding of why it is so important to do more research and by doing more research, we will be able to provide better help to those who suffer from this disorder and DID will be understandable and recognized as something worth doing research for.

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