The Rise and Fall of Dissociative Identity Disorder

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Abstract: Dissociative identity disorder (DID), once considered rare, was frequently diagnosed during the 1980s and 1990s, after which interest declined. This is the trajectory of a medical fad. DID was based on poorly conceived theories and used potentially damaging treatment methods. The problem continues, given that the *DSM-5* includes DID and accords dissociative disorders a separate chapter in its manual.

Key Words: History of psychiatry, dissociative identity disorder, multiple personality disorder

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MULTIPLE PERSONALITY AND DISSOCIATIVE DISORDERS

At the end of the 19th century, French psychiatrist Janet (1924) coined the term *dissociation*, describing a state of mind in which parts of the personality are separated into inaccessible compartments. American psychologist Prince (1906) popularized the concept by describing a clinical case associated with multiple personalities. Fifty years later, two American psychiatrists, Thigpen and Cleckley (1954), described a similar case, which later turned into a book and a Hollywood movie, *The Three Faces of Eve*. However, although the idea of multiple personality was dramatic, it did not initially trigger an epidemic of diagnosis. That only happened after the publication of another best-selling book (also made into a movie), *Sibyl* (Schreiber, 1973), describing a patient with multiple personalities who also reported severe child abuse.

Although the diagnosis of multiple personality was long considered rare, some authors now claimed that cases are quite common in clinical settings, albeit undiagnosed, and that community prevalence could be as high as 1%, which is the same as that of schizophrenia (Ross, 1991). At around the same time, *DSM-IV* (American Psychiatric Association, 1994) gave the condition a more descriptive and less dramatic name, dissociative identity disorder (DID). The number of articles on MEDLINE concerning multiple personality or DID increased during several decades: 39, between 1970 and 1979; two hundred twelve, between 1980 and 1989; three hundred ninety-one, between 1990 and 1999; but leveling off to 179, between 2000 and 2009. Even so, critics state that they had never seen a case and that DID is an artifact of suggestive therapy techniques (Piper and Merskey, 2004a). Thus, the symptoms of DID were shaped by what therapists believed and what patients were willing to provide.

Although no formal surveys of diagnostic practices were published, most observers in the 1980s and the 1990s were impressed by a high frequency of identification of a disorder that was once uncommon (McHugh, 2008). However, most clinical and research reports about this clinical picture have come from a small number of centers, mostly in the United States, that specialize in dissociative disorders. Many of these settings offer extended and costly inpatient treatment and claim to reintegrate the various “alters” into which personality had fragmented (Putnam, 1989). However, none of these researchers have published randomized controlled trials of their treatment methods for DID.

However, there was a more profound reason for the diagnostic epidemic. The increases in diagnosis in the 1980s and the 1990s were associated with a theory that the etiology of the condition was rooted in child abuse (Kluft, 1985). Although this causal link has been challenged, DID offered a drama of trauma, followed by redemption through psychotherapy.

Whatever controversies are attached to DID, dissociation, in the form of memory lapses and depersonalization, is a common phenomenon, and the categories included in *DSM-IV-TR* (American Psychiatric Association, 2000) also describe a number of less controversial syndromes. For example, most people have the experience, when driving long distances, of being unable to remember how they got from one point to another. Some people experience transient feelings of unreality under stress. Trance states are important for transcultural psychiatry (Spiegel, 1994). However, dissociative symptoms do not necessarily constitute a disorder. Moreover, as pointed out by researchers of dissociation (Kihlstrom, 2005; Lynn et al., 2012), the idea that personality can split into alters that take on an independent existence is unproven and is generally inconsistent with research in cognitive psychology.

DID AND RECOVERED MEMORY

The key to understanding the interest in DID are its association with child abuse and the theory that memories of traumatic experience during childhood can be forgotten by being repressed or dissociated. This leads to a therapeutic intervention described by most proponents of the diagnosis, the recovery of traumatic memories.

The concepts behind the DID diagnosis have a very strong resemblance to the early theories of Sigmund Freud (Breuer and Freud, 1893). Although the idea that childhood trauma causes “hysteria” was later down-pedaled by Freud and although the data on which it was based only emerged because of suggestive therapy techniques (Borch-Jacobsen and Shamdasani, 2011), it never disappeared entirely. The concept continues to have a hold on the imagination, as shown by its frequent use as a plot device in literature and cinema. The idea that research has proven a causal attribution has sometimes been taken for granted by observers outside the scientific community, including one influential philosopher (Hacking, 1995). Moreover, the idea that dissociation is a response to traumatic experiences during childhood increased the appeal of a DID diagnosis among clinicians, patients, and the general public. Recovered memory and dissociation became a way of validating and acknowledging the long-term effects of child abuse.

Even so, the relationship between trauma and dissociation has very little evidential support (Lynn et al., 2012). The stories of childhood trauma told by patients with DID have not been verified independently and could well be fabrications (Lynn et al., 2012). This is not to say that patients with this clinical presentation do not have a form of mental disorder. However, as Shorter (1994) notes, psychopathology can take many forms, depending on cues from the social environment. Thus, the epidemic of DID affected patients who

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would probably have received different diagnoses in other places and other times.

Prospective studies of child abuse (Fergusson and Mullen, 1999) show that, although there is an increased risk for psychological symptoms, most of those affected show high levels of resilience. It remains possible that childhood trauma may be a risk factor of dissociation in some patients, but this association is mediated by the presence of comorbid conditions. For example, research on borderline personality disorder (BPD; Zweig-Frank et al., 1994) shows that a diagnosis of BPD can account for links between reported childhood trauma and scores on an index of dissociative symptoms.

Research also shows that the capacity for dissociation, as measured by self-report, is not determined entirely by an adverse environment but is a heritable trait (Jang et al., 1998). This finding suggests that dissociative symptoms would be better understood in an interactive stress-diathesis model, in which adverse experiences amplify temperamental vulnerabilities.

The second theory behind DID is that traumatic memories can be either repressed or dissociated, making these unavailable to consciousness. This concept has been ubiquitous ever since Freud and Janet proposed it. However, there is very little experimental evidence supporting it. Thus, it has proved difficult to develop an experimental paradigm demonstrating the existence of repression (Holmes, 1990). In addition, no prospective research exists to show that dissociation is consistently associated with long-term disturbances of memory (Kihlstrom, 2005).

A third conceptual idea behind DID is that psychotherapeutic methods, including hypnosis, can "recover" memories of trauma. This conclusion has been criticized on several grounds. One is that the stories that are produced in therapy are not necessarily true but are stories. Although narratives can have a healing function, these can have malignant effects when families are unfairly blamed. This is a particular problem when therapists actively and persistently probe for traumatic memories (McHugh, 2008).

The most crucial point is that the therapeutic methods developed for dissociation are based on a false theory of human memory (McNally, 2003). Many therapists, beginning with Freud, have believed that everything that happens in one's life is recorded in the brain and that memory is a kind of a tape recorder (or a video recorder) of one's whole life. Actually, people do not remember most of what happens to them, and what they do remember is a reconstructed narrative, not a recording. Memories of the past are rarely factually accurate, but people tell old stories in new ways, re-creating and reinterpreting the past in light of the present. Few can recall childhood experiences with accuracy, and hardly anyone can remember life events before the age of 3 years (McNally, 2003).

If the memories of patients diagnosed with DID are narratives, these could easily be fabrications shaped by therapists who insist that traumatic events must have happened and by patients who offer therapists what they want to hear. The use of hypnosis, and the memories it creates, is a particularly worrying element. It has long been established that hypnotic trance is, in some ways, a form of socially determined role play (Lilienfeld et al., 1999; Spanos, 1996). The clinical features of DID may depend on role playing so that patients provide memories of trauma on demand and that the number of alters has a troubling tendency to increase over time, possibly because of a wish to keep therapists interested (Piper and Merskey, 2004a).

DISSOCIATIVE DISORDERS IN *DSM* MANUALS

In *DSM-II*, dissociative disorders were described as a subtype of "hysterical neurosis." In *DSM-III*, with the demise of the terms *hysteria* and *neurosis*, dissociative disorders became a diagnostic orphan and had to be grouped separately. Ironically, doing so greatly legitimized these diagnoses. Textbooks of psychiatry usually follow the *DSM* system and therefore have to include a chapter on dissociative disorders. These chapters are given to those who have written the most about the subject, for example, experts such as David Spiegel of Stanford University, a staunch supporter of DID who has now chaired several committees for *DSM*. The definition of DID in *DSM-IV* (American Psychiatric Association, 2000) strongly reflected Spiegel's point of view.

As we have seen, interest in DID has been strongest in a few centers and has been much less prominent among general psychiatrists. To promote the construct, proponents of the DID diagnosis have tried to root its assessment in scientific methods. The Dissociative Experiences Scale (Bernstein-Carlson and Putnam, 1993) is a self-report scale that has been frequently used in research. However, this measure, which measures trait-based capacity for dissociation, cannot be used to validate a clinical diagnosis of DID. There is also a semistructured interview measure, the Structured Clinical Interview for Dissociative Disorders (Steinberg and Hall, 1997). Robert Spitzer, the editor of *DSM-III*, made the unfortunate decision to allow the developers of this instrument to use the "SCID" trademark. However, if the criterion standard is a clinical diagnosis, an interview such as this cannot confirm its validity.

Institutional psychiatry has played an important role in legitimizing DID. The longtime editor of the *American Journal of Psychiatry,* John Nemiah, was a firm supporter. Those who criticized the diagnosis and proposed eliminating the category entirely (Piper and Merskey, 2004b) have been marginalized. The editors of *DSM-5* put David Spiegel in charge of revising its chapter on dissociative disorders, and the outline of the new system has now been published (Spiegel et al., 2011). The upshot is that the most widely used system of classification continues to legitimize dissociative disorders and will do so for years to come. Those who oppose the diagnosis have to hope that the diagnosis will eventually wither from disinterest. As we will see, this is already happening. Paradoxically, what keeps DID alive is this smaller niche, allowing it to be discussed in every textbook.

THE SIBYL FRAUD

Sibyl played an important role in popularizing DID, both among clinicians and the general public. However, we now know that the story was almost a complete fraud (Reiber, 2006). The woman who Schreiber called "Sibyl" was Shirley Ardell Mason. Nathan (2011) published detailed research on her life. Mason had many years of previous treatment but had never previously presented with dissociative symptoms. Her psychiatrist, Cornelia Wilbur, encouraged multiple personalities and insisted that she must have been abused as a child. At one point, Mason told another psychiatrist (ironically, Herbert Spiegel, David's father) that she presented with multiple personalities to please Wilbur but was happy not to do so with a different clinician. Moreover, both Wilbur and Schreiber gained fame (and money) from the book, and they had an inappropriately close relationship, even living together at times. Of particular relevance to the traumatic theory of dissociation, Nathan found no documentation of the horrific tales of abuse that Mason had been encouraged to tell Wilbur. In fact, Mason came from a reasonably normal family, and, although an unusually sensitive child, she was never abused (Nathan, 2011). Transcripts of the therapy sessions with Wilbur clearly show that this narrative was imposed on Mason, who may have been willing to go along with it because her relationship with her therapist was the most important one in her life.

DID AND CHILD ABUSE

At the same time as publications about DID became more frequent in the psychiatric literature, child abuse became an issue of major concern in American society. However, legitimate concern threatened to turn into mass hysteria. Abuse of children has been

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shown to be more common than was previously believed (Finkelhor et al., 2005; Fergusson and Mullen, 1999). However, one can predict little about long-term impact. Effects on outcome are highly variable, and child abuse is only a weak risk factor for the development of adult psychopathology (Pope and Hudson, 1995).

The theory of repressed trauma (Herman, 1992), that abused children need to forget adverse experiences, was followed by a best-selling book, *The Courage to Heal*, written by two teachers turned psychotherapists (Bass and Davis, 1988). In this view, the failure to remember child abuse could be interpreted as proof that such events must have happened. Bass and Davis also presented a list of common psychological problems, each of which was claimed to be a marker of repressed trauma. All these theories fly in the face of what is known about the effect of adverse experience on memory, that is, that psychopathology is often associated with an inability to forget (Lynn et al., 2012).

The methods used to recover memories were highly unreliable (McNally, 2003). Patients who are suggestible can produce dramatic stories, including "satanic ritual abuse." It was claimed that satanic rites were occurring, and involved the killing of babies, even if no one could ever locate the corpses of these murdered infants. Thus, entirely false memories can be produced under the prompting of charismatic therapists with strong preconceptions.

The concept that repressed memories of trauma are common also led to a rash of unwarranted accusations against families, particularly accusations of childhood incest (Piper and Merskey, 2004a, 2004b). In this way, questionable therapy practices associated with a diagnosis of DID destroyed lives. The epidemic of accusation was also not confined to clinical settings. Lurid charges of sexual abuse were made against day care workers, and suggestible children were convinced to testify against them in court. Several innocent workers were convicted, and it took years to secure their release. Most of these cases were based on the testimony of suggestible children. In a well-known incident, an accused policeman became convinced that he had committed child abuse even though he could not remember having done so, leading him to plead guilty and spend several years in prison (Ofshe and Watters, 1994).

Eventually, a reaction set in. A California therapist was successfully sued by a father unjustly accused of sexually abusing his daughter (Johnston, 1997). A psychiatrist at the University of Chicago who ran a unit for the treatment of dissociative disorders was sued and lost his license (Grinfeld, 1999). A mother whose ex-husband had been accused by their daughter (who is a clinical psychologist) founded the False Memory Foundation to combat misuses of therapy to support claims of abuse based on recovering traumatic memory (McHugh, 2008).

DID AS A PSYCHIATRIC FAD

Fads are novel ideas that initially earn great attention and then disappear from view, a pattern described by Best (2006) as "emerging, surging, and purging." DID is only one of many fads that have afflicted psychiatry during the last century (Berrios and Porter, 1995; Shorter, 1997; Wallace and Gach, 2008). Among the best known in the past have been frontal lobotomy (El-Hai, 2005) and depatterning (Collins, 2002), but some fads continue to affect current psychiatric practice (Carlat, 2010).

This situation reflects the undeveloped state of science in modern psychiatry. Even today, little is known about the etiology and pathogenesis of mental disorders. That situation is unlikely to change soon, and psychiatrists, even as they help patients, need to be patient while awaiting progress in theory and practice, which could take decades to bear fruit. However, as scientifically based medicine becomes more standard, fads may have a shorter half-life.

The DID fad ultimately had its roots in the writing of Freud. Thus, it suffered from many of the same problems that have afflicted all aspects of psychoanalysis (Hale, 1995; Paris, 2005), and its proponents have made the same mistakes as Freud. The database was unreliable, clinical observations were likely to be biased, and treatment methods were untested. In summary, although DID provided a dramatic narrative, it was quite unscientific in theory and practice. It was only when patients who had been harmed by the methods used to treat it started going to court that its days were numbered.

The current decline of interest in DID reflects a level of skepticism that inevitably tends to follow faddish concepts and practices. A second factor is that the treatment recommended was never shown to be successful. One review (Brand et al., 2009) summarized a series of trials in which dissociative symptoms were reduced, but the designs were pre-post rather than randomized clinical trials. Although the conclusion that treatment involving recovered memory can be seriously harmful has not been confirmed by systematic research, the observation has been widespread (McHugh, 2008) and may underlie some of the lawsuits that did so much to bring these practices into discredit.

Ultimately, the loss of interest in DID is rooted in psychiatry's current change of paradigm. Neither the theory behind the diagnosis nor the methods of treatment are consistent with the current preference for biological theories and pharmacological interventions. Theories and methods with a close resemblance to what Freud practiced in the 19th century cannot retain popularity. Scientific criticism of these concepts has also had a strong impact. As shown by its shrinking literature, the epidemic of DID is now behind us. Only *DSM-5* has failed to notice that this diagnosis fails to meet criteria for a valid diagnosis.

DISCLOSURES

The author declares no conflict of interest.

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