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Chapter · January 2010

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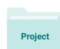

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CHAPTER 24

Dissociation and Dissociative Identity Disorder: Treatment Guidelines and Cautions

Steven Jay Lynn • Oliver Fassler • Joshua A. Knox • Scott O. Lilienfeld

WHAT IS DISSOCIATIVE IDENTITY DISORDER?

Interest in dissociation and dissociative disorders has waxed and waned from the time of Janet's (1889) landmark writings to contemporary attempts to understand dissociative phenomena in light of competing explanatory models and increasingly sophisticated experimental methods. From the eclipse of dissociation theory by early psychoanalytic theory, to the attack on dissociation by experimentalists later in the century (Rosenberg, 1959; White & Shevach, 1942), to the explosion of reports of cases of "multiple personality disorder" in the 1980's, to the ensuing skepticism regarding these reports in the 1990s and early 21st century, the study of dissociation has been permeated with conflict and controversy. Today, the most incapacitating and perplexing dissociative disorder—dissociative identity disorder (DID)—is among the most controversial of all psychiatric diagnoses. Accordingly, it is difficult for clinicians to chart a course through the welter of conflicting information on the topic and treat patients who present with vexing dissociative symptoms. Our goal is to provide a brief guide to scientifically based knowledge concerning DID by highlighting the tentative state of knowledge about this condition and the need for practitioners to appreciate the manifold sociocultural influences on the presentation of its symptoms.

According to DSM-IV [American Psychiatric Association (APA), 1994], DID is one of several dissociative disorders, all of which are marked by profound disturbances in memory, identity, consciousness, and/or perception of the external environment that "may be sudden or gradual, transient or chronic" (p. 477). Other dissociative disorders in DSM-IV include depersonalization disorder, dissociative fugue, and dissociative amnesia. According to DSM-IV, DID is characterized by the presence of two or more distinct personalities (i.e., relatively enduring pattern of perceiving, relating to, and thinking about the environment and self) or "personality states" (i.e., temporary patterns of behavior) that recurrently assume control over the individual's behavior. These alternate personalities or "alters" often exhibit psychological features that differ markedly from those of the primary or "host" personality and are identified by different names, ages, and genders. In addition, they can exhibit differences in vocabulary, general knowledge, and affect. In some cases, these features appear to be the opposite of those exhibited by the host personality. For example, if the host personality is shy and retiring, one or more alters may be outgoing or flamboyant. The number of alters has been reported to range from one (the so-called "split" personality) to hundreds or even thousands (Acocella, 1999). In general, women with DID tend to report more alters than men (APA, 1994).

Lynn, S. J., Fassler, O., Knox, J. A., & Lilienfeld, S. O. (in press). Dissociation and dissociative identity disorder: Treatment guidelines and cautions. In J. E. Fisher & W. T. O'Donohue (Eds.), Pracititioner's guide to evidence-based psychotherapy. New York: Springer.

According to DSM-IV, individuals with DID report significant episodes of amnesia for important personal information that cannot be explained by "normal forgetfulness." For example, they may report frequent periods of "lost time" lasting hours or days in which they cannot recall where they were or what they were doing. This amnesia is often reported to be asymmetrical, whereby the host personality knows little about the behaviors of the alters, but not vice-versa (APA, 1994).

Basic Facts about Dissociative Identity Disorder

Prevalence. Until recently, it was widely assumed that DID was exceedingly uncommon. Although some authors (e.g., Piper, 1997) claim that genuine DID is very rare (see also Rifkin, Ghisalbert, Dimatou, & Sethi, 1998), others (e.g., Ross, 1997) maintain that DID is at least as common (1–2%) as schizophrenia. Recent estimates of the prevalence of DID in inpatient settings range from 1–9.6% (Rifkin, Ghisalbert, Dimatou, Jin, & Sethi, 1998; Ross, Duffy, & Ellason, 2002).

Gender differences. Virtually all prevalence studies reveal a marked female predominance, with most sex ratios ranging from 3 to 1 to 9 to 1 across clinical samples (APA, 1994). This imbalanced sex ratio may be an artifact of selection and referral biases. For example, a large proportion of males with DID may end up in prisons (or other forensic settings) rather than in clinical settings (Putnam & Loewenstein, 2000).

Is dissociation dimensional or taxonic? A longstanding assumption has been that dissociation is a continuous (dimensional) attribute, ranging from nonpathological mental activities such as daydreaming, "highway hypnosis" (the experience of periods of "lost time" while driving long distances), and being absorbed in a book, to more pathological manifestations, such as DID. However, at least some recent evidence suggests that DID is taxonic; that is, categorical in nature. Several studies (Waller, Putnam, & Carlson, 1996; Waller & Ross 1997) using sophisticated statistical procedures have reported that nonpathological dissociation appears to reflect a dissociative trait (Modestin & Erni, 2004), whereas pathological dissociation can best be described as a distinct "type" or latent class (taxon) that can be identified by eight items derived from the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986). Waller and Ross (1997) estimated that the population base rate of pathological dissociation is 3.3%. Because being classified as a taxon member cannot be equated with DID (Modestin & Erni, 2004), it is likely that the prevalence of DID in the general population is much lower than 3%. Nevertheless, because Watson (2003) found that scores on the hypothesized dissociative taxon are unstable over time, further research will be needed to verify the existence of this taxon.

Malingering. Factitious disorders may account for 2–10% of inpatient dissociative disorders (Friedl & Draijer, 2000). There is widespread agreement that DID can be successfully malingered. For example, Kenneth Bianchi, one of the two Hillside Stranger murderers, is widely believed to have faked DID to escape criminal responsibility (Orne, Dinges, & Orne, 1984). Nevertheless, outside of criminal settings, cases of malingered DID are believed to be rare, and the substantial majority of individuals with this condition do not appear to be intentionally producing their symptoms.

Familial clustering. The results of several controlled studies indicate that DID co-aggregates within biological families (APA, 1994). A recent study (Waller & Ross, 1997) of 280 identical twins and 148 fraternal twins revealed that approximately 45% of the variance on a measure of pathological dissociation was attributable to shared environmental influences, with the remaining variance due to nonshared environmental influences. Adoption studies would help to further clarify the extent to which familial clustering is due to genes, shared environment, or both.

Controversies. The primary controversy surrounding DID is the question of whether DID is a socially constructed and culturally influenced condition rather than a naturally occurring response to early trauma (Merskey, 1992). Proponents of the posttraumatic model (PTM; Gleaves, 1996, Gleaves, May, & Cardena, 2001; Ross, 1997) contend that DID is a posttraumatic condition that arises from a history of severe physical and/or sexual abuse in childhood that engenders the compartmentalization of the personality as a means of coping with intense emotional pain. Advocates of the PTM cite data suggesting that perhaps 90% or more of individuals with DID report a history of severe child abuse (Gleaves, 1996).

In contrast, proponents of the sociocognitive model (SCM; Spanos, 1994, 1996; see also Aldridge-Morris, 1989; Lilienfeld et al., 1999; Lynn & Pintar, 1997; McHugh, 1993; Merskey, 1992; Sarbin, 1995) contend that DID results from inadvertent therapist cueing (e.g., suggestive questioning regarding the existence of possible alters, hypnosis), media influences (e.g., television and film portrayals of DID such as "Sybil"), and broader sociocultural expectations regarding the presumed clinical features of DID. Proponents of the SCM (Lilienfeld et al., 1999; Lilienfeld & Lynn, 2003; Merckelbach & Muris, 2001) further note that significant questions can be raised concerning the child abuse-DID link for the following reasons: (a) Many ostensible confirmations of this association derive from studies that lack objective corroboration of child abuse (e.g. Coons, Bowman, & Milstein, 1988) or are plagued with methodological shortcomings (Coons, 1994; Lewis, Yaeger, Swica, Pincus, & Lewis, 1997). (b) The reported high levels of child abuse among DID patients may be attributable to selection and referral biases common in psychiatric samples (e.g., patients who are abused are more likely to enter treatment). (c) Correlations between abuse and psychopathology tend to decrease substantially or disappear when the person's perception of family pathology is statistically controlled. (d) It has not been established that early abuse plays a causal role in DID. These considerations do not exclude an etiological role for early trauma in DID, but they suggest the need for further controlled research before strong conclusions (e.g., Gleaves, 1996; Gleaves et al., 2001) can be drawn.

Advocates of the SCM cite the following findings (Lilienfeld & Lynn, 2003; Lilienfeld et al., 1999) as consistent with the SCM or as a challenge to the PTM: (1) the number of patients with DID has increased dramatically over the past few decades (Elzinga et al., 1998); (2) the number of alters per DID individual has similarly increased over the past few decades (North, Ryall, Ricci, & Wetzel, 1993), although the number of alters at the time of initial diagnosis appears to have remained constant (Ross, Norton, & Wozney, 1989); (3) both of these increases coincide with dramatically increased therapist and public awareness of the major features of DID (Fahy, 1988); (4) mainstream treatment techniques for DID appear to reinforce patients' displays of multiplicity, reify alters as distinct personalities, and encourage patients to establish contact with presumed latent alters (Spanos, 1994, 1996); (5) many or most DID patients show few or no clear-cut signs of this condition (e.g., alters) prior to psychotherapy (Kluft, 1984); (6) The number of alters per DID individual tends to increase substantially over the course of DID-oriented psychotherapy (Piper, 1997); (7) psychotherapists who use hypnosis tend to have more DID patients in their caseloads than do psychotherapists who do not use hypnosis (Powell & Gee, 1999); (8) the majority of diagnoses of DID derive from a relatively small number of psychotherapists, many of whom are specialists in DID (Mai, 1995); (9) laboratory studies suggest that nonclinical participants who are provided with appropriate cues and prompts can reproduce many of the overt features of DID (Stafford & Lynn, 2002; Spanos, Weekes, & Bertrand, 1985); (10) until

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fairly recently diagnoses of DID were limited largely to North America, where the condition has received widespread media publicity (Spanos, 1996), although DID is now being diagnosed with considerable frequency in some countries (e.g., Holland) in which it has recently become more widely publicized; and (11) laboratory research does not support the assertion that consciousness can be separated into multiple streams by amnesic barriers to form an independently functioning alter personality (Lynn, Knox, Fassler, Lilienfeld, & Loftus, 2004).

These 11 sources of evidence do not imply that DID can typically be created in vacuo by iatrogenic or sociocultural influences. It seems likely that iatrogenic and sociocultural influences often operate on a backdrop of preexisting psychopathology, and exert their impact primarily on individuals who are seeking a causal explanation for their instability, identity problems, and impulsive and seemingly inexplicable behaviors. Some important aspects of these two models may prove commensurable. For example, early trauma might predispose individuals to develop high levels of fantasy proneness (Lynn, Rhue, & Green, 1988), absorption (Tellegen & Atkinson, 1974), or related personality traits. In turn, such traits may render individuals susceptible to the iatrogenic and cultural influences posited by the SCM, thereby increasing the likelihood that they will develop DID following exposure to suggestive influences. This and even more sophisticated etiological models of DID have yet to be subjected to direct empirical tests.

ASSESSMENT

Who Should be Ruled Out?

Borderline personality disorder. According to DSM-IV, the presence of alters, as well as other features of DID, must not be attributable to either substance (e.g., alcohol) use or a medical condition (e.g., temporal lobe epilepsy). In children, the symptoms must not attributable to imaginary playmates or other fantasy play.

[Au1]

Ross, Ellason, and Fuchs (1992) reported that their sample of DID patients qualified for an average of 8 Axis I disorders and 4.5 Axis II disorders. A substantial proportion of DID patients (i.e., a half to two-thirds; Coons et al., 1988; Horevitz & Braun, 1984) meet criteria for borderline personality disorder (BPD). Kemp, Gilbertson, and Torem (1988) reported no significant differences between BPD and DID patients on measures of personality traits, cognitive and adaptive functioning, and clinician ratings. Histories of sexual and physical abuse are also reported frequently in both patient groups, and BPD patients score well above the norms for the general population on measures of dissociation (Lauer, Black, & Keane, 1993). Lauer et al., (1993) suggested that DID is an epiphenomenon of the combination of BPD and high suggestibility.

Schizoaffective disorder and schizophrenia. Many DID patients meet criteria for schizoaffective disorder (Lauer et al., 1993). The fact that as many as half of DID patients have received a previous diagnosis of schizophrenia (Ross & Norton, 1988) is not surprising given that auditory and visual hallucinations are common in both DID and schizophrenia. DID patients have been reported to endorse even more positive symptoms (e.g., delusions, hallucinations, and suspiciousness) and Schneiderian first rank symptoms, which involve themes of passivity, than schizophrenic patients (Ellason & Ross, 1995; Steinberg, Rounsaville, & Cichetti, 1990). Ellason and Ross (1995) argued that the presence of positive symptoms can be used to formulate an accurate differential diagnosis. Whereas DID patients report that the voices they hear seem to originate inside of their heads, schizophrenic

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patients tend to perceive the origin of voices outside of their heads and possess less insight regarding the nature of their symptoms (Kluft, 1993).

PTSD. PTSD is one of the most commonly comorbid conditions with DID (Loewenstein, 1991). Moreover, PTSD patients are more likely to present with symptoms of dissociation (e.g., numbing, amnesia, flashback phenomena) than patients with major depression, schizophrenia, and schizoaffective disorder (Bremner, Steinberg, Southwick, & Charney, 1993).

What is Involved in Effective Assessment

General considerations. Given the probable importance of sociocultural influences in the presentation of DID, the practitioner should conduct a thorough assessment of the patient's exposure to information about DID conveyed by movies, books, magazines, the internet, and, often most important, previous therapists. The use of suggestive procedures (e.g., dream interpretation, guided imagery, journaling of incidents of abuse) should be noted as part of an evaluation of the demand characteristics and cues inherent in previous therapies. As with any patient, historical information regarding abuse and neglect should be obtained during the course of routine assessment. However, serious questions have been raised about the veracity of recovered memories of childhood abuse among DID patients. Thus, the credibility of reported memories should be carefully evaluated. In particular, memories that are traumatic, highly implausible, or both (e.g., satanic ritual abuse), should be corroborated if at all possible. Measures of suggestibility (Stanford Scale of Hypnotic Susceptibility; & Hilgard, 1962) and fantasy proneness (ICMI; Wilson & Barber, 1981) can also provide valuable information insofar as dissociative individuals tend to score high on measures of hypnotic suggestibility (Covino, Jimerson, Wolfe, Franko, & Frankel, 1994) and fantasy proneness (Rauschenberger & Lynn, 1995). Both attributes predispose individuals to affirmative responses to leading questions and the creation of false memories (Eisen & Lynn, 2001). [Au2]

Because of the association of DID symptoms with BPD as well as self-defeating and passive-aggressive (negativistic) personality disorders (Ellason, Ross, & Fuchs, 1995), a careful assessment of suicidality is warranted, along with an evaluation of self-mutilative behavior, which has also been linked with dissociation (Vanderhoff & Lynn, 2001).

Administer standardized measures. A comprehensive assessment of dissociative symptoms and experiences should include the administration of one or more widely used measures of dissociation. The Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986) is a 28-item screening measure. Each item is scored from 0 to 100, and although a cutoff score of 30 or above is suggestive of a dissociative disorder (Carlson, Putnam, Ross, & Torem, 1993), the DES should not be used by itself to arrive at a diagnosis. Structured interviews including the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) (Steinberg, Cicchetti, Buchanan, Hall, & Rounsaville, 1993) and the Dissociative Disorders Interview Schedule (DDIS, Ross, Heber, & Norton, 1989) can be used to formulate a diagnosis. The DDIS permits an evaluation of childhood physical and sexual abuse as well as BPD, somatization disorder, and major depression. Whereas the 131-item DDIS can typically be administered in 40 minutes, the 250-item SCID-D administration time can range from 10 to 180 minutes. However, the SCID-D affords the opportunity to rate patients' interview responses in terms of multiple dissociative symptoms (e. g., amnesia, depersonalization, identity alteration). The Clinician Administered Dissociative States Scale (Bremner et al., 1998), provides both the patient (19 items) and the therapist (8 items) with an opportunity to rate dissociative experiences (i.e., amnesia, deper-

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sonalization, and derealization). To avoid an undue emphasis on dissociative symptoms, and to glean valuable information across multiple domains of both abnormal and normal-range personality, we suggest that practitioners administer an omnibus personality measure such as the MMPI-2 or NEO-PI-R.

Conduct a functional analysis. We strongly recommend that practitioners conduct a functional analysis of the variables associated with the perception of the self as fragmented, and with the emergence of so-called alters. Questions for the practitioner to address are: (a) What thoughts, feelings, and actions are associated with the presentation of dissociative symptoms (e.g., amnesia, identity alterations)? (b) What personal and interpersonal variables are associated with the exacerbation, alleviation, and maintenance of dissociative symptoms? (c) What are the consequences and secondary gains associated with thinking of and presenting oneself as a "multiple?"

What Assessments are Not Helpful?

Assessment procedures that even subtly suggest a history of abuse or validate the manifestation of alters with separate histories (e.g., personality "system mapping" to establish contact with non-forthcoming alters, giving names to alters, prompting the emergence of alters) should be avoided. Therapists who repeatedly ask leading questions such as "Is it possible that there is another part of you with whom I haven't yet spoken?" may gradually elicit previously "latent alters" that ostensibly account for their clients' otherwise enigmatic behaviors (e.g., self-mutilation, rapid and intense mood shifts). Hypnosis has been associated with an increased risk of false memories, and should be not be used to recover ostensibly dissociated or repressed experiences. Repeated questioning about historical events is not helpful in that it can lead patients to believe that they have significant gaps (e.g., amnesia) in their autobiographical memories of childhood that they do not have (Belli, Winkielman, Read, Schwartz, & Lynn, 1998).

TREATMENT

What Treatments are Effective?

Individuals with DID are typically in treatment for an average of 6 to 7 years before being diagnosed with this condition (Gleaves, 1996). Such evidence raises the possibility that patients often develop unambiguous features of DID only after receiving unsuccessful psychotherapy. Anecdotal reports suggest that a panoply of treatments, ranging from hypnosis, to psychoanalysis, to family and couples therapy, to videotaped sodium amytal (so-called "truth serum") interviews, to cognitive-behavior therapy can be helpful in the treatment of DID (Caddy, 1985). Nevertheless, there is a dearth of systematic research on the treatment of DID, and controlled outcome studies are not available to inform recommendations regarding efficacious treatments.

What are Effective Self-Help Treatments?

To date, no self-treatment for DID is widely used or empirically supported.

Useful Websites

International Society for the Study of Dissociation: *www. issd.org*
International Society for Traumatic Stress Studies: *www.istss.org*
Society for Clinical and Experimental Hypnosis: *www.sceh.mspp.edu*
False Memory Syndrome Foundation: *www. fmsfonline.org*

What are Effective Therapist-Based Treatments?

As noted earlier, DID patients share many features with BPD patients. Accordingly, many of the tactics (e.g., cognitive-behavioral methods, mindfulness training, relaxation) found to be effective (Linehan,1993) with a borderline clientele would be expected to: (a) promote self-regulation (e.g., behavioral, affective, cognitive) and the acceptance of painful emotions in DID patients, and (b) minimize experiential avoidance, cognitive distortions, and the enactment of different "alters" to cope with conflicting emotions. We further suggest that education is essential to helping patients understand how they react to current stressors "as if" they have multiple personalities (e.g., sociocultural and suggestive influences in therapy, fantasy proneness and role enactment). However, it is imperative to underscore that dissociative and avoidant coping strategies are ineffective in the long term, and no matter how fragmented the personality seems to be, it is impossible for a person to truly possess more than "one personality" (Spiegel, 1993). For patients whose phenomenological experience of being a "multiple" is especially compelling, and who cannot be disabused of the erroneous idea that they harbor multiple personalities, images and metaphors that legitimize the "integration" of conflicting personalities (e.g., streams coming together and becoming a "strong" river) can be utilized. Kirsch and Barton (1988) suggested that when information gathering is rendered problematic by "shifting alters, "the metaphor of a "hidden observer" (i.e., "central switchboard," "executive center") can be used to obtain historical information. However, it is essential that the patient understand the metaphorical nature of this suggestion and not reify another "alter." A single "problem list" that does not confine specific issues and difficulties to discrete alters can be generated to create a viable treatment agenda. Exposure-based therapy, found to be efficacious in the treatment of posttraumatic stress disorder (Lohr, Hooke, Gist, & Tolin, 2003), along with cognitive-behavioral techniques, can be used to help patients cope with the lingering effects of traumatic experiences and dissociative symptoms that interfere with maintaining a present-centered, solution-oriented treatment focus.

What is Effective Medical Treatment?

Controlled outcome studies of the effects of pharmacological agents on DID are lacking. Accordingly, an empirical basis for medication guidelines has not been established. Pharmacological treatments generally focus on specific symptoms of dissociation and comorbid conditions, although different effects of medications have been reported across alters, and adverse effects following the use of neuroleptic medications have been reported (see Maldonaldo, Butler, & Spiegel, 2002).

Other Issues in Management

DID patients pose many of the same management problems as BPD patients. Practitioners should be prepared to set clear boundaries and limits in treatment and respond to suicidal crises, flamboyant displays of symptoms, challenges to the therapeutic alliance (e.g., "crises of trust," distortions of the practitioner's motives), and attempts to persuade the therapist of the "genuine" nature of the multiplicity and reported abuse history (e.g., "I can't work with you if you don't believe I was abused as an infant."). DID patients are likely to provoke strong and conflicting emotional reactions on the part of helpers, and attempts to challenge key aspects of the patient's presentation can be met with resistance.

How Does One Select Among Treatments?

There is no clear empirical basis for selecting among treatments. Nevertheless, we strongly recommend that practitioners avoid treatments that are suggestive in

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nature (e.g., hypnosis, journaling, guided imagery, dream interpretation), and use empirically supported methods to treat both comorbid conditions (e.g., depression, anxiety, PTSD) and symptoms within and across so-called alters.

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