Dissociative Disorders

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The *DSM-5* (American Psychiatric Association, 2013) defines the key feature of dissociative disorders as "a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior" (p. 291). *DSM-5* identifies three major dissociative disorders: (a) dissociative identity disorder (DID; formerly called multiple personality disorder); a disruption of identity characterized by two or more distinct personality states and recurrent gaps in the recall of everyday events; (b) dissociative amnesia, the inability to recall important autobiographical information, usually of a traumatic or stressful nature, inconsistent with ordinary forgetting; and (c) depersonalization/derealization disorder, with depersonalization including experiences of unreality, detachment, being an outside observer of one's thoughts, feelings, sensations or actions and derealization including experiences of unreality or detachment with respect to one's surroundings. *DSM-5* also includes a fourth category—"other specified dissociative disorder"—intended for individuals who do not meet full criteria for any dissociative disorder. Conditions in this category include those characterized by chronic and recurrent symptoms (i.e., mixed dissociative symptoms), identity disturbances due to prolonged and intense coercive persuasion, acute dissociative reactions to stressors, and dissociative trance. A fifth category in *DSM-5* is unspecified dissociative disorder, which encompasses situations in which an individual fails to meet criteria for a specific dissociative disorder and there is insufficient information available to make a more specific diagnosis. As in all *DSM-5* diagnoses, the symptoms must cause clinically significant distress or impairment and must not be attributable to drugs, medication, or another medical condition. In depersonalization/derealization disorder, the symptoms must be present for at least 1 month, an important stipulation given that approximately 50% of adults on average have experienced one or more episodes of depersonalization/derealization in their lifetimes.

The *DSM-5*'s conceptualization of dissociative disorders represents a departure from the previous edition of the diagnostic manual (*DSM-IV-TR*; American Psychiatric Association, 2000) in three important respects. First, in *DSM-IV-TR,* Dissociative Fugue (i.e., short-lived reversible amnesia for personal identity, involving unplanned travel or wandering) was listed as a separate diagnosis. In contrast, in *DSM-5*, dissociative fugue is coded as a condition that accompanies "dissociative amnesia," but no longer retains the status of a separate nosologic category.

Second, the requirement that a person diagnosed with DID must experience two or more distinct identities that recurrently take control over his or her behavior is no longer present in *DSM-5*, which replaces the term "identities" with the phrase "distinct personality states." *DSM-5* also notes that, in some cultures, shifting identity states may be described as an experience of "possession" (p. 292). Moreover, *DSM-5* now stipulates that signs and symptoms of personality alteration "may be observed by others or reported by the individual" (p. 292), apparently loosening the criterion for the definition of personality states. In cases in which alternate personality states are not witnessed, it is still possible to diagnose the disorder when there are "sudden alterations or discontinuities

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in sense of self and sense of agency … and recurrent dissociative amnesias" (p. 293). The most recent description of core symptoms of DID represents an evolution from *DSM-II* (American Psychiatric Association, 1968), which used the term "multiple personalities," through *DSM-IV*, which relabeled the condition as "Dissociative Identity Disorder" to emphasize alterations in identity, rather than fixed and/or complete "personalities," to the most current, yet still poorly defined designation of shifting "personality states" as crucial to the diagnosis.

A third departure from *DSM-IV-TR* is that depersonalization disorder is not treated as a distinct diagnosis from derealization disorder; both are now diagnosed as Depersonalization/Derealization Disorder. Aggregating these formerly separate diagnostic entities is supported by findings (Simeon, 2009) that individuals with derealization symptoms do not differ from those with depersonalization accompanied with derealization in salient respects (e.g., illness characteristics, comorbidity, demographics).

Estimates of the lifetime prevalence of dissociative disorders of any sort vary greatly, ranging from as high as 46% in inpatient settings and 18% among Turkish women in the general population, to as low as 1% among college students (see Lynn et al., 2012). Researchers have reported the lifetime prevalence of dissociative identity disorders to be as high as 14% among women in a chemical dependency unit (Ross, Kronson, Koensgen, & Barkman, 1992) and as low as 1 – 2% among general psychiatric patients and individuals in the general community (American Psychiatric Association, 2013). The rates of dissociative amnesia are also highly variable, with estimates varying from 0.2% to more than 7% (Lynn et al., 2012). The most consistent prevalence rates are reported for depersonalization/derealization disorder, typically falling in the range of 1 – 3% (Hunter, Sierra, & David, 2004). The reasons for large discrepancies in prevalence rates is not entirely clear but contributing factors may include the use of different methods to measure dissociative symptoms; differences in diagnostic base rates across psychiatric facilities; and diagnostic biases, such as differing levels of skepticism regarding dissociative disorders, across clinicians.

The prevalence of dissociative amnesia and depersonalization/derealization disorder is similar in men and women. Although DID is between three and nine times more common in adult women than men, sex differences are negligible among children in clinical settings. Moreover, compared with adult men, adult women tend to manifest more "identities" (sometimes called "alters") and more acute symptoms (e.g., hallucinations, flashbacks, amnesia) (American Psychiatric Association, 2013). Nevertheless, the imbalanced sex ratio among adults may be the byproduct of selection and referral biases, insofar as a large proportion of males with DID are incarcerated or treated in forensic rather than psychiatric settings.

Structured interviews and self-report measures, including the widely used Dissociative Experiences Scale (Bernstein & Putnam, 1986) have been developed, although they have not been used on a consistent basis in studies of the prevalence of dissociative disorders. Measures of dissociation have been validated that capture more transient dissociative state as well as trait dissociation, and measures of dissociation have been created for children as well as adults.

Dissociative disorders tend to be highly comorbid with other mental health problems. For example, comorbidity rates between DID and borderline personality disorder, major depression, and substance-use disorder have been reported to exceed 70%, and DID also co-occurs on a frequent basis with schizoaffective disorder, posttraumatic stress disorder, avoidant and obsessive-compulsive personality disorders, sleep problems, and suicidal and aggressive behaviors (Lynn et al., 2012). Depersonalization/derealization also occurs frequently in the context of other conditions, including acute stress disorder, major depression, hypochondriasis, and personality disorders (e.g., avoidant, borderline,

obsessive-compulsive), with particularly high rates of co-occurrence with panic disorder, sometimes exceeding 80% (Hunter et al., 2004). The differentiation between DID and feigned or malingered DID may pose problems in criminal courts when DID is introduced as an excuse for criminal responsibility.

Dissociative disorders are among the most controversial conditions in *DSM-5*. For example, skepticism has been expressed regarding the existence of dissociative amnesia in that, with the exceptions of those affected by substance-use disorder and dependence or brain injury, individuals who have experienced traumatic events are unlikely to forget them (Lynn et al., 2012). Indeed, victims of rape or people who experienced other highly aversive events typically do not dissociate or repress memories of those events but instead recall them all too well, as exemplified in posttraumatic stress disorder.

The most heated controversy has swirled around the genesis of DID, with two perspectives—the trauma model (TM; Dalenberg et al., 2013) and the sociocognitive mode (SCM; Lilienfeld et al., 1999; Spanos, 1994)—vying for empirical support. The TM contends that dissociation represents a defensive attempt to cope with the negative emotional repercussions of highly aversive events, such as childhood sexual abuse. The trauma model finds support in the often (but not consistently) documented association between childhood trauma and current dissociative symptoms.

The SCM, sometimes called the fantasy model of dissociation (Dalenberg et al., 2012), challenges the contention that DID is the product of trauma and rejects the classical view that people come to develop multiple "personalities" as a defense against the emotional repercussions of severe trauma such as childhood abuse. Instead, the SCM proposes that the symptoms of DID often emerge later in life, and are the products of suggestive procedures in psychotherapy (e.g., hypnosis, suggestive questions, guided imagery, repeated questions about personality "parts"), media influences (television and film portrayals), and broader sociocultural expectations regarding the link between trauma and "multiple personalities." The model also contends that dissociation overlaps with fantasy proneness and cognitive failures (e.g., absent-mindedness, poor attentional control), which increase suggestibility and vulnerability to sociocognitive influences. The SCM holds that a causal link between trauma and dissociation cannot be easily established for the following reasons: (a) the presence of comorbid pathology with dissociative symptoms renders interpretation of the link between trauma and dissociation difficult to interpret; (b) diagnoses of DID are often not made by raters blind to trauma status; and (c) in many studies, the presence of a history of traumatic events has been based on retrospective self-reports, rather than on objective data.

Proponents of the TM (Dalenberg et al., 2012), in turn, have (a) criticized the SCM as failing to provide evidence for a strong link between dissociation, fantasy, and suggestibility/false memories; (b) contended that trauma accounts for variance in dissociation beyond that predicted by fantasy proneness, but not vice versa; and (c) argued that research has provided consistent evidence for a link between trauma and dissociation, even when objective measures of trauma are used. Nevertheless, SCM theorists have criticized the methodology of these latter studies of the trauma–dissociation connection and suggested that the findings are not uniformly consistent with the TM. Relatedly, SCM theorists have pointed out that dissociative experiences can be produced by drugs such as ketamine, indicating that trauma is not a necessary precursor to dissociation, and that people diagnosed with DID do not uniformly report a history of trauma. The study of dissociation would be advanced by consideration of nontrauma pathways to dissociation and greater theoretical specification of the precise role of trauma in dissociation (i.e., is trauma a necessary cause, a sufficient cause, or merely a nonspecific risk factor for dissociation?).

Although these competing perspectives differ in important ways, the TM and SCM have evolved recently to converge in notable respects regarding the conceptualization of the origins of dissociation. For example, there is agreement that biological (e.g., genetic) vulnerabilities, developmental factors, poor social support, family environment, and psychiatric history may play a role in the emergence of dissociative experiences. Moreover, some proponents of the TM now acknowledge that individuals with DID come to mistakenly believe they are more than one person, a view entirely consistent with the SCM. Although individuals with DID may hold the subjective belief that they house separate "personalities," researchers have found little or no evidence for interidentity amnesia when objective measures of memory are employed (e.g., behavioral tests).

Some SCM theorists, in turn, have softened their position to accommodate the idea that trauma may play a nonspecific causal role in dissociation by increasing stress levels and negative emotionality, which can foster perceptions of circumstances (e.g., a terrorist attack, natural disaster) being "unreal" and dissociative reactions that are the product of imagination (e.g., viewing the self from out of the body). The SCM also acknowledges that memory fragmentation may occur following a highly aversive event, insofar as the event may not be fully encoded and may produce anxiety, cognitive failures (e.g., attentional lapses), and fantasy activity that interfere with narrative cohesion. Moreover, the SCM grants that short-term dissociative reactions may persist on a longer-term basis in certain individuals predisposed to negative emotionality, particularly in the presence of comorbid psychopathology.

Recently, researchers have proposed that disruptions in sleep may play a role in producing dissociative experiences. According to this view, stressful events may engender a labile sleep-wake cycle and unusual sleep experiences (e.g., hypnagogic hallucinations) that bring about intrusions of sleep phenomena (e.g., dreamlike experiences) into everyday life, thereby engendering or exacerbating dissociative experiences and symptoms (Watson, 2001). Van der Kloet, Merckelbach, Giesbrecht, & Lynn (2012) reviewed clinical and nonclinical studies using a variety of measures that assess sleep and dissociation. With a single exception, the 23 studies yielded correlations between measures of sleep disturbance and dissociation in the range of $r = .30 - .55$. Additionally, sleep loss induced in the laboratory intensifies dissociative symptoms, and normalizing sleep decreases dissociative symptoms (van der Kloet et al., 2012). Disruptions of the sleep-wake cycle also interfere with memory and attentional control, thereby producing the attention deficits, cognitive failures, and memory fragmentation evidenced by highly dissociative individuals and dissociative patients (Giesbrecht, Lynn, Lilienfeld, & Merckelbach, 2008). The sleep-trauma hypothesis is consistent with the possibility that sleep disturbances increase fantasy proneness, cognitive failures, and suggestibility—all of which are variables associated with the SCM. Accordingly, this model may provide a partial opportunity for integration of the TM and the SCM.

The treatment of dissociative disorders has proven to be controversial, given concerns about suggestive procedures producing iatrogenic (harmful) effects, specifically the "creation" or therapist-patient co-construction of DID in psychotherapy. Ethical constraints obviously preclude studies that examine the potential negative effects of suggestive influences in psychotherapy. Nevertheless, it is prudent that psychotherapists eschew leading questions and other suggestive interventions (e.g., hypnosis, asking if another "personality" or "personality state" is present) when probing for histories of abuse and exploring and "uncovering" possible personality states.

Trials of medication have met with little success in treating depersonalization/derealization disorder and DID, and randomized controlled trials (RCTs) comparing psychotherapeutic approaches are conspicuously absent. Brand, Classen, McNary, and Zaveri (2009) identified eight studies (none RCTs) that examined

treatment outcomes for dissociative disorders, including DID, and reported generally positive findings. Although proponents of the TM and the SCM agree that psychological treatments may reduce symptoms of dissociation, in the absence of rigorously controlled clinical trials, any changes in symptoms reported in previous studies may be due to placebo effects and other nonspecific factors, regression to the mean, and natural coping processes, rather than the specific effects of treatment. Although dissociative disorders continue to be a topic of controversy, it is becoming increasingly evident that multifactorial explanations are necessary to provide a complete account of these conditions.

SEE ALSO: Acute Stress Disorder; Depersonalization Disorder/Derealization Disorder; Posttraumatic Stress Disorder

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