Dissociative Disorders

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Glossary

Acute stress disorder A disorder that encompasses many of the symptoms or features (including dissociative symptoms) of posttraumatic stress disorder and persists from 3 days to 1 month following exposure to a traumatic event or events.
Alter personality A part of the purported dissociated personality system of an individual with dissociative identity disorder.
Comorbidity The co-occurrence of two or more pathological conditions, symptoms, or disorders; here referring to multiple psychological conditions, symptoms, or disorders, which may or may not be causally related.
Hypnagogic hallucination A vivid hallucination that occurs at or close to the onset of sleep.
Inter-identity amnesia Impairment in autobiographical memories, factual information, or experimental stimuli available to one putative personality state or identity relative to another such state or identity in which no memory impairment is present.

Introduction: Major Dissociative Disorders

Since Janet (1889) introduced the concept of dissociation, dissociative disorders have been among the most controversial diagnoses in psychology and psychiatry. It is perhaps not surprising that the dramatic and often perplexing symptoms of dissociative disorders have divided the scientific community and provided fodder for vivid and often melodramatic media depictions, as dissociative disorders are marked by a "disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior" (p. 291).

Indeed, in their most extreme presentation, dissociative symptoms are manifested as dissociative identity disorder (DID, formerly called multiple personality disorder). The most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association (APA), 2013) describes DID as characterized by (1) identity disruption, manifested in two or more distinct personality states ('alters') and (2) recurrent gaps in the recall of everyday events, important personal information, and traumatic events that are not accounted for by ordinary forgetting.

The current criteria for a diagnosis of DID represent a shift from the previous diagnostic scheme (DSM-IV-TR; APA, 2000), which required that one or more 'identities' or 'personality states' take control over one's behavior. Moreover, DSM-5 explicitly states that the alterations in personality states may be self-reported or observed by others. If alternate personality states are not observed, DID can still be diagnosed when there are "sudden alterations or discontinuities in sense of self of agency… and recurrent dissociative amnesias" (p. 293). The DSM-5 represents the most significant departure from DSM-II (DSM-II; APA, 1968), which included the descriptor "multiple personalities," a term that became indelibly associated with images of DID in the public consciousness. It is also now possible to diagnose DID when the expression of personality states arises in the cultural context of experienced possession (e.g., spirit, ghost, supernatural being, and outside person) and when the experience is recurrent, unwanted, and involuntary.

A second major dissociative disorder, dissociative amnesia, excludes the symptom of different identity states fundamental to a diagnosis of DID, and is instead associated with profound and unusual memory deficits. Amnesia may be limited to one or more specific events, or may extend to life history and identity. One poorly understood manifestation of dissociative amnesia is dissociative fugue, a reversible, often short-lived condition in which amnesia for identity or other important autobiographical information is accompanied by apparently purposeful traveling or wandering to a new location, often a new city. Although fugue was formerly a separate diagnostic entity, DSM-5 provides an option to code dissociative amnesia with or without fugue.

A third major dissociative disorder, depersonalization/derealization (DP/DR) disorder, combines into one disorder what were listed as two distinct conditions in DSM-IV-TR (APA, 2000): DP (e.g., feelings of unreality or detachment related to the self, observing the self as an outsider, absent self, distorted time sense, and emotional/physical numbing) and DR (e.g., feelings of unreality or detachment with respect to surroundings; dreamlike, foggy, lifeless, or distorted experiences of objects of people; American Psychiatric Association, 2013, p. 302). The decision to meld DP and DR was spurred by research showing that individuals with prominent DP and DR symptoms are generally comparable in terms of important characteristics regarding the course and severity of their condition, the comorbidity of symptoms with other conditions, and demographic characteristics (Simeon, 2009). Episodes of DP/DR must be persistent or recurrent to warrant a diagnosis,

as transient symptoms may be experienced by as many as 74% of individuals in the general population over the course of a lifetime (Hunter *et al.*, 2004).

As in all DSM-5 disorders, to qualify for a diagnosis, the symptoms must cause significant distress or impairment in functioning and not be attributable to substance use or another medical condition. Some dissociative symptoms produce considerable distress or impairment, yet do not necessarily meet full criteria for any of the major dissociative disorders. DSM-5 includes a category called 'other specified dissociative disorder' to acknowledge this possibility and requires that clinicians specify the reasons why symptoms fail to cross the diagnostic threshold. Cases that might fall into this category include dissociative symptoms following prolonged and intense coercive persuasion (e.g., torture and imprisonment); acute, typically short-term dissociative reactions to stressful events; discontinuities in sense of self and agency not sufficiently pronounced to meet criteria for DID; and 'dissociative trance' (i.e., loss of awareness or narrowing of immediate awareness of surroundings and accompanying unresponsiveness to stimuli). Finally, in cases such as in emergency room settings in which there is inadequate information to make a specific dissociative disorder diagnosis, or in which the clinician does not wish to designate the reason that criteria are not met for a specific disorder, there is a residual diagnostic category called 'unspecified dissociative disorder.'

Prevalence

Estimates of the prevalence of pathological dissociation or dissociative disorders vary with respect to whether a general or a clinical population is sampled and both within and among disorders. For example, Spitzer *et al.* (2006) reported a rate of 0.3% among students, whereas other researchers (Seedat *et al.*, 2003; Vanderlinden *et al.*, 1991; Waller and Ross, 1997) found that 2–3% of the general population reported either very high (pathological) dissociation test scores or qualified for a dissociative disorder diagnosis. In clinical populations, the rates of dissociative disorders range from a low of 12% among outpatients in Turkey (Şar *et al.*, 2000) to 15% of psychiatric inpatients (Saxe *et al.*, 1993) to a high of 40.9% in an inpatient setting (Ross *et al.*, 2002).

Among dissociative disorders, the most consistent estimates pertain to DP/DR disorder and typically hover around 1–3% in community and population-based surveys, with notably higher rates (16%) in inpatient samples (Hunter *et al.*, 2004). The prevalence of dissociative amnesia is lowest, yet still highly variable, with estimates ranging from 2% to more than 7% (see Lynn *et al.*, 2012a,b). DID prevalence rates also range widely, from a low of less than 1% in psychiatric inpatients (Rifkin *et al.*, 1998) and less than 1% in the general population (Akyüz *et al.*, 1999) to a high of 14% among patients in a chemical dependency unit (Ross *et al.*, 1992).

Gender differences are generally not evident across dissociative disorders, with the exception of DID, in which women are as much as nine times more likely to be diagnosed with the disorder than men, and in which more so-called alter personalities and more acute symptoms such as flashbacks and amnesia are more likely to be present in women. Discrepancies in diagnostic rates are probably attributable to the use of different (1) assessment instruments, (2) diagnostic criteria, (3) diagnostic base rates, and (4) attitudes and beliefs about dissociative disorders across settings.

Assessment and Comorbidity

Well-validated and reliable assessment instruments have been developed to evaluate dissociative experiences and symptoms and diagnose dissociative disorders. The most widely used trait measure of dissociation is the Dissociative Experiences Scale (Bernstein and Putnam, 1986). Measures of more temporary dissociative states as well as other trait measures have been validated for children and adults, and individually administered structured interviews based on established (DSM) criteria are available to diagnose dissociative disorders.

In arriving at a diagnosis, one should consider differential diagnoses, as dissociative disorders frequently co-occur with other psychological disorders and medical conditions. For example, DR/DP symptoms are often evident in schizophrenia, panic disorder, depression, posttraumatic conditions such as posttraumatic stress disorder (PTSD) and acute stress disorder, and several personality disorders (see Lynn *et al.*, 2012a,b). In dissociative amnesia, it is particularly important to rule out medical conditions, especially neurological conditions such as seizures and head injuries, which may account for significant memory impairments (DSM-5; APA, 2013). DID is highly comorbid with borderline personality disorder, substance abuse, and major depression, overlapping in as many as 70% of cases, with increased risk of dissociative disorders in cases of schizoaffective disorder, avoidant and obsessive compulsive personality disorders, posttraumatic conditions, sleep problems, and increased suicidal and aggressive behaviors (Lynn *et al.*, 2012a,b).

Controversies

The dissociative disorders have attracted considerable skepticism and controversy. Skepticism centers on the popular view that dissociative disorders are posttraumatic conditions (posttraumatic model (PTM)) that arise in response to highly aversive events, such as childhood sexual or physical abuse (Dalenberg *et al.*, 2012; Gleaves, 1996). In the most severe disorder, DID, trauma sufferers are thought to develop amnesia for key events, 'multiple personalities'/personality states, or both, in response to trauma to segregate painful feelings and thoughts and to defend against the full-blown repercussions of traumatic events. Correlations between measures of dissociation and traumatic events provide support for this position (see Dalenberg *et al.*, 2012).

Nevertheless, researchers have argued that reports of extensive amnesia are often not credible, can be accounted for by brain injury or neurological conditions, and fly in the face of evidence that memories for highly aversive events are often vivid and intrusive (as in the case of PTSD), rather than dissociated or repressed (see Bernsten and Rubin, 2013). Pope *et al.* (2007) suggested that dissociative amnesia is a contemporary culture-bound syndrome and offered a reward of

US$1000 "to the first individual who could find a case of dissociative amnesia for a traumatic event in any fictional or non-fictional work before 1800" (p. 225).

Proponents of the competing sociocognitive model (SCM; Lilienfeld *et al.*, 1999; Spanos, 1994) argue that trauma may play little or no role in the symptom presentation of DID, which is better accounted for by social and cognitive variables. According to the SCM, stage setters for DID include (1) media influences (e.g., the Academy award-winning movie *The Three Faces of Eve* and the Emmy award-winning movie *Sybil*); (2) suggestive techniques in psychotherapy (e.g., hypnosis, guided imagery, and other suggestive memory techniques; suggesting, encouraging, and prompting distinct personalities, and conversing with them); (3) high suggestibility and the tendency to fantasize and confuse imaginings with 'reality' (i.e., fantasy proneness), thereby increasing the risk of false memories of childhood abuse; and (4) cognitive failures, including poor attentional control and absentmindedness. Advocates of the SCM also point to the enormous surge of diagnosis of DID in the past 30 years following dramatic media depictions, the fact that most cases of DID are diagnosed by a relatively small number of professionals in a relatively small set of countries where the diagnosis has been popularized, research showing that complex false memories can be instantiated in a sizable minority of individuals, and studies calling into question the assumption of inter-identity amnesia in patients with DID (see Boysen and VanBergen, 2013; Lynn *et al.*, 2012a,b). Moreover, sociocognitive theorists have argued that a specific link between trauma and dissociation has not been reliably established due to (1) the substantial comorbidity between DID and other conditions, (2) the lack of consistently positive correlations when objective measures of trauma and dissociation are used and people are assessed repeatedly over time, and (3) questions regarding the assessment of dissociation and bias engendered by raters' knowledge of patients' trauma status (Lilienfeld *et al.*, 1999).

Proponents of the PTM have countered that (1) the link between suggestibility and fantasy proneness, on the one hand, and false memories, on the other, is neither consistent nor impressive; (2) trauma can predict dissociation above and beyond fantasy proneness; and (3) some longitudinal studies using objective measures provide strong evidence for an association of trauma and dissociation (Dalenberg *et al.*, 2012). Although SCM theorists have criticized the research base for these contentions, they have acknowledged that trauma may play a nonspecific role in producing dissociation, whereas PTM theorists have conceded that DID is a disorder of self-understanding, that is, a disorder in which people come to believe that they harbor multiple indwelling identities and act in accordance with this belief. Moreover, these previously competing models now concur that variables such as the family environment and genetic and biological factors need to be considered to provide a complete account of dissociative disorders.

Theorists sympathetic to the SCM have further argued that an expanded model that considers sleep disruptions may provide a partial bridge between SCM and PTM perspectives (van der Kloet *et al.*, 2012). Specifically, traumatic or stressful events may produce a labile sleep cycle and unusual sleep phenomena (e.g., hypnagogic hallucinations) that engender the intrusion of sleep-like mentation into daily life. Such mentation may in turn foster or exacerbate dissociative symptoms by increasing fantasy proneness, cognitive failures, and suggestibility. This model thus accords a potential role for both traumatic events and variables posited by the SCM in producing dissociative symptoms and is supported by research demonstrating that sleep deprivation increases dissociative symptoms (Giesbrecht *et al.*, 2007) and that a sleep hygiene program decreases dissociative symptoms (van der Kloet *et al.*, 2012).

Treatment

The PTM and SCM carry markedly different treatment implications. The PTM implies that working through or processing early traumatic experiences should play a vital role in therapy, as such experiences are presumed to lie at the heart of dissociative psychopathology. Brand and Loewenstein (2014) recently suggested that their analysis of treatment outcomes of trauma-oriented therapies shows that interacting with 'dissociated self-states' improves clinical outcomes. Still, there are indications that some patients may deteriorate with treatments that rely on recovering memories and identifying alter personalities and 'parts' (Lynn *et al.*, in press).

The SCM does not contest that certain patients present to clinicians with symptoms of DID, but it questions the genesis of such symptoms. Accordingly, the SCM implies that it is important to emphasize from the inception of therapy that patients are 'unitary' individuals who have come to see themselves as housing separate identities or personality states. Therapists inspired by the SCM would (1) not necessarily focus on past traumatic events, (2) eschew the use of suggestive techniques (e.g., 'uncovering personalities,' hypnosis), and (3) inculcate skills that promote the ability to cope with negative affect and enhance emotion regulation. Education regarding the sociocognitive origins (e.g., media influences) of symptom presentation would also be a priority.

Nevertheless, research on the effectiveness of treatment of dissociative disorders is conspicuously scant. Pharmacological approaches to treatment have not been found to be especially helpful (Somer *et al.*, 2013) and often are no more effective than a placebo. Although isolated case studies of treatment (e.g., family therapy and behavioral modification, Dollinger, 1983; psychodynamic psychotherapy) have appeared sporadically in the literature, as of 2009, only eight controlled studies evaluated treatment outcomes for DID and other dissociative disorders (Brand *et al.*, 2009). Recently, Brand *et al.* (2014) reported decreased levels of dissociation, PTSD, general distress, and depression among patients with DID and dissociative disorder not otherwise specified who were treated by community providers over the course of a 30-month treatment and follow-up.

Nevertheless, because there are no randomized controlled trials of treatments for dissociative disorders, some seemingly promising treatment gains reported to date could be attributable to regression to the mean, natural coping processes, fluctuations in the course of the disorder, demand characteristics, placebo effects, and other nonspecific factors, underscoring the pressing need for rigorously controlled

research. At present, researchers should evaluate the use of empirically supported cognitive-behavioral and mindfulness interventions in the treatment of dissociative disorders to target affect dysregulation, behavioral avoidance of distressing thoughts and images, and promote activation of adaptive behaviors in everyday life.

See also: Adult Victims of Intimate Partner Violence: Mental Health Implications and Interventions. Childhood Stress. Posttraumatic Stress Disorder. Psychotherapy. Stress

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