

From Multiple Personality Disorder to Dissociative Identity Disorder: A Clinical Overview of Diagnostic and Treatment Considerations

Karen E. Hart
PhD Student

College of Juvenile Justice and Psychology
Prairie View A&M University
Fulbright Scholar

William Allan Kritsonis, PhD
Professor

PhD Program in Educational Leadership
Prairie View A&M University
Member of the Texas A&M University System
Visiting Lecturer (2005)
Oxford Round Table
University of Oxford, Oxford, England
Distinguished Alumnus (2005)
Central Washington University
College of Education and Professional Studies

ABSTRACT

This article seeks to enlighten readers about the myriad of clinical issues surrounding the diagnosis of Multiple Personality Disorder (MPD) currently known as Dissociative Identity Disorder (DID). In addition to providing a literature review of the historical development of this complex diagnostic category, it summarizes the etiology and prevalence of the seemingly illusive disorder. Finally, the dichotomy of symptoms, heterogeneity within MPD/DID subtypes as well as potential treatment modalities will be analyzed in an effort to promote professional awareness, ensure relevant assessment practices and guide intervention strategies for this personality disorder.

Introduction

Within the annals of psychology, few personality disorders have been the target of intense scrutiny and marked skepticism as Multiple Personality Disorder (MPD) which is currently known as Dissociative Identity Disorder (DID). However, within the last thirty years, it has been met with renewed interest among clinicians and laymen alike – all determined to decipher whether the disorder’s roots were indeed iatrogenic, sociological, trauma-based or simply factitious. Although there have been definitional changes between the diagnostic criteria for MPD and DID, the two terms will be used synonymously in this paper to refer to the phenomenon in which two or more distinct personality states or identities are recurrently responsible for an individual’s behavior.

Purpose of the Article

The purpose of this article is to enlighten readers about the myriad of clinical issues surrounding the diagnosis of Multiple Personality Disorder (MPD) currently known as Dissociative Identity Disorder (DID). In addition to providing a literature review of the historical development of this complex diagnostic category, it summarizes the etiology and prevalence of the seemingly illusive disorder. Finally, the dichotomy of symptoms, heterogeneity within MPD/DID subtypes as well as potential treatment modalities will be analyzed in an effort to promote professional awareness, ensure relevant assessment practices and guide intervention strategies for this personality disorder.

Diagnostic Criteria

Despite its renaissance in the last three decades, MPD/DID is far from novel. Reports of several personalities existing in one person date back to biblical times as seen in the Gospel of Mark’s account of a Demoniac aptly named Legion (as cited in Phelps, 2000). The clinical features of MPD/DID have been noted in some form in every edition of the Diagnostic and Statistical Manual (*DSM*). It was known as *Dissociative Reaction* in the primer version of *DSM* of 1952 and as *Hysterical Neurosis, Dissociative Type* in the *DSM-II* of 1968 (Phelps, 2000).

The term *Multiple Personality Disorder* initially appeared as a separate diagnostic category in *DSM III*, but prior to this its criteria were subsumed with somnambulism, amnesia and fugue states. In that 3rd edition, the disorder was defined as “the existence within the individual of two or more distinct personalities each of which is dominant at a particular time” (American Psychiatric Association, 1980, p. 257). It was subsequently explained in *DSM – III- R 3rd edition, revised* as “the existence within the individual of two or more distinct personalities or

personality states” (American Psychiatric Association, 1987, p. 269). In *DSM IV (1994)* fourth edition, *Multiple Personality Disorder* underwent not only a change in nomenclature, but also a change in one of its essential defining features. The hallmark of this disorder was now characterized as “the presence of two or more distinct identities or personality states that recurrently take control of behavior” (American Psychiatric Association, 1994, p. 484). Since that revision, MPD has been and is currently known as Dissociative Identity Disorder (DID).

The change in this definition was substantial: the distinct personalities were no longer existent within the individual but diagnosis hinged upon behaviors being displayed in different states/identities. In *DSM-IV-TR (2000) text revision*, MPD maintains its nomenclature as DID with the following diagnostic criteria (American Psychiatric Association, 2000, p. 529):

- The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to and thinking about the environment and self)
- At least two identities or personality states recurrently take control of the person’s behavior
- Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness
- The disturbance is not due to the direct physiological effects of a substance or general medical condition.

When seen in children, these symptoms must not be attributable to imaginary playmates or other fantasy play.

In considering the true nature of MPD/DID, debate continues about whether it is a state or a trait with the pivotal question being whether the disorder is a condition of sorts or merely a problem with the client’s personality (Brenner, 1996). In an effort to bring clarity to this matter, Loewenstein (2005) concludes that MPD/DID is the result of personality development going awry as a result of severe repetitive abuse/trauma typically before the age of 5. Similarly, Kluft (2005) believes MPD/DID to be a chronic dissociative condition arising out of intense childhood trauma which occurs at a time that the individual lacks the psychological resources to cope with the event. In an effort to counteract the horrors of the trauma, the client ingeniously conjures up alternate identities and resourceful fantasies to modify a reality that is too painful or frightening to accept. Clients with MPD/DID are deemed to operate in three realities: an *actual historical reality* as best as the memory of events have been preserved; a *modified historical reality* in line with cognitive distortions, post-event influences and other contaminants; and a *reality from inner world of the alternate identities* which can be misperceived as actual events in the host’s account of reality (Kluft, 2005).

Theoretical Applications

In terms of how the traditional schools of thought conceptualized this disorder, Psychoanalytic Theory purports that MPD/DID is due to motivational behaviors stemming from

an unsatisfactory identification with the same sex parent. Behavioral Theory accounts for this disorder by various behavioral repertoires being inadvertently stamped in as learned and reinforced when displayed over time/across settings in the presence of certain stimuli. Other plausible explanations for the etiology of MPD/DID include self-contempt; self alienation; self hypnosis; neurological dysfunction and seizure related activity (Phelps, 2000).

Prevalence Rates

Aptly described by Gutheil (as cited in Kluft, 1999) as *a psychopathology of hiddenness*, MPD/DID is believed to be grossly under recognized. Ross (as cited in Phelps, 2000) estimates its prevalence among children and adults in the general population as 1%. Reportedly only 6% of these clients are overtly symptomatic and they spend an average of 6.8 years in the mental health care system under a minimum of three other diagnoses before being accurately assessed as having MPD/DID (Brenner, 1996).

There are many reasons to account for this failure to diagnose and remediate MPD/DID in a timely manner. They include a clinician's unfamiliarity with the clinical manifestations of MPD/DID; the underlying belief that it is a rare, attention seeking, malingering or a factitious disorder; or perhaps a presumption that it is an atypical presentation of some other, more common, mental disorder. Other tentative explanations are that institutions are unwilling/unable to provide the extent of treatment recommended for its successful outcome or that there is an unacknowledged fear of persons with MPD/DID due to problems associated with intervention in cases of memories of childhood abuse/trauma (Kluft, 2005). Information cited in Phelps (2000) indicates that there has been an increase in the amount of MPD/DID reported from the mid 1970s to the mid 1980s – substantially more than in the preceding two hundred years. Kluft and Foote (1999) believe that there may be some culture bound factors at work in the diagnosis of MPD/DID since the majority of the reported cases occur almost exclusively in North America.

Assessment of Symptoms

Kluft (2005) asserts that due to the subtle manifestations that characterize the majority of cases of the disorder, clinicians have a greater probability of observing symptoms and accurately diagnosing MPD/DID during a window period following either psychosocial stressors, exposure to original trauma triggers, threats to loved ones or medical events. While not empirically validated, there are twelve signs believed to be noteworthy during a preliminary investigation into the possibility of MPD/DID. They are:

- at least three prior diagnoses for psychiatric disorders in the client
- fluctuating levels of functioning in key areas of life
- psychiatric and somatic symptoms experienced concurrently

- client's distortion of time and the inability to recollect behaviors
- reports of observable changes in the client by significant others
- a history of unsuccessful treatments that should have worked given the client's diagnosis at the time
- client's inability to recognize his/her handwriting and personal possessions
- voices heard within one's head (experienced as separate entities) urging the client toward certain behaviors more than 80% of the time
- client's use of third person or 'we' during self referential speech
- a history of child abuse
- client's inability to recall events from ages 6-11
- the presence of other personalities elicited via hypnosis or a drug facilitated interview (Kluft, 2005, p. 633).

Clients with MPD/DID often present with hypnotizability as well as concomitant anxiety, affective and somatoform symptoms, and many of them exhibit features of Borderline Personality Disorder. Very often, family and friends are oblivious to the client's dissociative style of coping despite the tremendous pain, embarrassment and confusion it evokes in the client (Kluft, 2005). He went on to opine that the best approach for expeditiously and efficaciously diagnosing MPD/DID is to approach each case with neither skepticism nor enthusiasm. Rather, he admonishes clinicians to consider the possibility of MPD/DID in every client, but not to be consumed by a passion to find it in all of them. There are several standardized instruments for the diagnosis of MPD/DID, however the following are preferred by experts in this field: the Dissociation Experience Scale (DES) with a score of at least 30 being indicative of MPD/DID and Structured Clinical Interview for the Diagnosis of DSM Dissociative Disorders, Revised (SCID-D-R) where a score of at least 16 is characteristic of MPD/DID (Kluft, 2005).

Another method favored by some clinicians is posing questions to the client in order to tap into his/her mental status in six areas. They are his/her dissociative processes (i.e. behavior, linguistics, personality shifting, etc), hypnotic potential, amnesia, somatoform symptoms, posttraumatic stress and affective symptoms. Other less formal methods utilized when MPD/DID is suspected, but difficult to confirm, include having the client keep a journal for twenty to thirty minutes a day to detect changes in handwriting and linguistics, and/or prolonged interviews to elicit the switching/appearance of other personalities which tend to occur after two to three hours (Kluft, 2005).

Treatment

The cloud of mysticism and polarized opinions regarding the etiology and epidemiology of MPD/DID have done much to hinder the development of tailored treatment modalities (Kluft, 1999). The path to therapeutically blending identities in clients with MPD/DID is as varied as the clients themselves. No longer is unification of the personalities the overarching goal of treatment because by failing to acknowledge and work on problematic character traits relapse is inevitable within the unified person. Additionally, Brenner (1996) postulated that the failure of hypnosis, as

a traditional method for achieving long term psychic bonding between the alternate personalities, verifies the need for a more savvy form of treatment.

Fine (1999) underscores the fact that clients with MPD/DID are under the influence of several self-generated hypnotic realities. For this reason, there is a need for treatment modalities that will allow the client to reabsorb and reprocess life experiences. As a way of achieving this, she devised the Tactical Integration Model which is a modified cognitive therapy module. Its structured and purposive work offers MPD/DID clients the safety, predictability and consistency needed for successful intervention. The cognitive-affective distortions and dysfunctional schemata that serve as the basis for the alternate personalities are the focus of this therapy. By restructuring the thinking of the various personalities, preparation is made for the abreactive work (cathartic release) that is critical to the welding of personalities as opposed to the mere shifting of their boundaries. The hallmark of the Tactical Integration Model is that it empowers clients with MPD/DID to progressively conquer the weaknesses of pathological dissociation and to adopt less maladaptive defenses (Fine, 1999).

Treatment modalities enumerated by Kluft (1999) include *Hypnosis* to relieve anxiety and provide a safe haven to safely explore the alternate personalities, and *Mapping* which enables the therapist to become familiar with the various personalities by a visual of their clusters, layers of development and potential roles in the client's functioning. *Eye Movement Desensitization and Reprocessing (EMDR) Therapy* is another technique of choice which pairs relaxation movements of the eyes with painful recollections in order to facilitate the client's desensitization to the memory. Reports indicate that although EMDR therapy is highly effective, it should be reserved until the therapeutic alliance is well established since it can bring too much traumatized material, or too many alternate personalities, to the surface at one time (Kluft, 1999).

Creative Art Therapy has also been touted as having tremendous worth in the treatment of MPD/DID as it readily converts the paradoxes, cognitive errors and other inconsistencies of this disorder into tangible form. According to Cox and Cohen (2005), clients with MPD/DID paradoxically overcome their stymied verbal abilities and express what was repressed for years by graphically layering symbolic meanings while still being in control of the rate of disclosure. Often the artwork work depicts the client's internal political system, abreactions, chaos, fragmentation, barriers, threats, induction, trance, switching and alert states. While medication is not able to remediate the basic symptoms of MPD/DID, psychopharmacology has proven successful in alleviating certain target symptoms for many of the comorbid conditions (Loewenstein, 2005).

Concluding Remarks

In conclusion, after decades of a shadowy existence in the realm of mental health, one cannot help but become optimistic about the future diagnostic and treatment possibilities for Multiple Personality Disorder (MPD) under its current nomenclature of Dissociative Identity Disorder (DID). The goal of this article is to promote professional awareness, ensure relevant assessment practices and guide intervention strategies for this personality disorder. In light of the increasing body of knowledge and the emergence of standardized diagnostic instruments, it is

hoped that MPD/DID will no longer be marginalized by skeptics or overindulged in by headhunters. Rather it is believed that the diagnosis and treatment of this grueling personality disorder will rise in clinical priority thereby reducing the barriers to its effective and timely treatment.

References

- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders. DSM-III* (3rd ed.). Washington, DC: Author.
- American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders - Revised. DSM-III-R* (3rd ed. revised). Washington, DC: Author.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders. DSM-IV* (4th ed.). Washington, DC: Author.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders. DSM-IV-TR* (4th ed. text revision). Washington, DC: Author
- Brenner, I. (1996). The characterological basis of multiple personality. *American Journal of Psychotherapy*, 50(2), 154-166.
- Chase, T. (1987). *When rabbit howls: The troops for Truddi Chase*. New York, NY: Jove Books.
- Cox, C. T. & Cohen, B. M. (2005). The unique role of art making in the treatment of dissociative identity disorder. *Psychiatric Annals*, 35(8), 695-697.
- Fine, C. G. (1999). The tactical integration model for the treatment of dissociative identity disorder and allied dissociative disorders. *American Journal of Psychotherapy*, 53(3), 361-376.
- Kluft, R. P. (1999). An overview of the psychotherapy of dissociative identity disorder. *American Journal of Psychotherapy*, 53(3), 289-319.
- Kluft, R. P. (2005). Diagnosing dissociative identity disorder. *Psychiatric Annals*, 35(8), 633-643.
- Kluft, R. P. & Foote, B. (1999). Special section: Dissociative disorders. *American Journal of Psychotherapy*, 53(3), 283-288.
- Loewenstein, R. J. (2005). Psychopharmacologic treatments for dissociative identity disorder. *Psychiatric Annals*, 35(8), 666-673.
- Phelps, B. J. (2000). Dissociative identity disorder: The relevance of behavior analysis. *The Psychological Record*, 50(2), 235-249.