

The dissociative identity disorder diagnosis controversy



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Dissociative Identity Disorder (DID), formerly known as Multiple Personality Disorder (MPD), has been widely recognized and studied over the years. Although Dissociative Identity Disorder was officially accepted by the DSM-IV as a valid psychiatric diagnosis, intense debate about its validity is still common. There are two basic positions that dominate the controversy of DID. There are some who believe that it is a valid diagnosis. Proponents of DID argue that those who resist to diagnose their patient's with DID and fail to recognize the disorder are not well trained. While others argue that DID is not a valid psychiatric diagnosis. These people argue that DID is caused by misguided individuals who look continuously searches for the right therapist until they receive the diagnosis that they wanted. In addition to that, these people believe that DID is an iatrogenic phenomenon brought on by incompetent therapists through hypnosis and suggestions.

For those who argue that DID is a valid diagnosis they point out that the diagnosis of Dissociative Identity Disorder is extremely complex. One of the reasons that it's complex to diagnose is because of how difficult it is to differentiate from many other syndromes. In addition to that, DID can even coexist with more familiar and less controversial syndromes. In 1984, Coons stated that DID can be confused with other dissociative disorders such as psychogenic amnesia and fugue, and depersonalization disorder.

Furthermore, DID can also be confused with atypical dissociative disorder experience by those who were in prisoner or hostage situations and dissociates from the stress such as physical and emotional abuse that they endure caused by their captors. Since phobias, mood swings and conversion reactions like pseudo seizures, paralysis, and blindness are common with

anxiety, affective, and somatoform disorder they may also co-exist with multiple personality disorder. In order to obtain more evidence that a patient has DID, Coons suggested that information from external sources such as family members, friends, coworkers, and hospital staff is important. When asking these people, a clinician should ask about evidence of personality changes, persistent lying, use of third person, handwriting changes, and many others subtle signs that may provide evidence of DID (Coons, 1984). In addition to Coons, in a study conducted by Horevitz and Braun (1984), they found that DID can co-exist with borderline personality. They studied 93 patients with “ confirmed” diagnoses of DID. During the study they were only to evaluate 33 of the 93 cases. They found that 23 of the 33 or 70% of their sample also qualified for the diagnosis of borderline personality (Horevitz & Braun 1984). Similar to the studies conducted by Horevitz and Braun, and Coons, Clary, Burstin, and Carpenter concluded that DID has a lot in common with borderline personality. They drew their conclusions from 11 patients who were poor and referred through public agencies and women’s shelter. On their study, Clary et al. noted the difference between their findings and Richard Kluft’s (1982) findings. Kluft found borderline characteristics in only 22. 8% of his 70 subjects. 45% of them were described as “ neurotic mixtures” and 32% were described as “ hysterical-depressive.” Clary et al. assumed that their results were different from Kluft because Kluft’s patients were from a private psychoanalytic practice. Because of this, their functioning is better because of the demands intensive psychoanalytic psychotherapy entails (Clary, Burstin, & Carpenter, 1984).

Proponents of DID like Carol North, Jo-Ellyn Ryall, Daniel Ricci, and Richard Wetzel point out documented physiologic differences between personalities of patients with DID. These claims were then supported by the argument that these symptoms could not be replicated by normal people or professional actors. This is because, there are distinctive patterns among the different personalities that a patient with DID has. These differences can be detected through the “ positron emission tomography (PET) scans, evoked potentials, voice prints, visual acuity, eye muscle balance, visual field size, galvanic skin response, electroencephalographic patterns, electromyography, and cerebral blood flow (North et al., 1993, pg. 29).”

Proponents argue that DID patients are quiet, unassuming, and shy individuals who do not seek public attention. According to Kluft (1985), DID patients try to disguise their conditions because they are worried about the reactions that they’re going to get from reluctant therapists. In different studies conducted by Kluft, he found multiple times the reluctance that DID patients feel when seeing a therapist. In one of his studies, he found that only 40% of patients with DID showed subtle hints of the disorder while 40% showed no overt signs at all. In that study he found that the diagnosis of DID was an inverse relationship to how clear the symptoms were in the patient. During this study he also found that multiples who enter treatment do because of affective, psychotic-like, or somatoform symptoms as opposed to classical DID symptoms. Since the presentation of the disorder is often subtle, Kluft points out that it is important for clinicians to work very hard to elicit a history compatible with DID. Similar to Coons, Kluft specifically mentioned that it’s important for clinicians to use indirect inquiries for

patients who show the symptoms of DID (Kluft, 1984). In 1986 he found that 50% of DID patients withheld evidence of DID during their first assessment, and 90% said that at one point in their lives they tried to hide the manifestations of DID. Kluft also found that there are some cases where the symptoms of DID are not voluntarily provided to the therapist because patients are unaware that they have the disorder (Kluft, 1986). In spite of a lack of consensus that DID is a valid psychiatric disorder, proponents of DID, like Kluft, have divided DID into subtypes. Later Kluft (1991) described the typology of DID presentation that includes the following types: “ Classic MPD, latent MPD, posttraumatic MPD, extremely complex or fragmented MPD, Epochal or sequential MPD, isomorphic MPD, coconscious MPD, possessioniform MPD, reincarnation/mediumistic MPD, atypical MPD, secret MPD, ostensible imaginary companionship MPD, covert MPD, phenocopy MPD, somatoform MPD, Orphan symptom MPD, switch-dominated MPD, ad hoc MPD, modular MPD, quasi-roleplaying MPD, and pseudo-false positive MPD (North et. al, 1993, pg. 30).”

Another person who believes that DID is a valid psychiatric disorder is Brad Foote. Foote (1999) wrote a paper that features why DID can easily be mistaken for hysterical phenomena. One of the main critiques that other people have is that DID does not occur “ naturally.” Instead, its symptoms are a modern version of “ hysteria.” In this view, many believe that patients may create or report dissociative symptoms both intentionally and unintentionally in order to assume the sick role. Opponents believe that this sick role is advantageous because of the attention that they get from friends, family, and their therapist. In addition to that, some proponents believe that

the therapist has a big influence on the patient's pathology and thus contributes to this phenomenon. According to this view, patients did not have any symptoms of DID present prior to seeing a therapist. On the other hand, those who treat DID patients argue that: " 1. There is a naturally occurring presentation of DID, prior to therapist suggestions; 2. Patients do not embrace the DID diagnosis willingly, and in fact usually fight at least as hard to reject as, for extremely ego-dystonic; 3. DID symptoms do not disappear when ignored; and 4. The disorder actually begins in childhood, in the context of overwhelming trauma, and there could not possibly be caused by the adult therapist together with the patient (Foote, 1999, pg. 321)."

Foote describes that for a typical DID patient, powerlessness takes place in a severe level. He states that it is common for a DID patient to have a long history of abuse, usually including sexual abuse. When it comes to diagnosing DID, Foote explains a situation in which a typical DID patient will find herself in. If the therapist's bias that the DID patient is creating her symptoms to seek attention, this bias will only be confirmed by all of the drama and attention that the patient will have. Whether or not the patient does anything dramatic depends on the therapist. Subsequently, if the patient is talking to a skeptical listener, the patient will feel powerless and will cause her to give up, or become hysterical and desperate in her communications in order to explain to her therapist her symptoms.

Furthermore, if the therapist has a strong bias that " switching" from one personality to another is feigned, there are no data that could falsify this statement. If the patient's switch is subtle the observer would think that there is no big deal and it doesn't seem like the patient has a different

personality. Similarly, if the patient has a dramatic switch the therapist
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would believe that her actions are exaggerated and obviously unreal. With this said, however, Foote wanted to clarify that DID diagnosis is not immune from factitious presentations for the purpose of attention-seeking. However, skepticism can become a barrier to the possibility of the diagnosis to be perceived. To conclude, Foote wanted to point out that first, DID by its nature is unavoidably dramatic and that this causes clinicians to be unconvinced before they have ever seen a DID patient. Because of this, he encourages clinicians to be open-minded and be aware of how complicated DID can be. He believes that if a clinician takes their time to patiently immerse him/herself in the world of DID, they will discover the possibilities of DID that are not readily available superficially. Second, Foote points out that it's important for clinicians to, " Hopefully, we can call upon our own internal resources of calmness and confidence that if a story is true it will ultimately be heard, and proceed to communicate accordingly (pg. 342)."

According to Frank Putnam (1996), There are three basic criticism when it comes to the validity of DID. The first one is that DID is an iatrogenic disorder caused by the psychiatrist. Second, critics say that DID is produced by the media. Finally, critics say that DID case numbers are increasing exponentially over the years. For the first argument on DID being caused by a psychiatrist, Putnam points out that there are at least two clinical studies that have shown that there are no distinct differences between those who are diagnosed with DID and was treated with or without hypnosis. Also, many patients who have never been treated using hypnosis was diagnosed with DID. This shows that the accusation that the misuse of hypnosis is responsible for the disorder is not accurate. Second, by looking at decade's

worth of research on the media effects on behavior, Putnam says that it is clear that exposure to specific media is not a sure cause of a certain behavior. He points out that the portrayal of violence in the media is more common than the depiction of DID. Yet, critics say that the small amount DID portrayals in the media is significantly responsible for the increase in diagnosed cases. Finally regarding DID cases increasing exponentially; Putnam says that it's common for critics to inflate their numbers without any evidence supporting their figures. According to him, after plotting the numbers of published cases of DID he found that they have increased but not as dramatic as critics make it sound. In fact, over the same period of time other disorders such as Lyme disease, obsessive-compulsive disorder, and chronic fatigue syndrome have shown an equal or faster increase in published cases compared to DID. These results reflect the results of basic advancement in the medical field. Disorders increase in published cases may be due to the new discoveries of symptoms that used to be unrelated. As new symptoms are found to be related to certain disorders, the more the physicians can identify the condition. Ultimately, Putnam believes that DID meets the standards of " content validity criterion, criterion-related validity, and construct validity considered necessary for the validity of a psychiatric diagnosis (pg. 263)."

One of the controversial topics about DID and its diagnosis is that hypnosis elicit DID. Richard Kluft, a Clinical of Professor of Psychiatry in Temple University School of Medicine believes that hypnosis or suggestion may be the reason some patients have alternate personalities. However, he believes that iatrogenesis or hypnosis do not explain DID. While Putnam (1986) did

not detect and differences in clinical presentation, symptoms, or past history between patients who were hypnotized and those who weren't. Furthermore, Ross et al. (1989) conducted a study where they studied 236 patients who were diagnosed with DID. They found that only a third of these patients had been hypnotized prior to being actually diagnosed with DID. In addition to this study, Ross conducted another study where he compared DID patients of psychiatrists who specialize in DID and patients of psychiatrists who did not specialize in this disorder. They concluded that DID is not iatrogenic. The idea of iatrogenesis has been continuously disputed. The study that Ross et al. (1989) found compelling evidence that shows that DID is a genuine disorder with consistent core features with compelling evidence.

Nicholas Spanos, a Professor of Psychology at Ottawa's Carleton University conducted two experiments which explore DID. He argues that DID patients are not passive victims. Instead, they are patients who do things to purposefully be diagnosed with the disorder. He also argued that therapists assist these patients achieve their goals. The therapists provide encouragement, information, and validation for the different identities. For his first experiment in 1984, he had forty-eight undergraduate volunteers as his subjects. They were asked to role-play an accused multiple murderer named Henry or Betty whose lawyer decided to enter a not guilty plea. They were told that a "psychiatrist" would interview them and might even use hypnosis. If hypnosis was used they were asked to also role-play being hypnotized. The subjects were not told anything about DID. There were three possible conditions that eight men and eight women were randomly assigned to. In the first condition, the subjects were asked if they felt the same thing as

Harry or Betty or if they felt any different. In the second condition, subjects were told that they had complex personalities but hypnosis would allow the therapist to get behind the “ wall” that hid their inner thoughts from awareness. Furthermore, the hypnotist would be able to talk to their other personality under hypnosis. In the third, which was the control group, subjects were told that personality was complex and included walled-off thoughts and feelings. Spanos also administered a five-item sentence completion and a differential test to all subjects (it included all their different roles, where a second personality was enacted). After the “ psychiatrist” told the subjects their personality, they asked the same four questions to each subject. The responses were rated by judges who didn’t know the subject’s treatment groups. The results showed that 81% of the subjects who were asked if they felt the same thing as Harry or Betty or are they different and 31% of subjects in hidden-part treatment adopted a new name. 70% of those subjects who adopted a new name had two different identities. 63% of subjects in the hypnotic treatments displayed spontaneous amnesia. While, none of the control subjects used a different name or had amnesia. In his discussion Spanos makes four points. First, only the subjects who were hypnotized used another name, reported two different identities, and amnesia. Second, all but one subject who had multiple personalities admitted guilt on the second administration. Those who had no multiple personalities continuously denied guilt. Third, Spanos points out how easy it is to fake multiple personality even without the knowledge of DID. Finally, Spanos points out that multiple typically show contrasting personalities. Spanos believes that the amnesia of his subjects was a strategic way to

control the subject's ability to recall a memory in response to the situation at hand (Spanos 1984).

Another point that opponents want to make is that DID is well suited for providing patients a way to avoid being responsible for their actions. Kluft (1985) described some DID patients who value their disorder. In hospital wards, other patients complain that DID patients avoid accountability and responsibility. DID may also be accounted for the failures that a person with DID wants to avoid facing. DID patients use this disorder as an excuse for their difficulties or failures to explain why they were in the situation that they were in. According to Bliss, another way that DID can be beneficial to others is that it shows an outlet to express behaviors that are deemed unacceptable, such as sexual behaviors, physical aggressions, or substance abuse. An alternate personality may abuse substances or rape, while the host personality would never do such a thing. This fits the descriptions that alternate personalities are usually irresponsible and likes to act out with the host personality as proper. Alternate personalities are also created to manage unpleasant emotions that the patient wants to avoid. Specific emotions are assigned to a personality as a way to avoid having to acknowledge strong or painful emotions. (Kluft, 1985).

Since the case of Eve Black became famous Thigpen and Cleckley wrote a paper where they showed concern for the " epidemic" of DID cases. There were thousands of patients who travelled thousands of miles to see different therapists until they received the diagnosis that they wanted. Not only that, but they go through great lengths such as talking on the phone in different voices, sending photographs of different " selves," and writing letters with <https://assignbuster.com/the-dissociative-identity-disorder-diagnosis-controversy/>

different handwritings for every paragraph. When it comes to these people, these desperate actions would not stop until they were diagnosed with DID. Another category of patients wrongly diagnoses with DID were attention-seeking hysterics who are affected by the labeling process. While, the last category that they described are groups of individuals who aren't satisfied with their self-concept so they use dissociation to allow the unacceptable aspects of their personalities to be expressed (Thigpen & Cleckley, 1984).

Proponents of DID assert that DID is a genuine disorder that has a valid diagnosis, whereas skeptics argue that DID is an iatrogenic or faked condition. These two different arguments may both be persuasive but neither of them does not answer the question of the validity of DID. It is important to evaluate these arguments to determine the extent of the diagnosis of DID. Current knowledge of the clinical phenomenology of DID cannot be considered as either proof or disproof that DID is a valid diagnostic entity. Kluft calls for " active research rather than fruitless debate (pg. 3)." Future studies on DID will have many opportunities to address the challenges that both proponents and opponents of DID diagnosis validity pose.