

1999

Dissociative Identity Disorder - in Benner & Hill's "Baker's Encyclopedia of Psychology & Counseling"

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Recommended Citation

McMin, Mark R., "Dissociative Identity Disorder - in Benner & Hill's "Baker's Encyclopedia of Psychology & Counseling"" (1999).
Faculty Publications - Grad School of Clinical Psychology. Paper 210.
http://digitalcommons.georgefox.edu/gscp_fac/210

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experience to protect oneself from painful memories or events. Minor forms of dissociation such as daydreaming are considered normal and common, but more severe forms such as DID are considered to be psychiatric disorders. Those with DID compartmentalize their experiences and coping responses into separate personality states, referred to as alter personalities. Although DID can cause social and occupational deficits, it is also important to recognize the dissociative defenses of DID as adaptive (Ludwig, 1983). Dissociation is often the psychological tool used to survive traumatic and horrifying childhood events.

Although the phenomenon of dissociation can be traced back as far as 400 B.C., contemporary discussions of dissociation and multiple personalities originated with Pierre Janet, Morton Prince, and William James in the late 1800s and early 1900s. The splitting of self into alter personalities was studied in the laboratory, although without adequate experimental conditions and controls, and was commonly discussed among those interested in mental health until the 1930s. As behaviorism and psychoanalysis gained momentum, and as the diagnosis of schizophrenia increased, discussions of dissociation and reported cases of multiple personality disorder almost disappeared from the scientific literature. In recent years, as cognitive explanations for psychopathology have again become more prevalent, interest in dissociative phenomena has been renewed. Multiple personality disorder was renamed dissociative identity disorder with the publication of the *DSM-IV*.

Clinical Presentation. In the context of a relatively safe adult environment, memories that have previously been sealed off and personified in an alter personality sometimes escape their normal boundaries and invade other aspects of consciousness. Troubling dreams, black-out periods, and vague feelings of depression or anxiety often bring people with DID to treatment. In some cases those with DID have been diagnosed and treated for other psychological disorders such as major depression or schizophrenia before being correctly diagnosed. Many times the primary personality is unaware of the alter personalities until after the diagnosis is made.

The *DSM-IV* includes four diagnostic criteria for DID. First, the individual must experience two or more distinct personality states, each with a stable pattern of perceiving and relating to self and others. For example, a woman known as Terri to most of her friends and co-workers may also have an alter personality named Ellen. Whereas Terri is docile and dependent, Ellen may be audacious and offensive. Terri and Ellen share the same body, although they write, speak, and behave differently. Although this example suggests only two personalities, many people with DID have many more than two alter personalities. Second, at least two of the personality states have repeatedly taken control of the client's

Dissociative Identity Disorder. Dissociative identity disorder (DID), formerly known as multiple personality disorder (MPD), is one of five dissociative disorders identified in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* published by the American Psychiatric Association (1994). Common to all dissociative disorders is capacity to segregate and isolate chunks of

behavior. Terri may have black-out periods during which Ellen goes to parties, gets drunk, and acts impulsively. Ellen, in contrast, may always be aware of Terri's behavior but have little power to take control until Terri is feeling overwhelmed with the social demands of a novel situation. Third, there must be significant memory gaps that cannot be explained by normal forgetfulness. Terri may see many people around town who seem to know her well, yet she cannot recall ever meeting them. Ellen may have no recollections prior to the age of ten years. Fourth, DID is not diagnosed if the condition can be attributed to substance abuse or a medical condition.

Etiology. Although various causes for DID have been considered and explored, the most consistent finding is severe, repetitive childhood trauma. More than 80% of DID clients report being sexually abused as children, most commonly in the form of incest (Putnam, Guroff, Silberman, Barban, & Post, 1986). The abuse usually comes from a parent or primary caregiver. The majority of DID clients also report being physically abused and experiencing extreme neglect (see Abuse and Neglect). A relatively high proportion (about 40%) report being witness to a violent death; 20% report being raised in extreme poverty. Although the idea is controversial, many believe that cultic or ritual abuse is a frequent cause of DID.

Most children have a rich capacity to imagine, and when this imaginary capacity is coupled with severe trauma it can lead to a dissociative defense system to protect the child from pain. Extreme trauma keeps children from developing a consistent sense of self that transcends a variety of situations and contexts.

Assessment and Treatment. Assessing DID can be quite difficult for at least three reasons. First, the one with DID often does not know about the alter personalities and might be quite surprised to hear the diagnosis of DID. Second, a safe therapeutic relationship is usually required before alter personalities make themselves known to the counselor. Such a relationship often requires many weeks or months of treatment, thus deferring an accurate diagnosis until relatively late in the treatment relationship. Some short-term therapies may start and finish without the alter personalities revealing themselves. Third, some people have been improperly diagnosed with DID by therapists who are overly zealous to diagnose dissociative disorders or cultic ritual abuse, resulting in widespread concern about misdiagnosis and false memories. It is essential that counselors and psychotherapists avoid suggesting DID, even when some initial symptoms suggest dissociative phenomena are occurring. The most reliable way to diagnose DID is to have a conversation with an alter personality at the client's initiative without prior suggestion or discussion of DID.

As with most psychological disorders, a variety of treatments have been proposed for DID. The common themes of various treatment approaches in-

clude a safe and trusting therapeutic relationship, understanding the struggle for control that occurs among various alters, the importance of uncovering secrets from the past, and properly handling transference and countertransference. Many people with DID have an alter personality with the capacity to look objectively at the various alters and thereby help their therapists understand the personality system. This type of alter is referred to as the internal self-helper. Many forms of therapy for DID call upon the counselor to identify and collaborate with the internal self-helper as early as possible in the treatment relationship. The ultimate goal of treatment is to integrate the various aspects of personality that have been compartmentalized by dissociative defenses.

Those with DID often experience spatial metaphors to understand their various personalities. For example, in the middle of treatment the client may perceive each alter to live in a separate room inside his or her body. Ideally the metaphor will shift throughout the treatment process so that ultimately the various alter personalities are in a common room making decisions together and cooperatively.

Considerations for Christians. Whereas most therapists perceive all alter personalities to play a vital role in adaptive functioning and thus work to integrate all personalities in the process of treatment, a number of Christian authors and therapists have suggested that some alters may be demonic in nature and should be expelled from the personality. Although DID is not specifically described in Scripture, there is ample evidence that Jesus believed in demonic possession and often cast demons out of troubled people (see, e.g., Matt. 8:32; Mark 1:34; Luke 11:14).

If demons are sometimes part of the personality system in DID clients, then it is untenable from a Christian perspective to work toward integrating all the alter personality states into the final integrated self. This creates the difficult task of determining which if any of the alter personalities are demonic in nature or influenced by demonic activity. It also challenges Christian counselors to develop a theological position on the possibility of demon possession and/or demon oppression with Christian clients. Friesen (1992) suggests that supernatural influences should at least be considered when the alter personality feels like an external intruder to the client and schizophrenia has been ruled out. He further suggests that supernatural influences are likely if the alter is repulsed by Christian symbols or the name of Jesus, the client shows indication of supernatural abilities such as telepathy, or an evil presence is sensed by people other than the client.

Another issue of particular interest to pastors and Christian counselors is the relationship between cultic ritual abuse and DID. In the absence of firm evidence from law enforcement agencies, there is increasing skepticism about the prevalence of cult-

related ritual abuse. Nonetheless, some compelling clinical evidence suggests that ritual abuse does occur and is related to DID (Young, Sachs, Braun, & Watkins, 1991). The prevalence of ritual abuse remains unknown. Because many with dissociative disorders are quite suggestible and because of the high risks associated with false memories of abuse, counselors must be cautious not to plant ideas of cultic or ritual abuse by asking leading questions or making direct suggestions. McMinn and Wade (1995) found that Christian counselors were no more likely than nonreligious psychologists to diagnose DID, and they were only slightly more likely to attribute their clients' symptoms to cultic ritual abuse.

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See DISSOCIATIVE DISORDERS.