

Dissociative identity disorder: Time to remove it from DSM-V?



Numan Gharaibeh, MD
Staff psychiatrist
Department of psychiatry
Danbury Hospital
Danbury, CT

Examining the logic behind arguments to perpetuate a controversial diagnosis

What is it about dissociative identity disorder (DID) that makes it a polarizing diagnosis? Why does it split professionals into believers and nonbelievers, stirring up heated debates, high emotions, and fervor similar to what we see in religion?

The DID controversy is likely to continue beyond the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V), slated for publication in 2012. Proponents and opponents claim to have the upper hand in arguments about the validity of the DID diagnosis and benefits vs harm of treatment. This article examines the logic of previous and new arguments.

1. The fallacy of equal-footing arguments

When 301 board-certified U.S. psychiatrists were surveyed in 1999 about their attitudes toward DSM-IV dissociative disorders diagnoses:

- 35% had no reservations about DID
- 43% were skeptical
- 15% indicated the diagnosis should not be included in the DSM.¹

Only 21% believed there was strong evidence for DID's scientific validity. On balance, published papers appear skeptical about DID's core components: dissociative amnesia and recovered-memory therapy.²

Dr. Gharaibeh is an attending psychiatrist on the inpatient unit at Danbury Hospital in Danbury, CT. He teaches psychiatric residents from New York Medical College during their rotation in Danbury Hospital and physician assistant students from Quinnipiac University, Hamden, CT.

DID skeptics are sometimes accused of “denial” or “reluctance” to accept this diagnosis. Informed skepticism is acceptable—even encouraged—in making a diagnosis of malingering, factitious disorder, some personality disorders, substance abuse, and psychotic states, to name a few. Why is informed skepticism about DID frowned on?

In medical and surgical specialties, informed skepticism is encouraged so that the practitioner challenges his or her assumptions about a possible diagnosis through a methodical process of inclusion, exclusion, and hypothesis testing. I argue that little or no skepticism is substandard practice, if not negligence.

Bertrand Russell’s celestial teapot parable (Box 1)³ exposed the fallacy of equal-footing arguments (ie, in any debate or argument that has 2 sides, the 2 sides are not necessarily on equal footing). Russell’s argument is valid for any belief system relying on faith. Now that DID is in the “ancient book” (DSM-IV), the burden of proof by some magical logic has shifted to “nonbelievers.” In law that is called precedent, but law is even less scientific than psychiatry and not the best example to follow. A mistake made 100 years ago is still a mistake.

2. Illogic of causation

Piper and Merskey’s extensive literature review^{4,5} examined the presumed association between DID and childhood abuse (mostly sexual). They found:

- no proof that DID results from childhood trauma or that DID cases in children are almost never reported
- “consistent evidence of blatant iatrogenesis” in the practice of some DID proponents.

One can easily turn the logic around by claiming that a DID diagnosis causes memories of childhood sexual abuse.

As for patients’ presumed reluctance to report childhood abuse, I witnessed in every one of my 15 alleged cases of DID (all female) not reluctance but a strong tendency to flaunt their diagnosis and symptoms and an eagerness to re-tell their stories with graphic detail, usually unprovoked. Patients with a DID diagnosis seem

Box 1

Bertrand Russell’s ‘celestial teapot’ analogy on religion

In 1952, British philosopher Bertrand Russell used the analogy of a teapot in space to illustrate the difficulty skeptics face when questioning unfalsifiable claims. Russell’s argument involved religious belief, but it is valid for other belief systems relying on faith. Here is the celestial teapot analogy:

“If I were to suggest that between Earth and Mars there is a china teapot revolving about the Sun in an elliptical orbit, nobody would be able to disprove my assertion provided I were careful to add that the teapot is too small to be revealed even by our most powerful telescopes. But if I were to go on to say that, since my assertion cannot be disproved, it is intolerable presumption on the part of human reason to doubt it, I should rightly be thought to be talking nonsense. If, however, the existence of such a teapot were affirmed in ancient books, taught as the sacred truth every Sunday, and instilled into the minds of children at school, hesitation to believe in its existence would be a mark of eccentricity and entitle the doubter to the attention of the psychiatrist in an enlightened age or of the Inquisitor in an earlier time.”

Source: Reference 3

to have a “powerful vested interest”—to borrow Paul McHugh’s expression⁶—in sustaining the DID diagnosis, symptoms, behaviors, and therapy as an end in itself.

DID proponents acknowledge that iatrogenic artifacts may exist in the diagnosis and treatment. However, they almost immediately insinuate that DID patients’ “subtle defensive strategies” generate these artifacts. Greaves’ discussion of multiple personality disorder⁷ acknowledged that overdiagnosis may be driven by therapists’ desire to “attain narcissistic gratification at ‘having a multiple [sic] of their own’” but blamed this on “neophytes.”

3. Tautology in DID’s definition

DSM-IV’s criterion A for DID is in fact a definition: “the presence of 2 or more distinct identities or personality states (each with its own relatively enduring pattern of

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An extensive review found no proof that DID results from childhood trauma or that DID cases in children are almost never reported

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DSM-IV criteria A and B for dissociative identity disorder show circularity and redundancy; if criterion A is met, then B must be met

Table

A meaningless word? 'Dissociation' is used to describe many things

Daydreaming or fantasizing
Memory lapses caused by benzodiazepines
Preoccupation with everyday worries
Preoccupation with internal stimuli (such as auditory hallucinations or delusional thoughts)
Poor attentiveness
Histrionic/theatrical behavior to avoid upsetting the patient or to provide a face-saving explanation
Daydreaming while driving ('highway dissociation' or 'highway hypnosis')
Getting engrossed/captivated by a novel, a movie, or a piece of radio journalism or music

perceiving, relating to, and thinking about the environment and self)."⁸ Together, criteria A and B show circularity and redundancy. If A is met, then B must be met because "a person's behavior" is part of her or his identity and personality state, which was established in A.

Tautology is a major shortcoming of the descriptive system for psychopathology in general. Of greater clinical value are observing a patient's actions, listening to his or her words, learning his or her history, studying his or her expressions, and noting his or her relationships.⁹

4. Bewitchment by language

Psychiatrists could spend hours over strong cups of coffee arguing the meanings of terms such as "dissociation," "presence," "identity," "personality state," etc. Psychiatry has been targeted unfairly regarding where it falls on the subjectivity-objectivity axis, but it has not fared that differently from other medical specialties.¹⁰ Psychiatry, however, depends much more on language.

Consider slippery terms such as personality, identity, self, dissociation, integration, alters, ego, ego states, trance states, personality states, unconscious, etc. Lack of precision, variability in use of words and their meaning, and variability in understanding

the concept that these terms try to communicate make speaking a common language extremely difficult. To borrow from Wittgenstein, psychiatrists' intellect is bewitched by language.¹¹

Words fail to communicate experiences such as the taste of red wine or the feeling of sand beneath bare feet. It is almost futile to try to define dissociation, identity, personality states, etc., using words or even pictures. More definitions and agreement on stricter definitions would not provide greater clarity or solve the problem of first-person authority.

An example is found in DID's criterion B: "at least 2 of these identities or personality states recurrently *take control of the person's behavior*" [italics mine]. "Possession" seems to be a fitting word! Whether it is an alter or the devil taking control is a technicality. Even more acceptable would be possessed by inconsolable anger, possessed by fierce jealousy, possessed by lust, possessed by hatred and vengeance, possessed by and obsessed with love, possessed by cocaine, etc.

Dissociation is used to describe so many things that it has become almost meaningless (*Table*). I refer not only to definitional imprecision but also to a lack of consensus on the nature of the concept itself.

The word "control" is another term on whose meaning almost no 2 psychiatrists agree. Consensus on definitions is elusive when words become divorced from the concepts they were intended to describe.

5. Validity of first-person authority

The skeptic's attempt to investigate a subjective phenomena—especially DID—is bound to break on the rocks of the first-person authority, to borrow Donald Davidson's words.⁹ To support reliability and validity of the diagnosis, dissociation researchers rely on "scales" and "instruments" to give the impression of objectivity, empiricism, and "science" hard at work. However, a quick look at some of the questions on these "instruments" reveals their assault on reason and intellect (*Box 2, page 35*).¹²

Proponents who claim DID is "sufficiently validated for inclusion in the current

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and future versions of DSM” are to be commended for adding “much more research is needed in several areas.”¹³ Piper and Merksley’s review^{4,5} concluded that DID could not be reliably diagnosed.

6. Does a DID diagnosis do harm?

Webster’s¹⁴ defines iatrogenic as: “Resulting from the activity of a physician. Originally applied to a disorder or disorders inadvertently induced in the patient by the manner of the physician’s examination, discussion, or treatment, it now applies to any condition occurring in a patient as result of medical treatment, such as a drug reaction.”

A DID diagnosis has been blamed for misdiagnosis of other entities,¹⁵ patient mismanagement,¹⁶ and inadequate treatment of depression.¹⁷ Even when DID is treated with the best of intentions, undesired negative effects may result from psychotherapy, and some patients experience worsening of symptoms and/or deterioration of functioning.^{18,19}

In *Creating Hysteria*, Acocella²⁰ cites examples of harm done to [alleged DID] patients and their families, including 2 high-profile cases under the care of a member of the DSM-IV work group on dissociation.

7. How is self-deception possible?

The ability to self-deceive has advantages and disadvantages,²¹ and widespread deception is possible. Richard Dawkins’s *The God Delusion*,²² Christopher Hitchens’s *God is Not Great*,²³ and Michael Shermer’s *Why People Believe Weird Things*²⁴ are recent exposés of how self-deception and deception by charismatic figures occurs despite the progress “reason” has made.

As with other belief systems that become entrenched in the face of criticism, DID proponents accuse critics of denial, reluctance, and adopting “defense[s] against dealing with the reality of child abuse in North America.”²⁰ One wonders why just North America! Why not Africa, with its children in Sudan, Somalia, Zimbabwe—to name a few—enduring enough abuse to spread around the world several times over?

Box 2

Sample statements from the Adolescent Dissociative Experience Scale (A-DES)*

A-DES: *I get so wrapped up in watching TV, reading, or playing a video game that I don’t have any idea what’s going on around me.*

Comment: Although this item seems like a joke, it is not meant as one. It is meant to be part of the serious business of science. Isn’t that what any ‘normal’ human would do if he or she has enough attention and concentration?

A-DES: *People tell me I do or say things that I don’t remember doing or saying.*

I get confused about whether I have done something or only thought about doing it.

I can’t figure out if things really happened or if I only dreamed or thought about them.

People tell me that I sometimes act so differently that I seem like a different person.

Comment: These items are crafted in a way to encourage false positives. First, ‘people tell me’ does not qualify as an ‘experience.’ Second, one wonders why the scale was made up of declarative statements instead of questions. Third, ‘I seem like a different person’ is a leading statement.

A-DES: *I am so good at lying and acting that I believe it myself.*

Comment: This should be an immediate tip-off that the reporter is unreliable.

A-DES: *I feel like my past is a puzzle and some of the pieces are missing.*

Comment: Isn’t this the human condition?

*A-DES statements are italicized; comments by Dr. Gharaibeh are in plain text

Source: Reference 12

Proponents also allege that part of the reason for “professionals’ reluctance” to embrace DID is the “subtle presentation of the symptoms.”²⁵ In other words, it is not reluctance; it is ignorance, with the insinuation that nonbelievers or skeptics are not smart enough to pick up on the subtle clinical presentation. I can’t see why professionals would be ignorant when it comes to dissociation as opposed to schizophrenia, depression, bipolar disorder, and almost all DSM-IV disorders. Why this selective ignorance exists remains unexplained.

Clinical Point

Even when DID is treated with the best of intentions, undesired negative effects may result from psychotherapy



Dissociative identity disorder

Clinical Point

Strong adherents have a lot to gain from perpetuating DID; skeptics would gain nothing if DID were to disappear from DSM in 2012

8. Experts and conflict of interest

DSM-V's guidelines on conflict of interest are very welcome. One hopes conflict of interest does not refer only to financial relationships with pharmaceutical companies. Conflicts of interest can exert unseen influence, which—if made clear—would have a direct bearing of the reliability and trustworthiness of the published literature. Strong adherents have a lot to gain from perpetuating DID. Nonbelievers, skeptics, and opponents would gain nothing if DID disappeared from DSM today or in 2012.

The first potential conflict of interest for DID "experts" is financial gain. For example, a psychologist saw 1 of my patients (before I came to the scene) for 5 years for 3 sessions a week (2 for adult alters and 1 for childhood alters), with annual earnings of nearly \$20,000. A self-declared expert would need only 10 patients to be better off than most psychiatrists.

The second potential conflict of interest is personal gain in the form of narcissistic gratification, as mentioned above. Although DID proponents blame neophytes, "teachers" are no less prone to narcissistic gratification. Under this umbrella falls the DID experts' interest in recognition, fame, and easily acquired expertise. One may argue that self-arrogated expertise in this realm is much ado about nothing.

The third potential conflict of interest is the very process of becoming an "expert." The bias of this process is evident because if one does not accept *a priori* the presence of DID, he or she will never be admitted to the exclusive club of "DID experts." To attain the status of authority or expert on this subject, one must be a believer. Otherwise, how would one claim to have diagnosed and treated hundreds of DID cases? It is a feedback loop that can't be broken.

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Related Resources

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