The History of Dissociative Identity Disorder

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Abstract

The history of dissociative identity disorder (DID), previously known as multiple personality disorder (MPD), is complex and vague. DID can be traced back four thousand years to the ancient civilizations of Greece and Egypt with the beginning documentation of hysteria. DID has as its principal characteristic, dissociation, whose history begins with Franz Anto Mesmer, induced somnambulism, and hypnotism. Interest in MPD peaked in the late 19th century and then declined early in the 20th century (Ross, 1996) and many factors influenced DID's unique progression. Controversy surrounds the diagnosis; some researchers and clinicians accept its validity while others question its existence. The disorder also has similar symptoms to many other disorders and therefore a correct diagnosis is crucial. Today DID is a valid diagnosis and it's history can be seen in the progression of diagnoses in the Diagnostic and Statistics Manual for Mental Disorders from hysteria to DID (DSM I through DSM IV-TR, 1952-2000).

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Felida, a Belgian teenager living in the late nineteenth century, often passed from her "first state" to her "second state" and would return to her normal "first state" later in the day (Hacking, 1992). Her "first state" consisted of the standard hysterical symptoms of the time: defective tactile sensations, no sense of taste, diminished sense of smell, depression, partial anaesthesia, [and] occasional convulsions when under stress (Hacking, 1992). In the second state she was more lively and cheerful, yet her second state was not able to remember what happened during her first-state (Hacking, 1992). This is the life of a person with dissociative identity disorder (DID).

Dissociative identity disorder, previously known as multiple personality disorder (MPD), is a complex mental illness that affects one in every hundred people (Haddock, 2001). At present the DSM IV-TR, created by the American Psychiatric Association (APA, 2000), classifies a person as having dissociative identity disorder if they meet the following criteria: (a) 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); (b) at least two of these identities or personality states recurrently take control of the person's behavior; (c) inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness; (d) the disturbance is not due to the direct physiological effects of a substance (e.g. blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures) and in children the symptoms are not attributable to imaginary playmates or other fantasy play (APA, 2000).

DID, has as its principle characteristic - dissociation. When people dissociate they may feel disconnected from themselves or disconnected from the world around them; this

disconnection can become so enveloping that the person may distort time and may not be able to recall what happened during the dissociated state (Haddock, 2001). Many humans engage in defense mechanisms when faced with overwhelming stress; dissociation is one example of a defense mechanism. It "can be thought of as both a neurobiological response to threat and a psychological defense to protect one from an overwhelming experience" (Haddock, 2001, p.14). A psychological disorder may result when this dissociation interferes with life functioning after the trauma when there is no longer a threat to the person (Haddock, 2001); this is when a person may develop DID.

The history of dissociative identity disorder is complex and vague, much like the illness itself. Even today, doctors have trouble diagnosing people with DID. Therefore, the history, the development in the Diagnostic and Statistics Manual (APA, 1952, 1963, 1980, 1984, 1994, 2000), and the causes of dissociative identity disorder will be presented so as to view DID in the context of its time and to shed light on the complexity of the illness.

DID Debate

Throughout history, there has been controversy as to whether or not DID can be considered an actual disorder. Opinions about DID range from believing the diagnosis to be a fiction co-created by patient and clinician, to accepting the validity of the diagnosis (Cardena and Spiegel, 1996). Those in opposition to the clinical diagnosis hold that 'personality states' or alter personalities are created by therapists or psychoanalysts as a result of suggestion and therefore do not truly exist (Hacking, 1992). Horevitz (1994) identifies two interesting questions relating to the controversy surrounding DID - have clinicians become so fascinated with the possibility of multiplicity in patients that they covertly elicit it during therapy? Or, have clinicians become

better diagnosticians of the secret inner worlds of childhood trauma survivors? (Horevitz, 1994) This skepticism exists in the minds of many researchers and clinicians.

However, the American Psychiatric Association recognizes dissociative identity disorder as a significant and actual mental illness, which gives validity to the illness itself. Another controversy surrounding dissociative identity disorder is the concern with what exact terms are sufficient and necessary to diagnose a patient as having DID. Continuous revisions of the DSM show the chronological development of a dissociative identity disorder diagnosis through the first DSM (1952) to the present DSM IV-TR (2000). This development shows the struggle for a clear and precise diagnosis of a complex and controversial disease. It also shows the main problem with the history of dissociative identity disorder – the degree to which naming and defining an illness helps to arrive at a correct diagnosis and treatment.

Differential Diagnosis

The multiple personality literature has reported cases of people with DID that have as many as 100 distinct personalities (or alters) (Hacking, 1992); differences between personalities can range from minimal to extreme. Most personalities have their own names, but some respond to certain titles, which depict the role that the alter plays (i.e., protector, overseer, guardian, demon; Flora, 1988). Each personality may exist at a different age, gender, ethnicity, sexual orientation, and time frame. Different alters display unique symptoms and may adopt a unique style of speech, make-up style, and wardrobe and can have different skills, hobbies, and friends (Flora, 1988). These differences constitute the largest problem in the treatment of dissociative identity disorder – a correct diagnosis.

Some of the major indicators of DID include symptoms such as hearing inner voices, nightmares, panic attacks, depression, eating disorders, chemical dependency, loss of time,

handwriting differences, difference in appearance, and severe headaches that are associated with the switching of personalities (Haddock, 2001). Most psychiatric patients are comorbid, they fit the diagnostic criteria for more than one disorder and the average DID patient meets the criteria for three to four other psychological disorders (Acocella, 1999). A person may not be initially diagnosed with DID because of the distinct personality controlling them at that moment and that specific 'person's' behavior. For example, if one alter is highly depressed and that alter is in control of the person when visiting a therapist for the first time, that person would at the start of therapy be diagnosed as depressed. Therefore, care must be taken when diagnosing patients and clinicians must be aware of DID's specific characteristics so as to not incorrectly diagnose.

DID must be distinguished from a variety of other disorders because several other diagnoses are often confused with DID (Kahn and Fawcett, 1993). First it must be differentiated from symptoms that are caused by the direct physiological effects of a general medical condition (APA, 2000). Second, it must also be distinguished from dissociative symptoms due to complex, partial seizures (although they can co-occur). And DID must not result from the physiological effects of a substance (APA, 2000). A diagnosis of DID takes precedence over other dissociative disorders and individuals should be differentiated from people with trance or possession symptoms (who would be diagnosed as Dissociative Disorder Not Otherwise Specified) (APA, 2000). Most importantly DID must be distinguished from other disorders with overlapping symptoms: including Schizophrenia and other Psychotic disorders, Bipolar disorder (with rapid cycling), Anxiety disorders, Somatization disorders, and Personality disorders (APA, 2000).

The Etiology of DID

DID, previously thought of as Multiple Personality Disorder, has often been linked with hysteria, somnambulism (i.e., mesmerism/hypnosis), demonic possession (Flora, 1988; Veith,

1965), and trance states (Ross, 1996). The most important and direct historical link to DID is the mental illness, hysteria, which has been documented and discussed since the earliest recordings of medicine (Veith, 1965). Hysteria is the manifestation of physical symptoms (i.e., convulsions, paralyses, strangulation, breathing problems, numbness, pain) or psychological symptoms (i.e., anxiety, emotional outbursts, 'spells') or both, in the absence of any clear natural cause (Acocella, 1999). Hysteria dates back four thousand years in to the ancient civilizations of Greece and Egypt when Hippocrates recorded a case of hysteria in which he connected the illness to a "wandering uterus" (Acocella, 1999; Flora, 1988; Veith, 1965).

"Hysteria" is derived from the Greek word *hystera,* which means "uterus" and traditionally hysteria has been identified as a disease of women. The word to describe this illness sheds light on the first understanding of its causes. It was believed to be a disorder that only affected women and was caused by alterations in the womb; this association between the illness and a woman's womb expressed the effect that disordered sexual activity could have on emotional stability (Veith, 1965). Today, the most widely accepted cause of DID is childhood sexual abuse; in a survey done by The National Institute of Mental Health on 100 MPD cases, 97% of the patients reported experiencing significant trauma in childhood (Hacking, 1992). Perhaps the women in ancient times were also dissociating because of traumatic reasons, which may parallel childhood sexual abuse in the present. Some cases of hysteria could have in fact been DID because of the similarity in causes (sexual) as has been demonstrated with DID. Veith (1970) argues that much of what has been called hysteria at different periods would now be described by other names and how we would describe hysteria now would have been attributed to other diseases in earlier times.

In the medieval era social attitudes toward hysteria changed; the preoccupation with demonology and witchcraft altered societal perceptions of a hysteric from that of a sick human being to that of someone who was possessed on purpose and "in cahoots" with the devil (Veith, 1965). With the rise of Christianity organic theories of hysteria were replaced by supernatural explanations and unusual female complaints were seen to be the work of the devil (Acocella, 1999). DID is diagnosed three to nine times more frequently in adult females than in males (APA, 2000) and in earlier times the majority of people accused of being witches, possessed, or hysterical were also women.

During the seventeenth century, Thomas Willis (considered to be the father of neurology) introduced the notion that hysteria stemmed from the brain, primarily the nervous system, instead of from alterations in the womb. He believed hysterical fits were caused by "spirits inhabiting the brain, being now prepared for explosions" and seldom admitted to the uterus as the starting point of the disorder (Veith, 1965, p. 131). From his own experiences Willis was convinced that hysteria was not limited to women, and therefore could not be a problem of the uterus. Yet, he did believe that women were more susceptible to hysteria than men, because "Women, from any sudden terror and great sadness, fall into mighty disorder of spirits, where men from the same occasion are scarcely disturb'd at all" (Veith, 1965, p. 133). Thomas Willis went on to publish a book on nervous disorders, which included hysteria, and popularized the term "nervous". Several books were published after Willis to clarify what the term "nervous" applied to and to explain specific nervous disorders. Even Philippe Pinel's Nosographie (1798) contained a reference to nervous – one of his five classes of diseases was titled *neuroses.* This fourth class of disease included hysteria and was discussed under the title of "Genital Neuroses

of Women", suggesting that Pinel also recognized hysterical symptoms only in women. Yet, he described similar symptoms in men under different titles (Veith, 1965).

Later, in the eighteenth century Franz Anto Mesmer, for his dissertation, drew upon Richard Mead's argument that "gravity produced 'tides' in the atmosphere as well as in the water and that the planets could therefore affect the fluidal balance of the human body. Mesmer associated this 'animal gravitation' with health" and introduced his theory of "animal magnetism" (Gillispie, 1974). His findings took on new life when he "began treating his own patients…[applying] magnets to his patients bodies…" which "produced dramatic results, especially in the case of a young woman suffering from hysteria." (Gillispie, 1974, p. 326) Mesmer popularized "induced somnambulism" and in "1784 his followers, led by the Chastenet de Puysegur brothers, extended mesmeric 'rapport' into something new: mesmeric induced hypnosis." (Gillispie, 1974, p. 327) This was the beginning of medical and public methods of getting people into an altered consciousness. It brought about the possibility of a conscious and subconscious life – a strange new phenomena for the people of the eighteenth century (Gillispie, 1974).

In 1843 James Braid changed the name "induced somnambulism" to hypnotism, derived from the Greek word "hypotikos", which means sleep inducing (Flora, 1988; Veith, 1965). Morton Prince, a physician, states his thoughts on hypnotism and how it relates to personality.

> …hypnotism has always been treated as if it were something bizarre, a mental condition that stood apart as something distinctly different from all other conditions; whereas it is only one of a large category of conditions characterized by alteration of the personality. In this category are to be found various clinical types of alteration, some normal some abnormal, all due to the same processes and mechanisms…states of hypnosis are as varied and multiform as there are possible combinations of the psychological and physiological components of personality. Even in the same person several different states may develop, each exhibiting different memories, traits, and other personality characteristics (Prince, p.145, 1929).

Today, a relationship is found between hypnotism and DID, based on a person's ability to dissociate (in other words to be in a hypnotic state). Some researchers presently believe that most people suffering from DID are more easily hypnotized (able to dissociate easier) than other people without the disorder. The DSM-IV-TR reports that individuals with DID score toward the upper end of the distribution on measures of hypnotizability and dissociative capacity (APA, 2000). Yet, other researchers call in to question this link between hypnotizability and dissociation. Whalen and Nash (1996) report that there is not compelling evidence to support the notion that hypnotizability and dissociativity are overlapping traits – and in fact they believe that the two exist independently of one another.

Later, in the nineteenth century the first apparent classification of multiple personality disorder was called "double consciousness" (Hacking, 1992). During this time the physician Robert Brudenell Carter (1828-1918) came up with the first theory of repression as a cause of hysteria. Carter developed three main factors as the cause of hysteria: "[1] the temperament of the individual, [2] the event or situations which trigger the initial attack, and [3] the degree to which the affected person is compelled to conceal or 'repress' the exciting causes" (Veith, 1965, p.211). Further, he believed that sexual passion was the most frequent and important determinant causing hysteria. A relationship concurrent with contemporary thought about DID is seen. Current causal evidence and the understanding of dissociation in a DID patient mirrors Carter's first two factors in his theory of repression, which he believed caused hysteria. In Breuer and Freud's Studies on Hysteria (1957), many of the cases presented would meet current DSM-IV criteria for dissociative identity disorder. And childhood sexual trauma is reported in several of these case histories (Ross, 1996).

In France (1875), a switch in labeling occurred; consciousness began to be referred to as "personality" and dual personality cases briefly dominated French psychology (Hacking, 1992). Pierre Janet, the man who coined the term 'dissociation' studied some of these French multiples in the 1880s. The connection between childhood trauma and multiple personalities became a topic of speculation during this time and even though there are not very many detailed reports of multiples from this period, there are enough to validate a connection between abuse and dissociation. Yet, a theory of abuse would not dominate the multiple personality literature until 1975 (Hacking, 1992). Currently, reports of abuse by DID patients are still called into question. The DSM-IV-TR reports that controversy still surrounds the accuracy of child abuse reports – namely because childhood memories may be subject to distortion and some individuals with DID are especially susceptible to suggestive influences (APA, 2000).

DID is also associated with trance and possession; the actual history of dissociation begins with the experiences of shamans. The psychological basis of DID and other dissociative disorders can be seen in trance and possession states found in most cultures throughout history (Ross, 1996). Flora (1988) describes the relationship between possession and multiple personalities by stating:

> There is a strong possibility that MPD existed along with possession for thousands of years, only to go undetected. By definition, possession could be considered a type of multiple personality. It was only after the decline of the phenomenon known as possession, during the nineteenth century, that multiple personality case histories started turning up in the mesmerist literature and later in the medical reports (p.5).

Still, the question persists of whether or not possession (in this case spirit possession) is actually DID (Fiske, 11-24-02). People in cultures such as the Moose, Balinese, Kaluli and Azande, who are spirit mediums, display almost identical symptoms to those of Westerners diagnosed with MPD. Spirit mediums cannot remember what happens when they are possessed (they dissociate

from themselves), they take on several different personalities, and the dissociation is not a result of physiological effects of a substance or medical problems (Fiske, 11-24-02).

Alan Fiske, an anthropologist, poses the question, “Is it a psychological disorder? Or is it culturally, socially relevant part of society that has disappeared in the present Western world?” (Fiske, 11-24-02). In many cultures certain forms of dissociation are seen as normal and are cultivated through various techniques such as fasting, self-immolation, and solitude (Ross, 1996). In tribes such as the Azande, in Africa, DID does not exist by name and can only be seen in spirit possession, which is useful and highly regarded in Azande culture. While in the Western world a woman who has multiple personalities often creates a tough male protector personality, an individual in another culture may have a mythological, spirit, or deity protector personality (Ross, 1996). Therefore a link between possession and dissociative identity exists. The presence of cultural factors contributing to the conceptualization of dissociate states precludes a consistent description of the state across cultures.

The Rise and Fall of Dissociation in the 20th Century

During the late nineteenth and early 20th century, interest in dissociation was unique in the psychiatric world. Interest in multiple personality disorder peaked in the late nineteenth century and then dropped off to nearly zero early in the 20th century (Ross, 1996). Many factors influenced why dissociation became so unpopular in the early 20th century. The first are the theories of Sigmund Freud. Freud’s seduction theory (Miller, 2000), a repression model of psychopathology, explained away any childhood sexual abuse and did not allow treatment of dissociative symptoms. As a result of Freud’s influence, dissociative diagnoses became irrelevant to mainstream psychology at that time (Ross, 1996).

The second influence on the severe decline in interest in dissociation is the creation of the term and the recognition of the disorder, schizophrenia. Bleuler coined the phrase schizophrenia, which means *split mind* in Greek. He stated that "it is not alone in hysteria that one finds an arrangement of different personalities one *succeeding* the other: through similar mechanisms schizophrenia produces different personalities existing *side by side*" (quoted in Ross, 1996, p. 5). It seems that Bleuler may have chosen the term schizophrenia because many of his descriptions of schizophrenics are actually descriptions of what we now call DID (Ross, 1996). The problem lies in the similar symptoms of both diseases. One of the main characteristics of schizophrenia is hearing voices. Yet, a patient with DID may think they are hearing voices because of semi-consciousness of their other personalities. Evidence shows this problem: even after DID had been well established, two studies show that undiagnosed DID patients received incorrect diagnoses of schizophrenia in 25% and 40% of the cases in the two series (Ross, 1996). This is the trouble with dissociative identity disorder: it is extremely hard to diagnose and can often be mistaken for a number of other disorders. Further, many experts question whether or not the disease even exists.

During the mid 20th century (1920 to 1950) academic interest in MPD and dissociation diminished and only a few papers were published on the subject, per year, worldwide; no other disorder has ever disappeared from mainstream psychology and medical study like dissociation did during this time (Ross, 1996). Then in the 1980's interest in dissociation, specifically DID, returned and reported cases increased by thousands of percents (Ross, 1996). The most important factor behind this extreme increase in interest in MPD is the coming together of two forces, the child protection movement and feminism (Acocella, 1999). Also, The Vietnam war had ended and psychiatric studies on war veterans were beginning to reveal that severe trauma

could have long-term psychological consequences on an individual, which made it easier for society to accept the fact that childhood abuse could manifest into multiple personality disorder (Ross, 1996).

Another factor that influenced the resurgence in popularity of MPD is the way it was displayed in the mass media. Two books, The Three Faces of Eve and Sybil were published in 1957 and 1973 respectively, which depicted the lives of a person with multiple personality disorder. Both were later made into successful Hollywood movies, which had a huge impact on public perceptions and awareness of multiple personality disorder. While The Three Faces of Eve did not include any history of child abuse (which became a social problem in 1961) Sybil brought multiple personality disorder and child abuse into the public consciousness. Interestingly, when Chris (the multiple in the famous The Three Faces of Eve) was diagnosed with MPD, prior to 1957, she was told she was probably the only person in the world with this disorder, yet thirty years later there were thousands of reported cases (Ross, 1996).

The Evolution of DID in the DSM

In 1952, in the first edition of the DSM, hysteria was not included as an illness. Similar symptoms were described in terms of a "conversion symptom" (Veith, 1965), which alluded to hysteria. But there *was* a disorder listed in the first DSM that refers to hysteria – dissociative reaction. Dissociative reaction (which was formerly classified as a type of conversion hysteria) includes dissociated states such as depersonalization, dissociated personalities, stupor, fugue, amnesia, dream states, and somnambulism. The DSM-I specifically states:

> This reaction represents a type of gross personality disorganization, the basis of which is a neurotic disturbance…The repressed impulse giving rise to the anxiety may be discharged by, or deflected into, various symptomatic expressions, such as…dissociated personality, etc (APA, 1952, p. 32)

It is in the DSM-II (1963) where we see the first mention of 'multiple personality', which falls under the category of "Neuroses", specifically "Hysterical Neuroses" "Dissociative Type". The DSM-II defines this disorder as: "In the dissociative type, alterations may occur in the patient's state of consciousness or in his identity, to produce such symptoms as amnesia, somnambulism, fugue, and multiple personality" (APA, 1963, p. 40). In 1980, with the release of the next volume of the DSM, DSM III, dissociative disorders were finally recognized as a type of mental illness and specific diagnostic criteria for multiple personality disorder was included. The DSM-III presented the following three criteria for multiple personality disorder: the existence within the individual of two or more distinct personalities, each of which is dominant at a particular time; the personality that is dominant at any particular time determines the individual's behavior; and each individual personality is complex and integrated with its own unique behaviour patterns and social relationships (APA, 1980). The DSM-III went on to discuss associated features of the disorder itself such as age of onset, course, impairment, complications, predisposing factors, prevalence, sex ratio, and familial pattern.

In 1987 a revised edition of the DSM-III came out, the DSM-III-R, which contained interesting changes in its MPD classification. The major heading of "Dissociative Disorders" was expanded to include (in parenthesis) "or Hysterical Neuroses, Dissociative Type" (APA, 1987, p. 269) which shows a small return to the DSM-II position (Flora, 1988). It also contains a subclassification for "conversion type" (APA, 1987, p. 257), which is described much like symptoms of hysteria in the past. This is an important historical change because at this time, in 1987, doctors again realized that symptoms of hysteria were part of MPD. The DSM-III-R makes slight changes to the actual diagnostic criteria for MPD as follows. The existence within the person of two or more distinct personalities or personality states each with its own relatively

enduring pattern of perceiving, relating to, and thinking about the environment and self; and at least two of these personalities or personality states recurrently take full control of the persons behavior (APA, 1987, p. 272). With these changes, the link to the next and most recent DSM (IV) is visible.

It is very interesting that the first three DSMs (and the third revised edition) do not include any mention of amnesia or loss of time in the diagnostic criteria for MPD, because it was considered a dissociative disorder at the time – and dissociation itself has always been thought to contribute to memory loss. Finally, with the fourth DSM (1994) there is a connection with amnesia and memory loss and it is evident in the re-labeling of MPD to DID in the diagnostic criteria section C.

Summary

Multiple personality disorder is an interesting phenomenon with an equally interesting history. Hacking accurately describes the problems and intricacies concerning multiple personality disorder. He states, "The history of multiple personality disorder (MPD) cruelly illustrates our vast reservoir of confusions about the mind and its maladies….Its past and present put on display the wobbly relations between behavior, diagnosis, therapy, surrounding culture and madness" (Hacking, 1992, p. 4). Multiple personality disorder is representative of the history of psychiatry in general; mental illness is extremely complicated and it seems we may never fully understand the human mind and the way it works. Many discrepancies and controversies concerning DID and MPD exist in the literature. Much research and clarification on the subject is needed. Only time will further our understanding of this illness, just as time has allowed us to better understand the complex human psyche.

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