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The Proposed Etiologies of Dissociative Identity Disorder

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ABSTRACT: Dissociative Identity Disorder (DID) evolves after suffering consecutive, traumatizing forms of abuse during an individual's early years. Repetitive abuse can lead an individual to develop two or more personalities, and then experience memory loss or other cognitive gaps in his or her early childhood that continue to the present day. This can have devastating effects on millions of people because a significant percentage of affected individuals do not recognize the symptoms or choose to believe that DID does not exist. By analyzing the literature currently available, this article creates a central base of popular and emerging models that clinicians use to diagnose DID. With a more informed understanding of what prompts the diagnosis, researchers can pinpoint the factors that lead to DID, which will allow for earlier recognition. This review alerts researchers and clinicians that DID is a legitimate disorder. This review also highlights the fact that effective treatments are available, but that more research is needed to grasp the nature of the mechanisms that drive the development of DID.

KEYWORDS: Dissociative Identity disorder, etiology, models, trauma

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INTRODUCTION

With a growing body of research addressing its roots, Dissociative Identity Disorder (DID) has become well known, even though mysteries still surround it. According to the American Psychiatric Association, Dissociative Identity Disorder entails the presence of two or more personalities, which are distinct from each other, along with extreme forgetfulness (5th ed., DSM 5; American Psychiatric Association, 2013). The various models addressed in this paper represent different ideas developed during the last five decades.

Researchers have similar thoughts concerning the development of DID and the crucial role that traumatic events can play in its development. However, it is unclear which factors play the greatest role. With factors including child development, neurological development, Post Traumatic Stress Disorder (PTSD), and impact of the caregiver, pinpointing a central cause behind DID presents a challenge that this paper hopes to resolve. Not fully understanding the current established models can lead clinicians to misdiagnose a client's symptoms, further hurting the client.

MODELS

The Trauma Model

Research has determined that those diagnosed with DID experienced various forms of extreme trauma (e.g., physical, sexual, or emotional abuse) during their childhood, and that a lack of affection and attention from their caregivers provokes the development of multiple personalities (Cohen, 2004). DID is also associated with forgetfulness that cannot be adequately explained as a physiological or environmental problem (e.g., drugs or alcohol). Putnam (1997) categorizes memory loss abnormalities into four primary types: (1a) memory loss of one's biographical information; (2a) difficulty determining if a certain memory is real; (3a) difficulty remembering recalled events; and (4a) "compartmentalizing" information regarding events that have taken place.

Experts disagree about the relevance of traumatic events in the psychological development of DID. Little research addresses why certain traumatic events trigger this disorder in some but not in others. The Trauma Model, developed by Ross (2010), is used to study the co-morbid disorders that a person with DID may have and ranks

the disorders according to frequency of certain events occurring in a single person. Those disorders that tend to have a higher frequency of occurrence (e.g., Major Depressive Disorder), combined with childhood trauma, can lead to a higher chance of developing DID. The Trauma Model concludes that those with DID indicate they have been diagnosed with one or more other mental disorders.

Using instruments such as the Dissociative Identity Disorder Interview Schedule, which only assesses physical and sexual abuse, Ross (2010) tested his hypothesis that women with DID reported more sexual abuse as children than did men. In addition, Ross wanted to determine whether men and women diagnosed with DID reported similar trauma and abuse experiences as did men and women who were not diagnosed with DID. His results supported his hypothesis: the data indicated that women said they were sexually abused as a child more than men who reported experiencing sexual abuse (Ross, 2010). His results also found that the recollections of a person's childhood with DID are somewhat similar to a person who has not been diagnosed. That is, individuals diagnosed with DID, as well as individuals not diagnosed with DID, are able to recall a history of abuse, even if they only remember small parts of that abuse (Ross, 2010). Although his results provide insight into how sexual abuse can play a major role in the development of DID, especially with women, the study gives rise to more unanswered questions regarding the childhood similarities between those diagnosed and those who are not.

The Fantasy Model

While the Trauma Model focuses on traumatic emotional events, the Fantasy Model is based on the reverse. Researchers indicate that dissociation can emerge before the occurrence of traumatic events (Dalenberg et al., 2012). They looked at both models and discussed the discrepancy between the etiology of DID in the Fantasy Model and that of the Trauma Model. A person first develops an abnormal dissociation and then, as the mind wanders into a "fantasy," the person associates these fantasies or dysfunctional thoughts with being dissociated from his or her self (Dalenberg et al., 2012). After excessive mental wandering, or "day-dreaming," an individual may create extensive, albeit false, stories to accompany those thoughts.

False stories can become a part of any person's life and

can develop into memories that the person believes to be true, including traumatic events that never occurred. Researchers believe that those with DID can recall false memories of a certain event because they cannot distinguish particular events from reality or fantasy—especially memories of events that occurred during childhood (Dalenberg et al., 2012).

The Fantasy Model is contrary to the popular belief as to how an individual may develop DID. It emphasizes that few clinicians believe that dissociation can occur before traumatic events are reported by the individual. This could decrease the importance of traumatic events and the role those events play in the onset of DID (Dalenberg et al., 2012). While Dalenberg and colleagues (2012) believed traumatic events play a small role in the development of DID, they focused on the biological aspects of the mind and how those aspects come into play, especially when it comes to creating false stories.

Neurodevelopment

Often, researchers seek to understand how the brain functions when a traumatic experience occurs, how a person learns to cope with that experience, and how those experiences can evolve into DID. Forrest (2001) investigated how certain parts of the brain, when not fully developed or when damaged, can affect the development of DID. By using scans and other imaging equipment such as an MRI to visualize the prefrontal lobes (e.g., Orbitofrontal Cortex, which functions as a memory regulator), researchers can better see how we control our behaviors (Forrest, 2001). Imaging can assist researchers in getting a detailed look of the brain of individuals with and without DID. Forrest (2001) explored how people with DID develop amnesia barriers that convince an individual that their behaviors and events taking place are the result of multiple personalities. Understanding the differences in the physicality of the brain can aid the process of diagnosing because clinicians can use this technology as a diagnostic resource.

Psychodynamic Development

Psychodynamic theories addressing the onset of DID focus on observing human functioning, drives, and interactions, and researchers consider the specifics of the psychological development of a child. MacGregor (1996) explored the psychological abnormalities of children and the possible impairments that arise from those abnormalities that can lead to a major impact on

their daily lives. For example, ego development in normal children allows a healthy amount of role-playing that can extend into exaggerated behavior. Children are expected to switch between characters, to have imaginary friends, and to live out different lives in their minds (MacGregor, 1996). However, maintaining childhood fantasies into later years can lead to a child having difficulties with separating fantasy from reality. Researchers look at dissociation as a typical behavior in children that may increase when children attempt to cope with traumatic events (MacGregor, 1996).

Meditation Model

Trauma, as experienced by anyone, can lead to dissociation and/or the development of other non-DID disorders. Dalenberg and Carlson (2012) analyzed various models that address the correlation of early trauma and dissociation in people living with Posttraumatic Stress Disorder (PTSD). The Mediation Model focuses on the common understanding that abuse can lead to PTSD, but when dissociation plays a role, the memories of trauma can, to some extent, be minimized (Dalenberg and Carlson, 2012). This model supports the hypothesis that dissociation contributes to the diminished memory of trauma for individuals with DID.

The Component Model

The Component Model theorizes how trauma and dissociation are projected onto other dissociative disorders, like DID and PTSD. Symptoms include voices of different personalities that were involved in trauma, misconceptions of one's past, losing time in the present day, and having difficulty remembering the past (Dalenberg and Carlson, 2012). The more traumas experienced, the more often symptoms occur. Varying levels of dissociation can also impair an individual's daily functioning.

Avoidance as a pathway to dissociation is also discussed by Dalenberg and Carlson (2012), who find that this is due to the number of different personalities that prevent the individual from knowing his or her complete past in order to avoid knowledge of the abuse. The Component Model moderately follows what is stated in Diagnostic Statistical Manual of Mental Disorders (American Psychiatric Association, 2000, 4th ed., text rev.) concerning DID and dissociation that occurs after experience trauma (Dalenberg and Carlson, 2012).

Caregiver Support

Winnicott (1954) described a state of personalization that occurs when a mother plays an active role in her infant's early-life stages. This includes creating a safe environment in which a child feels secure and can better manage unpleasant, and possibly traumatic circumstances. Conversely, when a primary caregiver is absent, the child becomes accustomed to that environment. A lack of maternal care and protection can lead to a child dissociating from the current negative situation to an isolated figure, in which defensive entities are created (Winnicott, 1954). Although Winnicott's research was completed over sixty years ago, his findings are still relevant to today's research.

While it is common to associate DID with present trauma, many clinicians look back to the emotional attachments an individual had as a child. Dysfunctions that occurred between the mother and the child can result in pathological dissociation and initiate the appearance of identities used to defend against any trauma that may happen later (McFadden, 2011). According to Stern (2003), disorganized attachment, along with or in addition to trauma, can produce a sensory and emotional overload that cannot be understood by the child. A lack of support from the caregiver causes the child to learn for him- or herself how to cope with the possible neglect and abuse, which can lead to the development of DID.

Socio-Cognitive Model

There has been much debate and research on the relevance of the Socio-Cognitive model in diagnosing DID. According to Gleaves (1996), this model does not acknowledge DID as a real psychiatric disorder. Gleaves states clinicians legitimize their clients' additional personalities and enable their development of this disorder. Others have agreed with the notion that DID is a socially reinforced (Lilenfeld et al., 1999). Alternate personalities that develop after consistent traumatic experiences become "roles" that the individual maintains. According to Lilenfeld and colleagues (1999), changes in our culture, along with complications from ineffective treatment, play a role in the cause of DID and can be responsible for the recent increase in the number of people who have been diagnosed. Researchers have noticed unsupportive information about the Socio-Cognitive model, including the lack of objectivity and false similarities to other enactments like "multiple enactments, including demonic possession, mass

hysteria, transvestism, and glossolalia" (Lilenfeld et al., 1999, p. 508).

Other Dissociative Disorders

Multiple disorders can share similar symptoms, as DID is one of several types of dissociative disorders. According to the Diagnostic Statistic Manual of Mental Disorders (4ed., text rev.), Depersonalization Disorder is defined as the "persistent or recurrent experiences of feeling detached from, and as if one is an outside observer of, one's mental processes or body" (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000). Those diagnosed with Depersonalization Disorder report seeing themselves outside of their body, feeling that someone is observing their actions, and having disconnections from their mind as if someone else has taken over (Simeon, 2004). Similar to DID, symptoms for Depersonalization Disorder include a feeling of detachment, witnessing an out-of-body experience, and confusing their body at that present time.

Although the prevalence of Depersonalization Disorder is about 2.4% of those diagnosed with a mental disorder, its similarities with DID in their shared symptoms make it difficult for clinicians to distinguish between the two dissociative disorders (Simeon, 2004). It is imperative to listen attentively and to recognize what is being stated by both the client and the client's alters to diagnose any disorder, including dissociative disorders.

LIMITATIONS

Limitations include the significant concerns surrounding the validity of DID, which have deterred researchers from studying it at length. There is also difficulty in determining which model is most used in practice. Disagreements regarding the best possible etiology of DID arise from these conflicting models. Much of the literature surrounding DID provides contrasting views about the validity of each of the models, thus making it difficult to locate literature that provides substantive information for any given model.

CONCLUSION

Research conducted on DID necessitates a holistic approach to ensure that no one model is the sole focus. Many researchers agree that trauma, specifically in childhood, plays a major role in the development of DID; however, deciding which other factors play a part



in DID's etiology, such as ego development, attachment of the caregiver, and even the responsibilities of the clinicians, make it more difficult to diagnose DID. Professional disagreements concerning DID's etiology also make it a challenge to diagnose, which can lead to the misdiagnosis of a client. This may further prevent the efficient use of the client's time with his or her clinician, delaying the help that is needed. While there may never be one specific, identified cause of DID, distinguishing and reaching consensus on the factors in its development and subsequent occurrence can provide meaningful assistance for both clients and clinicians.

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