Separating Fact from Fiction: An Empirical Examination of Six Myths About Dissociative Identity Disorder

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Abstract: Dissociative identity disorder (DID) is a complex, posttraumatic, developmental disorder for which we now, after four decades of research, have an authoritative research base, but a number of misconceptualizations and myths about the disorder remain, compromising both patient care and research. This article examines the empirical literature pertaining to recurrently expressed beliefs regarding DID: (1) belief that DID is a fad, (2) belief that DID is primarily diagnosed in North America by DID experts who overdiagnose the disorder, (3) belief that DID is rare, (4) belief that DID is an iatrogenic, rather than trauma-based, disorder, (5) belief that DID is the same entity as borderline personality disorder, and (6) belief that DID treatment is harmful to patients. The absence of research to substantiate these beliefs, as well as the existence of a body of research that refutes them, confirms their mythical status. Clinicians who accept these myths as facts are unlikely to carefully assess for dissociation. Accurate diagnoses are critical for appropriate treatment planning. If DID is not targeted in treatment, it does not appear to resolve. The myths we have highlighted may also impede research about DID. The cost of ignorance about DID is high not only for individual patients but for the whole support system in which they reside. Empirically derived knowledge about DID has replaced outdated myths. Vigorous dissemination of the knowledge base about this complex disorder is warranted.

Dissociative identity disorder (DID) is defined in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as a specifically locates the dissociative disorders chapter after the chapter on trauma- and stressor-related disorders, thereby acknowledging the relationship of the dissociative disorders to psychological trauma. The discontinuity in sense of self and agency, and with variations in autobiographical memory. The signs and symptoms of DID may be individuals with complex, posttraumatic developmental disorders, DID observed by others or reported by the individual. DSM-5 stipulates patients may suffer from symptoms associated with mood, anxiety, that symptoms cause significant distress and are not attributable to personality, eating, functional somatic, and substance use disorders, as accepted cultural or religious practices. Conditions similar to DID but with less-than-marked symptoms (e.g., subthreshold DID) are classified among “other specified dissociative disorders.”

Multiple personality states” have been described by renowned current debates about the validity and etiology of DID echo early theorists, including Pierre Janet, Sigmund Freud, Alfred Binet, debates about hysteria and also other trauma-based phenomena such William James, Benjamin Rush, Morton Prince, Boris Sidis, Enrico dissociative amnesia. Historically, trauma has stirred debate in the relationship between trauma and clinical symptomatology contributed
today be diagnosed with dissociative disorders. Early debates focused on misconceptions about trauma-related problems (such as attributing hysterical symptoms to psychosis). The absence of systematic documentation of the extent of child abuse further inhibited efforts to identify and define the complex syndromes that were closely associated with it.\textsuperscript{5}

Additionally, a broadening of the range of conditions subsumed by aSocial, scientific, and political influences have since converged to diagnosis of schizophrenia moved the etiological focus from traumafacilitate increased awareness of dissociation. These diverse influences and dissociation to a variant of genetic illness/brain pathology: include the resurgence of recognition of the impact of traumatic Rosenbaum\textsuperscript{26} documented that as the concept of schizophrenia began experiences, feminist documentation of the effects of incest and of to gain ascendancy among clinicians, the concept of DID markedly rose toward women and children, continued scientific interest in decreased—a change that likely occurred because schizophrenia and DID have some similar symptoms.\textsuperscript{8,26} Yet, early writers on psychoses/schizophrenia (e.g., Kahana, Kraepelin, Bleuler, Meyer, Jung, Schneider, and Bateson reference cases of “psychosis” that closely resemble, or are seemingly typical of, DID.\textsuperscript{27} Bleuler references many such cases, including some in which the ‘other’ personality is marked by the use of different speech and voice ... Thus we have here two different personalities operating side by side, each one fully attentive. However, they are probably never completely separated from each other since one may communicate with both.\textsuperscript{28(p 147)}

In this climate of renewed receptivity to the study of trauma and impact, research in dissociation and DID has expanded rapidly in the 40 years spanning 1975 to 2015.\textsuperscript{14,34} Researchers have found dissociation and dissociative disorders around the world.\textsuperscript{3,12,35–45} For example, in a sample of 25,018 individuals from 16 countries, 14.4\% of the individuals with PTSD showed high levels of dissociative symptoms.\textsuperscript{35} This research led to the inclusion of a dissociative subtype of PTSD in DSM-5.\textsuperscript{1} Recent reviews indicate an expanding and important evidence base for this subtype.\textsuperscript{14,36,46}

1. belief that DID is a “fad”
2. belief that DID is primarily diagnosed in North America by DID experts who overdiagnose the disorder
3. belief that DID is rare
4. belief that DID is an iatrogenic disorder rather than a trauma-based disorder
5. belief that DID is the same entity as borderline personality disorder
6. belief that DID treatment is harmful to patients

\textbf{MYTH 1: DID IS A FAD}

Some authors opine that DID is a “fad that has died.”\textsuperscript{50–52} A “fad” is defined as something (such as an interest or fashion) that is very popular for a short time.\textsuperscript{53} As we noted above, DID cases have been described in the literature for hundreds of years. Since the 1980 publication of DSM-III,\textsuperscript{36} DID has been described, accepted, and included in four different editions of the DSM. Formally recognized as a disorder for over three decades contradicts the notion of DID as a fad.

1. DID patients can be reliably and validly diagnosed with structured interviews. DID patients are consistently identified in outpatient, inpatient, and community samples around the world.\textsuperscript{12,37–45} And
2. DID patients can be differentiated from other psychiatric patients, healthy controls, and DID simulators in neurophysiological and psychological research.\textsuperscript{58–63}

3. DID patients can be reliably differentiated from other psychiatric patients, healthy controls, and DID simulators in neurophysiological and psychological research.\textsuperscript{58–63}

4. DID patients usually benefit from psychotherapy that addresses trauma and dissociation in accordance with expert consensus guidelines.\textsuperscript{54–66} An expanding body of research examines the neurobiology, phenomenology, prevalence, assessment, personality structure, cognitive patterns, and treatment of DID. This research provides evidence of DID’s content, criterion, and construct validity.\textsuperscript{14,55} The claim that DID is a “fad that has died” is not supported by an examination of the body of research about this disorder.
Belief That DID Is Primarily Diagnosed in North America

According to some authors, DID is primarily diagnosed in North America. We investigated this notion in three ways: by the world whenever researchers conduct systematic assessments using examining the countries in which prevalence studies of DID have been validated interviews. Table 1 lists the 14 studies that have utilized conducted; by inspecting the countries from which DID participants were recruited in an international treatment-outcome study of DID; or disorders to assess the prevalence of DID. These studies have been and by conducting a systematic search of published research to conducted in seven countries: Canada, Germany, Israel, the determine the countries where DID has been most studied. Netherlands, Switzerland, Turkey, and the United States. That is, the participants came from every selected empirical research studies in which DID or multiple personality disorder had been diagnosed in patients. We recorded authors’ countries and institutions, and whether structured interviews were used to diagnose DID. Over this nine-year period, 70 studies included DID patients. Significantly, these studies were conducted by authors from 48 institutions in 16 countries. In 28 (40%) of studies, structured interviews (SCID-D or DDIs) were administered to diagnose DID.

Belief That DID Is Primarily Diagnosed by DID experts

Lynn and colleagues argue that “most DID diagnoses derive from a small number of therapy specialists in DID.” Other critics voice similar concerns. Research does not substantiate this claim. For example, 292 therapists participated in the prospective treatment-outcome study of DID conducted by Brand and colleagues. The majority of therapists were not DID experts. Similarly, a national random sample of experienced U.S. clinicians found that 11% of patients treated in the community for borderline personality disorder (BPD) also met criteria for comorbid DID. None of the therapists were DID experts. In an Australian study of 250 clinicians from several mental health disciplines, 52% had diagnosed a patient with DID. These studies show that DID is diagnosed by clinicians around the world with varying degrees of expertise in DID.

Belief That DID Is Overdiagnosed

A related myth is that DID is overdiagnosed. Studies show, however, that studies examine dissociative disorders in general, rather than that most individuals who meet criteria for DID have been treated infocusing on DID, find that this group of patients are often not treated the mental health system for 6–12 years before they are correctly despite high symptomatology and poor functioning. A random sample diagnosed with DID. Studies conducted in Australia, China, and of adolescents and young adults in the Netherlands showed that youth have found that DID patients are commonly with dissociative disorders had the highest level of functional misdiagnosed. For example, in a study of consecutive admissions to an outpatient university clinic in Turkey, 2.0% of 150 patients were diagnosed with DID using structured interviews. Disorders in a nationally representative sample of German adolescents confirmed by clinical interview. Although 12.0% were assessed to have one of the dissociative disorders, only 5% of the dissociative/pyschiatric treatment. These findings point to the conclusion that patients had been diagnosed previously with any dissociative disorder, dissociative disorder patients are underrecognized and undertreated, rather than being overdiagnosed.

Why is DID so often underdiagnosed and undertreated? Lack of training, coupled with skepticism, about dissociative disorders seems to contribute to the underrecognition and delayed diagnosis. Only 5% of Puerto Rican psychologists surveyed reported being knowledgeable about DID, and the majority (73%) had received little or no training.
structured diagnostic interviews for dissociative disorders. This about DID. Clinicians’ skepticism, about DID increased as their pattern is also found in nonclinical samples. Although 18.3% of women knowledge about it decreased. Among U.S. clinicians who reviewed a in a representative community sample in Turkey met criteria for signs of an individual presenting with the symptoms of DID, only a third of the dissociative disorders group had received any type of psychiatric treatment. The authors concluded, “The majority of DID dissociative disorders cases in the community remain unrecognized and unserved.”

In short, far from being overdiagnosed, studies consistently document that DID is underrecognized. When systematic research is conducted, DID is found among the weakest by both experts and nonexperts. Ignorance and skepticism about the disorder seem to contribute to DID being an underrecognized disorder.

MYTH 3: DID IS RARE

Many authors, including those of psychology textbooks, argue that DID is a rare. The prevalence rates found in psychiatric inpatients, admissions and structured clinical interviews, find DID in 0.4%–6.0% of psychotic outpatients, the general population, and a specialized of clinical samples (see Table 1). Did is found in approximately 1.1%–1.5% of representative samples of trauma. For example, 6% of consecutive admissions in a highly community sample. Specifically, in a representative sample of traumatized, U.S. inner city sample were diagnosed with DID using the individuals from New York State, 1.5% met criteria for DID whenDID. By contrast, only 2.0% of consecutive psychiatric inpatients assessed with SCID-D questions. Similarly, a large study of individuals with DID. The community women in Turkey (n = 628) found 1.1% of the women had possession in their diagnoses, regardless of their accuracy. A study in Northern Ireland found a similar link between a lack of training about DID and misdiagnosis by clinicians. Psychologists more accurately detected DID than did psychiatrists (41% vs. 7%, respectively). Australian researchers found that misdiagnosis was often associated with lack of training about DID and with skepticism regarding the diagnosis. They concluded, “Clinic skepticism may be a major factor in under-diagnosis as diagnosis requires [dissociative disorders] first being considered in the differential. Displays of skepticism by clinicians, by discouraging openness in patients, already embarrassed by their symptoms, may also contribute to the problem.”

Inconsistent with the claim that DID is rare.

MYTH 4: DID IS AN IATROGENIC DISORDER RATHER THAN A TRAUMA-BASED DISORDER

One of the most frequently repeated myths is that DID is iatrogenically created. Proponents of this view argue that various influences—such as therapists who use leading questions and procedures, and media portrayals of DID—lead to dissociation. According to the latter (also known as the iatrogenic or “false memory” model), highly suggestive individuals enact DID following exposure to social influences that cause them to believe that they have the disorder. Thus, according to the fantasy model proponents, DID is not a valid disorder; rather, it is iatrogenically induced in fantasy-prone individuals by therapists and other sources of influence.

Dalenberg and colleagues concluded from their review and a single study conducted in a “normal” group of college students showed that students could simulate dissociation, and especially DID (i.e., between child sexual abuse and DID). That study, by Spanos and colleagues, documented that DID is a series of meta-analyses that little evidence supports the fantasy model. A single study conducted in a “normal” group of college students showed that students could simulate dissociation, and especially DID (i.e., 54% between child sexual abuse and DID). The students can engage in identity enactments when asked to behave as if trauma and dissociation were as strong in the study as they were in the DID group. Several recent controlled studies have found that DID individuals fantasize their abuse. Dissociation predicted only 1%–3% of the variance in suggestibility, thereby disproving the fantasy model’s notion that dissociative individuals are highly suggestible.
Two additional lines of research challenge the iatrogenesis theory of the second line of research challenging the iatrogenesis theory of DID: first, prevalence research conducted in cultures where DID is not documented the existence of dissociation and severe trauma in well-being, and second, evidence of chronic childhood abuse and childhood records of adults with DID. Researchers have found dissociation in childhood among adults diagnosed with DID. Three documented evidence of dissociative symptoms in childhood and classic studies have been conducted in cultures where DID was unknown in individuals who were not assessed or treated for DID virtually unknown when the research was in life (thus reducing the risk that these symptoms could be a result of structured interviews found DID in patients in China, despite the hypothesis).

Numerous studies have also found absence of DID in the Chinese psychiatric diagnostic manual. The documentation of severe child abuse in adult patients diagnosed with Chinese study and also two conducted in central-eastern Turkey in the 1990s. For example, in their review of the clinical records of 1990s, where public information about DID was absent—12 convicted murderers diagnosed with DID, Lewis and colleagues contradicted the iatrogenesis thesis. In one of the Turkish studies, representative sample of women from the general population (n = 994)agency reports, police reports) in 11 of the 12, and long-standing, was evaluated in three stages: participants completed a self-reported measure of dissociation; two groups of participants, with high versus a measure of dissociation, were administered the DID by a researcher blind to scores; and the two groups were then given clinical examinations (also blind to scores). The researchers were able to identify four cases of DID, all of whom reported childhood abuse or neglect.

Similarly, Swica and colleagues found documentation of early signs. Perhaps the “iatrogenesis myth” exists because inappropriate dissociation in childhood records in all of the six men imprisoned therapeutic interventions can exacerbate symptoms if used with DID for murder who were assessed and diagnosed with DID duringpatients. The expert consensus DID treatment guidelines warn that participation in a research study. During their trials, the men were assigned inappropriate interventions may worsen DID symptoms, although few occurred, they had nothing to gain from DID being diagnosed whilesuggested that inappropriate treatment creates DID. The only study to participating in the study. Their signs and symptoms of early date exterminating deterioration of symptoms among DID patients found dissociation included hearing voices (100%), having vivid imaginary that only a small minority (1.1%) worsened over more than one time-companions (100%), amnesia (50%), and trance states (54%), point in treatment and that deterioration was associated with Furthermore, evidence of severe childhood abuse has been found to dissociation or stressors in the patients' lives rather than with the medical, school, police, and child welfare records in 58%–100% of the therapy they received. This rate of deterioration of symptoms cases. These studies indicate that dissociative symptoms and compares favorably with those for other psychiatric disorders.

A history of severe childhood trauma are present long before DID is suspected or diagnosed.

### MYTH 5: DID IS THE SAME ENTITY AS BORDERLINE PERSONALITY DISORDER

Some authors suggest that the symptoms of DID represent a severe or One of the difficulties in differentiating BPD from DID has been the overly imaginative presentation of BPD. The research described the poor definition of the dissociation criterion of BPD in the DSM's below, however, indicates that while DID and BPD can frequently be various editions. In DSM-5 this ninth criterion of BPD is “transient, diagnosed in the same individual, they appear to be discrete stress-related paranoid ideation or severe dissociative symptoms.”

The narrative text in DSM-5 defines dissociative symptoms in BPD (“e.g., depersonalization”) as “generally of insufficient severity or duration to warrant an additional diagnosis.” DSM-5 does not clarify that when additional types of dissociation are found in patients who meet the criteria for BPD—especially amnesia or identity alteration that are severe and not transient (i.e., amnesia or identity alteration that form an enduring feature of the patient's presentation)—the additional diagnosis of a dissociative disorder should be considered, and that additional diagnostic assessment is recommended.

On the surface, BPD and DID appear to have similar psychological BPD and DID can also be differentiated on the Rorschach inkblot test. profiles and symptoms. Abrupt mood swings, identity Sixty-seven DID patients, compared to 40 BPD patients, showed disturbance, impulsive risk-taking behaviors, self-harm, and suicide greater self-reflective capacity, introspection, ability to modulate efforts are common in both disorders. Indeed, early comparative emotion, social interest, accurate perception, logical thinking, and studies found few differences on clinical comorbidity, history, obtrusibility to see others as potentially collaborative.

A pilot Rorschach psychometric testing using the Minnesota Multiphasic Personality study found that compared to BPD patients, DID patients had more Inventory and the Milon Clinical Multiaxial Inventory. Traumatic intrusions, greater internalization, and a tendency to engage However, recent clinical observational studies, as well as systematice complexity, complex contemplation about the significance of events. The DID studies using structured interview data, have distinguished DID from group consistently used a thinking-based problem-solving approach, BPD. Brand and Loewenstein review the clinical symptoms rather than the validating approach characterized by shifting back and and psychosocial variables that distinguish DID from BPD: clinically, forth between emotion-based and thinking-based coping that has been individuals with BPD show vacillating, less modulated emotions that documented among the BPD patients. These personality differences shift according to external precipitants. In addition, individuals who enable DID patients to develop a therapeutic relationship more BPD can generally recall their actions across different emotions and (almost) than many BPD patients.

With regard to the frequent comorbidity between DID and BPD, studies assessing for both disorders have found that approximately 25% of BPD patients endorse symptoms suggesting possible dissociated personality states (e.g., disremembered actions, finding
of self or sense of agency. Thus, the dissociated activity and intrusions objects that they do not remember acquiring\(^ {126}\) and that 10%–24% of of personality states into the individual's consciousness may be patients who meet criteria for BPD also meet criteria for experienced as separate or different from the self that they identify.\(^ {75,126,130,131}\) Likewise, a national random sample of experienced with or feel they can control. Accordingly, using SCID-D structured U.S. clinicians found that 11% of patients treated in the community for interview data, Boon and Draijer\(^ {128}\) demonstrated that amnesia, identity confusion, and identity alteration were significantly more severe in individuals with DID than in cluster B personality disorder patients, most of whom had BPD. However, DID and BPD patients did not differ on the severity of depersonalization and derealization. Both groups had experienced trauma, although the DID group had much more severe and earlier trauma exposure.

When the comorbidity between BPD and DID is evaluated specifically, the future, the neurobiology of BPD and DID might assist in their the patients with comorbid BPD and DID appear to be more severely comparison. Preliminary imaging research in BPD suggests the impaired than individuals with either disorder alone. For example, the frontal cortex may fail to inhibit excessive amygdala activation.\(^ {136}\) participants who had both disorders reported the highest level of amnesia and had the most severe overall dissociation scores.\(^ {139}\) personality states have been found in DID patients: neutral states are Similarly, individuals who meet criteria for both disorders have more dissociative amnesia.\(^ {125}\) and they also report higher scores of dissociative amnesia.\(^ {125}\)

What remains open for debate is whether a personality disorder Yet to be studied is the possibility that several overlapping etiological diagnosis may be given to DID patients, because attribution of clinical phenomenon to a personality disorder is not indicated if it is related to another disorder—in this instance, DID. Hence, the DSM-5 criteria for BPD may be insufficient to diagnose a personality disorder, because DID is not excluded. In this regard, some DID researchers have concluded that unmanaged trauma symptoms—including dissociation—may account for the high comorbidity of BPD in DID patients.\(^ {75,131}\) For example, one study found that only a small group of DID patients still met BPD criteria after their trauma symptoms were stabilized.\(^ {140}\) Resolution of this debate may hinge on whether personality disorder rather than a trauma-based disorder that involves dissociation as a central symptom.

In summary, DID and BPD appear to be separate, albeit frequently comorbid and overlapping, disorders that can be differentiated on validated structured and semistructured interviews, as well as on the Rorschach test. While the symptoms of DID and BPD overlap, preliminary indications are that the neurobiology of each is different. It is also possible that differences between DID and BPD may emerge regarding the respective etiological roles of trauma, attachment disruption, and genetics.

**MYTH 6: DID TREATMENT IS HARMFUL\(^ {52,69,151–153}\)**

Some critics claim that DID treatment is harmful.\(^ {52,69,151–153}\) Before reviewing the empirical literature, we will present an overview of the argument that DID treatment is consistent with empirical literature that documents improvements in the symptoms and functioning of DID patients who developed the disorder in childhood, with revisions in 1997, 2005, and 2011. The current standard of care for DID treatment is described in the International Society for the Study of Trauma and Dissociation’s treatments.

The benefit of accurately diagnosing (1) BPD without DID, (2) DID without BPD, and (3) comorbid DID/BPD is that treatment can be individualized to meet patients’ needs. A diagnosis of BPD without DID can lead clinicians to use empirically supported treatment for BPD. By contrast, the treatment of DID is different from the treatment of BPD and comprises three phases: stabilization, trauma processing, and integration (discussed below).\(^ {66}\) Given the severity of illness found in individuals with comorbid BPD/DID, clinicians should emphasize skills acquisition and stabilization of trauma-related symptoms in an extended stabilization phase. Early detection of comorbid DID and BPD alerts the therapist to avoid trauma-processing work until the stabilization phase is complete. The trauma-processing phase should be approached cautiously in highly dissociative individuals, and only after they have developed the capacity both to contain intrusive trauma material and to use grounding techniques to manage dissociation.

The standard of care for DID treatment is described in the International Society for the Study of Trauma and Dissociation’s treatment guidelines. \(^ {55,66}\) The first DID treatment guidelines were developed in 1994, with revisions in 1997, 2005, and 2011. The current standard of care for DID treatment is described in the International Society for the Study of Trauma and Dissociation’s treatment guidelines.
Early case series and inpatient treatment studies have shown that DID treatment is helpful, rather than harmful, across a wide range of dissociation-focused therapy. A study of consecutive clinical outcome measures among DID patients with treatment complexity suggests that treatment outcomes for DID are not directly addressed. The study, by Jepsen and colleagues, compared two groups of women who had experienced childhood sexual abuse—one without and one with a dissociative disorder (DID or dissociative disorder not otherwise specified). None of the DID patients had been diagnosed or treated for a dissociative disorder, and dissociative disorder was not the focus of the inpatient treatment. Thus, the methods of this study reduce the possibility of therapist suggestion. Although both groups had some dissociative symptoms, the dissociative disorder group was more severely symptomatic. Both groups showed improvements in symptoms, although the effect sizes for change in dissociation were smaller for the dissociative disorder group than for the non-dissociative disorder group ($d = 25$ and $60$, respectively). As a result of these findings, the hospital developed a specialized treatment program, currently being evaluated, for dissociative disorder patients (Jepsen E, personal communication, June 2013).

In short, claims about the harmfulness of DID treatment lack empirical support. Rather, the evidence that treatment results in remediation of dissociation is sufficiently strong that critics have recently conceded that increases in dissociative symptoms do not result from DID psychotherapy. To the same effect, in a 2014 article in *Psychological Bulletin*, Dalenberg and colleagues responded to critics, noting that treatment consistent with the expert consensus guidelines benefits and stabilizes patients.

### THE COST OF MYTHS AND IGNORANCE ABOUT DID

As we have shown, current research indicates that while approximately 1% of the general population suffers from DID, the disorder remains suffering and disability of DID patients. Younger DID patients appear undertreated and underrecognized. The average DID patient spends more years in the mental health system before being correctly diagnosed. These patients have high rates of suicidal and self-destructive behavior, experience significant disability, and often require expensive and restrictive treatments such as inpatient and partial hospitalization.

Studies of treatment costs for DID show dramatic reductions in overall cost of treatment, along with reductions in utilization of more restrictive levels of care, after the correct diagnosis of DID is made and appropriate treatment is initiated. The DID experts who wrote the guidelines recommend a tri-phasic, trauma-focused psychotherapy. In the first stage, clinicians focus on safety issues, symptom stabilization, and establishment of a therapeutic alliance. Failure to stabilize the patient or a premature focus on detailed exploration of traumatic memories usually results in deterioration in functioning and a diminished sense of safety. In the second stage of treatment, following the ability to regulate affect and manage their symptoms, patients begin processing, using, and resolving trauma. In the third and final stage of treatment, patients integrate dissociated self-states and become more socially engaged.

DID experts uniformly support the importance of recognizing and working with dissociated self-states. Clinicians in the TOP DD study of the alleged harmfulness of DID treatment. They did not find a single reported frequently working with self-states. While it is not possible to conclude that working with self-states caused the decline in symptoms, these improvements occurred during treatment that involved specific work with dissociated self-states. This finding is consistent with research challenges the conjecture that working with self-states harms DID patients.

In their review—from 2014—Brand and colleagues concluded that claims about the alleged harmfulness of DID treatment are based on non-peer-reviewed publications, misrepresentations of the data, autobiographical accounts written by patients, and misunderstandings about DID treatment and the phenomenology of DID.

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discourage scholars from pursuing research about DID and also inhibit funding for such research, which exacerbates, in turn, the lack of understanding about, and the currently inadequate clinical services for, DID.

CONCLUSION

An enduring interest in DID is apparent in the solid and expanding research base about the disorder. DID is a legitimate and distinct psychiatric disorder that is recognizable worldwide and can be reliably assessed for dissociation. Accurate diagnoses are critical for identified in multiple settings by appropriately trained researchers and appropriate treatment planning. If DID is not targeted in treatment, it also impede research about DID. The cost of ignorance about DID is high not only for individual patients, but for the whole support system in which they live (e.g., loved ones, health systems, and society). Empirically derived knowledge about DID has replaced outdated myths, and for this reason vigorous dissemination of the knowledge base about this complex disorder is warranted.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the article.

REFERENCES


95. Perniciaro LA. The influence of skepticism and clinical experience on the detection of dissociative identity disorder by mental health clinicians. Newton, MA: Massachusetts School of Professional Psychology; 2014.


123. Myrick AC, Brand BL, Putnam FW. For better or worse: the role of revictimization and stress in the course of treatment for dissociative disorders. J Trauma Dissociation 2013;14:375–89.


127. Kemp K, Gilbertson AD, Torem MS. The differential diagnosis of multiple personality disorder from


166. Lloyd M. How investing in therapeutic services provides a clinical cost saving in the long term. 2011. At http://www.hsj.co.uk/1-september-2011/1200418.issue


Prior to being renamed dissociative identity disorder, DID was referred to as “multiple personality disorder.” Dissociated personality states are referred to by various names, including identities, dissociated self-states, parts, and alters. Cited Here...

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