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Vissia et al (2016) claim that the etiology of Dissociative Identity Disorder (DID) is trauma-based. But how strong is their evidence?

In one study of many enfolded in the long-running controversy regarding the genesis of dissociative identity disorder (DID), Vissia et al. (1) administered self-report measures of trauma and fantasy to small subsamples (all n 's < 18) of DID patients, DID simulating actors, healthy comparison participants, and PTSD patients. Using Bonferroni-corrections, which further diminished their already low statistical power, they concluded that their data “consistently” support the Trauma Model of DID rather than the Sociocognitive Model (2), which holds that conspicuous dissociative symptoms (e.g., identity alterations) typically seen in DID are the byproducts of sociocultural expectations, often induced by iatrogenic psychotherapy, interacting with patients’ imaginative capabilities.

Vissia et al.’s conclusion is less than compelling. First, the authors seriously misrepresent the Sociocognitive Model. Like many others, they erroneously equate role-enactment, which is largely unconscious, with “simulation”, which is not. The Sociocognitive Model does not imply that people who consciously mimic the features of DID and attempt to role-play different personality states will resemble DID patients in most, let alone all, important respects, as this model acknowledges that DID patients genuinely believe that they harbor multiple indwelling identities and act accordingly. Still, researchers have found few or no differences between

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persons diagnosed with DID and healthy individuals simulating DID with respect to measures of memory, event-related potentials, self-reported dissociative experiences, and, importantly, interidentity transfer of information. This latter finding, which indicates that amnesia across identities is incomplete, casts doubt on the true, rather than the illusory or imagined, separation of identities in persons diagnosed with DID.

Although Vissia et al. are mistaken in their exaggerated claim that the “primary thesis” of the Sociocognitive Model is “that individuals with DID are highly suggestible” (p. 14), they are correct that the Sociocognitive Model emphasizes the role of sleep disturbances, suggestive psychotherapy, iconic media portrayals of DID, and fantasy proneness in the etiology of DID (2). But this model also stipulates that these factors are often or usually superimposed on genuine psychological problems, especially those marked by instability in mood and identity. For example, the overlap between borderline personality disorder and DID is high, typically in the range of 60%-80%. Thus, if DID patients resemble those in other diagnostic categories, such as PTSD patients, this finding cannot be construed as evidence against the Sociocognitive Model, because this model implies that people with certain disorders are at dramatically elevated risk for DID. Relatedly, contrary to the authors’ claim, it is not evident how the finding of high scores for depression in the DID group compared with simulators, PTSD patients, or healthy comparison participants provides differential support for the Trauma versus the Sociocognitive Model.

Replicating earlier research (3), Vissia et al. observed that their DID patients and their only clinical comparison group (i.e., PTSD patients) attained similarly high scores on measures of general sleep problems and fantasy proneness. This finding is at best ambiguous. DID patients scored almost two scale points higher on the fantasy proneness index than did PTSD patients and the lack of statistical significance of this difference might be due to the low statistical power; indeed, although Vissia et al. did not report effect sizes for the comparisons in Table 2, a calculation demonstrates that the Cohen’s d for this difference was .39, which is small to medium (although closer to medium) in magnitude. It would have been more informative had the authors collapsed the two clinical groups and then tested whether trauma self-reports are better (independent) predictors of dissociative symptoms than are fantasy proneness. Finding such pattern would have provided evidence for the Trauma Model.

Second, some of Vissia et al.'s findings seem to contradict the Sociocognitive Model. For example, DID patients were not more sensitive to misinformation on Gudjonsson's Suggestibility Scale (GSS) and did not produce more pseudomemories on a Deese-Roediger-McDermott (DRM) memory illusions task in comparison with PTSD patients. However, to evaluate the meaning of these null findings, it is essential to know how DID and PTSD patients were selected and instructed. If, for example, DID patients were forewarned by informing them that this study was intended to test a false memory-account of DID, or if they correctly discerned that scoring high on a measure of fantasy proneness would invalidate or undermine their role-enactments consistent with DID, they might have been especially motivated to produce accurate memory responses or to not endorse certain fantasy-related items. Indeed, literature shows that it is easy to lower suggestibility scores on the GSS by creating specific expectations in participants (4). Another potentially troubling point, not noted by the authors, is the low number of correct responses on the DRM (range 6.37-8.99) and the corresponding low levels of critical lure endorsements (range: 0.40-0.59). These aberrant results suggest floor effects for pseudomemories, possibly stemming from instructions.

Third, Vissia et al. observed one effect that clearly favors the Sociocognitive Model over the Trauma Model: DID patients endorsed significantly more symptoms on the Structured Inventory of Malingered Symptomatology (SIMS) than did all other groups. The authors attempt to explain this effect away by arguing post-hoc that the SIMS is a crypto-measure of dissociation. They concluded that the extremely high SIMS scores of DID patients in effect provide "support for the Trauma Model" (p. 13). There is, indeed, some shared item content between the SIMS and measures of dissociative symptoms. For example, the SIMS contains item such as "Recently, I've noticed that my memory is getting so bad that there have been entire days that I cannot recall", which can be interpreted as an experience alluding to dissociative amnesia. However, the majority of SIMS items refer to bizarre and atypical symptoms such as "Sometimes, when writing a phone number, I notice that the numbers come out backwards even though I don't mean to do it." Endorsing several of these extremely implausible items implies that the respondent is over-reporting symptoms (5). This, in turn, implies that other self-report information provided by the respondent should not be taken at face value. One way of dealing with this uncertainty is to exclude participants from the analyses who exceed the cut-point of the

SIMS. Another would be to treat SIMS scores as covariates. It is unclear how the results of Vissia et al. would have looked had they adopted these analytic approaches.

In sum, Vissia et al.'s findings do not offer convincing support for the Trauma Model. The authors overlooked the meaning of their null findings, overstated the value of their positive findings, and underestimated the falsificatory potential of their negative findings, thereby yielding a scientifically imbalanced appraisal of the evidence for the two major competing etiological models of DID.

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