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# The Problem with Dissociative Identity Disorder in the Media: Misrepresentation, or Inadequate Diagnostic Criteria?

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# The Problem with Dissociative Identity Disorder in the Media: Misrepresentation, or Inadequate Diagnostic Criteria?

By

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## Abstract

The highly popularized portrayal of Dissociative Identity Disorder (DID) in mainstream media has often been dubbed inaccurate; blamed on misrepresentations, bad applications of the diagnostic criteria, and the tendency to sensationalize mental illness. Through the analysis of five different depictions of DID in film, I find that all five characters met the minimum criteria for diagnosis according to the most recent edition of the Diagnostic and Statistical Manual (2013). Some depictions of DID predate the publication date of the current diagnostic manual by over 50 years, portraying symptoms that are widely recognized today but were neither accepted nor identified back then. From these findings, I argue that the controversy surrounding the supposed misrepresentation of the disorder in the media is not the result of inaccurate depictions, but rather that of indiscriminate diagnostic criteria. As the criteria required for a diagnosis of DID is one of inclusion, subjects are given multiple opportunities to meet the same criterion. Through the improved specification of diagnostic criteria, patients will need to meet more stringent benchmarks in order to receive a diagnosis. This will change the narrative surrounding DID patients. Misdiagnoses will likely decrease, and movies based on exaggerated symptoms will no longer be the face of DID.

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## Introduction

Dissociative Identity Disorder (DID) has been the topic of many popular films (herein defined as movies and television shows), most recently in the movie *Split* (Shyamalan, 2016), which came under fire shortly after its release for falsely portraying DID patients as violent (Brand & Pasko, 2017). *Split* (Shyamalan, 2016) portrays a man who kidnaps three teenage girls and ultimately murders two of them after transforming into his monster-like 24th identity. *Split* (Shyamalan, 2016) is not alone in receiving heavy criticism. The movie *Me, Myself, and Irene* (Farrelly & Farrelly, 2000), released in 2000, was protested by the National Alliance on Mental Illnesses prior to its release for perpetuating the myth that schizophrenia is a "split personality" (NAMI, 2000). While the former is the disorder that Jim Carrey's character is officially diagnosed with, the character is portrayed on screen as the latter. In addition, the 2016 television show *United States of Tara* (Spielberg, 2009) was denounced for showing the use of medication to treat dissociation, which effectively stopped the appearance of the main character's alternate personalities. According to a paper published four years after the premiere, no pharmacological treatment had yet to be found that reduced experiences of dissociation (Gentile et al., 2013), let alone eliminated it completely.

Although many films claim to tell the real story of a patient with multiple personalities, few actually do; the movie *The Three Faces of Eve* (Johnson, 1957), which tells the story of Chris Sizemore, is the exception. Contrasting this is the movie *Sybil* (Petrie, 1976), which, despite its claims, was proven to be largely fictional years later. While the publication of the 1973 book by the same name (Schreiber, 1973) brought attention to the possible link between childhood abuse and multiple personality (Coons, 1986), the movie adaptation proved to be controversial. Speculation surrounded the belief that the multiple personalities depicted on screen

were actually induced via shared psychosis between the patient and her treating psychologist, Dr. Connie Wilbur (Coons, 2013). Consequentially, the assumption that DID was not a "valid disorder of posttraumatic origin" persisted, believed to instead be a creation of psychotherapy (Gleaves, 1996, p. 42).

There are many factors that contribute to erroneous DID diagnoses. First, true DID patients rarely disclose their dissociative symptoms; rather, they avoid reporting them unless questioned directly. Since healthcare professionals are often not appropriately trained to diagnose dissociative disorders, the appropriate questions may never be asked, and symptoms from resistant patients may never be uncovered. This often results in the practitioner opting for a more familiar diagnosis, such as schizophrenia or borderline personality disorder. On the other end of this is the false diagnosis of DID, which is due in part to insufficient professional training. Another factor, though, is the large amount of information about DID in the media, whether that be through movies, television, testimonials shared on YouTube, or otherwise documented. While a patient may quality for a dissociative disorder diagnosis, some align their symptoms with DID before even entering a practitioner's office. Desperate to find a diagnosis to explain their life-long struggles, these types of patients learn about symptoms through mainstream media. When subsequently reporting or demonstrating them, many of these patients believe these experiences have actually happened. Rather than an intentional form of lying, the motivation for these patients is not conscious, as receiving a diagnosis often provides a sense of understanding and relief (Pietkiewicz et. al, 2021).

While all the described issues are contributing factors, the root of misdiagnosis lies within indiscriminate diagnostic criteria. The DSM was created to ensure consistency and reliability during diagnosis through the use of a common language by all practitioners (APA,

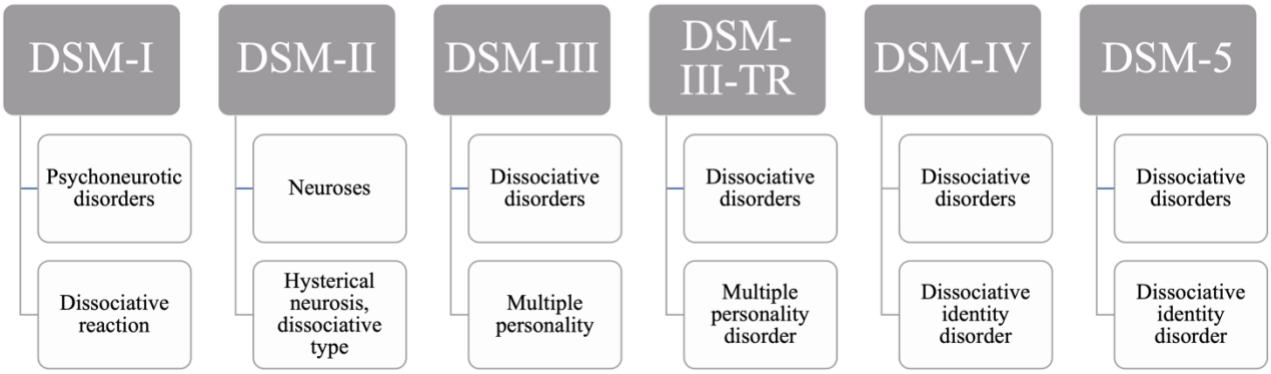
n.d.). Theoretically, practitioners who have never encountered a DID patient should be able to use the manual to provide a proper diagnosis, though this is not the reality of the situation. When patients present with symptoms that appear to fit the written criteria, these practitioners are not equipped with the specific information that is needed from the DSM-5 in order to distinguish fact from fiction. As a result, patients are misdiagnosed, improperly treated, and continue to suffer.

**History of the Disorder**

DID has a long history in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The first edition of the DSM (DSM-I), published by the American Psychiatric Association in 1952 as the first official manual of mental disorders (American Psychiatric Association [APA], 1987), was promoted as a glossary that contained only descriptions of the diagnostic categories, rather than diagnostic criteria. The origin of DID can be found within the "psychoneurotic disorders" category, originally given the name "dissociative reaction" (APA, 1952). When the second edition (DSM-II, 1986) was published sixteen years later, the diagnosis was moved to the broader "neuroses" category and renamed "Hysterical neurosis, dissociative type" (APA, 1968). The lack of diagnostic criteria within these two editions left clinicians on their own to define the boundaries of the diagnostic categories (APA, 1987), which was quickly recognized as problematic. Twelve years later in 1980, the third edition of the DSM (DSM-III) included diagnostic criteria for the first time. This edition also introduced the category "Dissociative disorders," which contained the newly renamed "Multiple Personality" (APA, 1980). In 1987, the DSM-III was revised (DSM-III-TR), renaming Multiple Personality to Multiple Personality Disorder (MPD), as well as defining the term "personality" (APA, 1987). Personality was defined as patterns of behavior, such as relating to, perceiving, and thinking about the environment and oneself, that are "deeply ingrained" (APA, 1987, p. 403). This clause

was re-worded in the fourth edition, published in 1994, as patterns that are "enduring." In addition, the DSM-IV defined personality states as the prominent aspects of personality that are exhibited in a "wide range" of contexts (APA, 1994, p. 770). Most importantly, the DSM-IV renamed the disorder previously known as MPD to Dissociative Identity Disorder (APA, 1994), which is what it is known as today. The DSM-5 was published in 2013 and contains the diagnostic criteria that is currently used to diagnose DID (APA, 2013), while the March 2022 release of the DSM-5-TR contained no changes to DID criteria (APA, 2022).

*Classification and Diagnostic Labels Throughout DSM History*




All four editions that contain diagnostic criteria for MPD or DID, require the existence of two or more "distinct personalities," which was later changed to "personality states" in the DSM-III-TR. This edition also states that each of these personality states has its own "relatively enduring" pattern of perceiving, relating to, and thinking about the environment and self (APA, 1987 p. 272). One criterion from the DSM-III states that one personality dominates and determines the individual's behavior at any given time (APA, 1980). The text revision in the DSM-III-TR changes this to "at least two of the identities recurrently taking control of the person's behavior" (APA, 1987 p. 272). This phrase remains the same in the DSM-IV (APA, 1994). The fourth and fifth editions of the DSM both contain criterion describing recurrent gaps in the recall of three different categories of memory that aren't consistent with "ordinary"

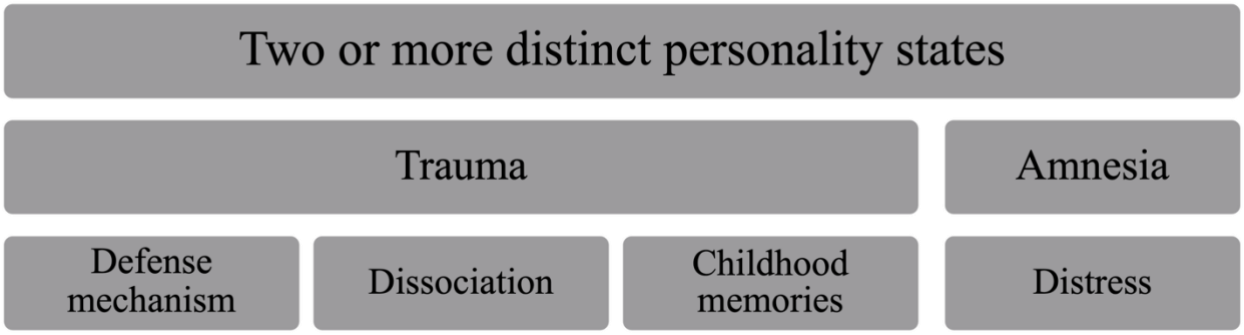
forgetfulness (APA, 1994 p. 487; APA, 2013 p. 292). The last criterion in the DSM-IV was updated to include a disclaimer that the disturbance was not due to the physiological effects of a substance and, in children, is not attributable to imaginary/fantasy play (APA, 1994). This criterion is carried over to the DSM-5, following the assertion that the symptoms must cause distress or impairment and that the disturbance is not part of a cultural or religious practice (APA, 2013).

In addition to these diagnostic criteria, each disorder in the DSM contains a detailed description. Beginning with the DSM-III, these descriptions include the prevalence rate, sex ratio, predisposing factors, and common features of the disorder to supplement and better understand the criteria laid out. (APA, 1980, 1987, 1994, 2013). Throughout history, the disorder has consistently been dominated by females in adult clinical settings (APA, 2013), which aligns with what has been portrayed in the media, as 3 of the 5 films I analyzed contain a female protagonist with DID. The presence of amnesia, including dissociative fugues, has been reported since the first edition of the DSM, as well as the signaling of a transition, labelled in the DSM-I as “freezing” (APA, 1952, p. 32). The DSM-II further describes that the symptoms begin and end “suddenly” (APA, 1968, p. 39), and the word “transition” is not utilized until the third edition (APA, 1980, p. 257, 258).

While DID is characterized via the five diagnostic criteria and associated features laid out in the DSM-5, the disorder is much more complex. Marked by its core feature of two or more distinct personalities presenting in one person (APA, 2013), dissociation is often understood as a defense mechanism, as the patient subconsciously tries to prevent an “overwhelming flooding of consciousness” when experiencing trauma (Gentile et al., 2013, p. 23). Essentially, the patient momentarily prevents themselves from being present because they cannot handle being

consciously aware of the traumatic experience. This dissociation creates a discontinuity of experience, which is often reported as amnesia. Upon learning to dissociate during traumatic experiences, the individual then, often arbitrarily, applies this response to other situations that may require escape (Gentile et al., 2013). This idea is the basis of the claim that DID patients are running away from their problems; however, the dissociation occurs subconsciously, and not as the result of a conscious decision.

*Critical Components of DID*




**Discourse in the Field Surrounding Diagnostic Validity**

The DSM-III (1980) was the first edition to contain detailed diagnostic criteria. It was also the first to describe common features and other information about the disorder, including the prevalence rate, which states that the disorder "is apparently extremely rare" (APA, 1980, p. 258). Just eight years later, the DSM-III-TR suggested that recent reports find the disorder to be "not nearly so rare" as was commonly thought (APA, 1987, p. 271). Rates of diagnosis skyrocketed in the early 1980s, with more people being diagnosed between 1981 and 1986 than in the preceding two centuries (OpenEd CUNY, n.d.). Some observers were impressed that a once uncommon disorder was being identified so frequently (Paris, 2012), speculating that the creation of new, more sophisticated diagnostic technology was to blame. As both interest and diagnostic rates fell in the 90s (Paris, 2012), it was concluded that the initial spike was likely caused instead by popularity following the release of *Sybil* (OpenEd CUNY, n.d.; Petrie, 1976).

As a result, acceptance of the disorder is not universal within the field. In 1999, of the over 300 board-certified psychiatrists that were surveyed, 43% expressed skepticism about the diagnosis, while 15% believed it should be outright removed from the DSM (Gharaibeh, 2009).

The release of the DSM-IV in 1994 confirmed this sharp rise in reported cases. The additional speculation about the possibility of overdiagnosis as well as conjecture on the reliability of patient recounts (APA, 1994) made the controversy surrounding the disorder clear. The manual, published 18 years after the release of *Sybil* (Petrie, 1976), describes the spike, likely in misdiagnoses, as a result of both media interest in the disorder and the suggestible nature of the individuals (APA, 1994). The first mention of this openness to suggestion is found in the DSM-III, which claimed that hypnosis could be used to elicit a switch in personalities (APA, 1980). Both the fourth and fifth editions built upon this framework, describing how DID patients receive high scores on standardized measures of hypnotizability (APA, 2013). The DSM-IV also finds that those diagnosed with DID tend to be "especially vulnerable to suggestive influences" (APA, 1994, p. 485). Under hypnosis, suggestions by the treating professional may result in the emergence of false memories, often referred to as "socially determined role play" (Paris, 2012, p. 1077).

Another common thread between patients is the underlying experience of severe emotional trauma in childhood (APA, 1980), which usually comes in the form of physical or sexual abuse (APA, 1994). The accuracy of these reports, though, is scrutinized as memories from childhood are subject to distortion (APA, 1994). In addition, since many stories of childhood trauma are often never verified, it is quite possible that memories of abuse could be the result of fabrication (Paris, 2021). It is also not uncommon for adults to lack recall of childhood events. Since memories are narrative stories and not recordings, they are rarely

factually accurate and are often altered and reinterpreted upon recall (Paris, 2012). In addition, the vulnerability of these patients, whether it be from trauma from actual or perceived child abuse, leaves them extremely suggestible. Many proponents of the disorder believe it to be to a result of iatrogenic artifacts, as narcissistic healthcare providers desire the gratification of treating a patient with DID (Gharaibeh, 2009). This is exemplified by the real-life case of Shirley Mason, otherwise known as Sybil, and her therapist Dr. Connie Wilbur. Wilbur was heavily interested in multiple personalities, and Mason was the perfect patient, as she was willing to go along with whatever Wilbur desired (Neary, 2011).

The International Classification of Diseases, tenth edition (ICD-10), the DSM's more expansive international counterpart, also includes a claim about the rarity of the disorder. The ICD-10 acknowledges the controversy within in the field, specifically about the extent to which the disorder may be culture-specific or even induced by patients or professionals during treatment (Pietkiewicz et. al, 2021). Though studies that find prevalence rates as small as 0.4% support the ongoing claims about the rarity of the disorder (Pietkiewicz et. al, 2021), other sources have reported rates as high as 28% (Gentile et al., 2013). In response to low prevalence rates, those who maintain the commonness of DID explain that patients simply go undiagnosed for long periods of time (Paris, 2012). On the other hand, some believe that the disorder is a result of "suggestive therapy techniques," shaped both by therapists' biases and ambitions, as well as patients' suggestibility (Paris, 2012 p. 1076). In addition, much of the available clinical research originates from just a handful of centers, despite none of their research including randomized control trials to improve validity. These centers allege to specialize in dissociative disorders while simultaneously advertising their costly inpatient treatments designed to reintegrate personalities (Paris, 2012). This approach to research might beg to question the

reliability of their methods and outcomes.

**Case Studies**

Stories of real people are largely made famous due to their portrayal in popular films, like that of *Sybil* (Petrie, 1976) and *Eve* (Johnson, 1957). Others, though, take the media by storm, often due to publicity surrounding a salient criminal trial. Most notably are the cases of Billy Milligan and Kenneth Bianchi. Following Milligan's success in receiving a verdict of not guilty by reason of insanity due to multiple personalities, the infamous Hillside Strangler attempted to do the same (McClary, 2008). His failure and admission to fabricating the disorder did not erase the damage that had been done towards contributing to the narrative that DID patients are violent criminals. The release of the movie *Split* (Shyamalan, 2016), which portrays a man with personalities capable of kidnapping and murder, reinforced this idea even further, resulting in over 20,000 people signing a petition to boycott the movie (Davidson, 2017). The myth may be widespread, but in reality, a 2017 study found that only 1.2% of patients with dissociative disorders received a criminal justice mental health referral over the previous six months, and less than 1% had been incarcerated over this same period of time (Webermann & Brand, 2017). Case studies like these provide a background for the sensationalizing of DID in the media.

*Christine "Sally" Beauchamp (Clara Norton Fowler)*

The case of Mary Reynolds, published by Dr. S.L. Mitchell in 1888, is heavily cited as the first known case of multiple personality in the world (Carlson, 1981). Reynolds experienced years of strange "fits" (Mitchell, 1888 as cited in Rogers, 1991, p. 3) before she woke up from a prolonged sleep with neither memory nor language (Mitchell, 1988 as cited in Carlson, 1981). Years later, the publication of Dr. Morton Prince's 590-page book titled *Dissociation of a Personality*, which described the case of Christine "Sally" Beauchamp (Prince, 1906) sparked a

rise in interest about the disorder (Rogers, 1991). Beauchamp, whose real identity was revealed as Clara Norton Fowler, sought Dr. Prince's help after experiencing headaches, bodily pains, insomnia, and exhaustion, as well as being told by her teachers and friends that she quickly changed mood and character. Dr. Prince dubbed the woman who showed up at his office for help as "BI," or "the Realist" (Rosenzweig, 1988, p. 45), noting that she was educated, conscientious, and sometimes unable to do what she wanted (Wehrstein, 2019).

While under hypnosis, two more possible identities emerged (Rosenzweig, 1988). BII was deemed by Prince to be a hypnotic state who held the memories of Fowler's life. Sally, or BIII, emerged as a vivacious, assertive, and rebellious child who tormented Fowler, labelling her as stupid, forcing her to tell lies, and destroying her things for her to find when she re-gained control. In 1899, Prince paid Fowler a visit and watched her instantly change from a nervous woman, who was unable to speak, into BIV, who was both chatty and pleasant before revealing herself as angry and selfish (Wehrstein, 2019). From Sally's writings, it was found that, in addition to Fowler's father having had a violent temper, she also blamed herself for multiple deaths. It is speculated that the overwhelming guilt from the death of her mother, who she felt she did not love enough, and her infant brother, who suddenly stopped breathing in her arms, caused the split. The genuine Fowler was a combination of BI, BII, and BIV, and it was she who ultimately experienced extended periods of control over her body. She was only overpowered by Sally, who represented the subliminal mind, in times of stress (Wehrstein, 2019).

*Chris "Eve" Sizemore*

At just two years old, Chris Sizemore witnessed three traumatic events within a short period of time. First, she watched as a drowned corpse was pulled from a ditch. Shortly after, she experienced a lumber mill worker get sawed in half. Lastly, her mother accidentally cut herself

in the kitchen while Chris watched as she bled. It was the combination of these experiences that was presumed to cause her split (Van Biema & Grant, 1989). As a child, Sizemore recounted receiving punishment for misbehaviors that she could not recall performing and taking tests in school that other personalities had prepared for (Weber, 2016). Only three personalities, Eve White, a shy housewife, Eve Black, a self-indulgent party girl, and Jane, a pleasant and sensible woman, initially revealed themselves (Weber, 2016). While these were the only three depicted in the movie recounting her story, *The Three Faces of Eve* (Johnson, 1957), 19 more emerged over the next 20 years until Chris finally became whole again (Van Biema & Grant, 1989). Some personalities did not know how to drive, and one opened a cloth store as an accomplished seamstress. At one point, Sizemore gained a significant amount of weight because her body was eating for three, with each of the three dominant personalities at the time not knowing that the others had already ate (Weber, 2016).

Despite her accurate diagnosis, Sizemore revealed that the film itself was "slightly misleading" in a question-and-answer session in 1988 (Sizemore & Huber, 1988). While the movie ends in a successful reintegration at age 29, Sizemore was not cured until the mid-70s, over 20 years after the film's release. Diagnosed at a time when multiple personalities were essentially unheard off, the book and subsequent movie allowed "split personality" to become a household term, setting the stage for *Sybil*, the 1973 book (Schreiber, 1973) and 1976 movie (Petrie, 1976) by the same name (Rogers, 1991). Sizemore went on to live a life free of dissociation as a mental health advocate before dying of a heart attack at the age of 89 (Weber, 2016).

*Shirley "Sybil" Mason*

Both the book (Schreiber, 1973) and movie, *Sybil* (Petrie, 1976), claimed to tell a strange,

yet true story, based on the experiences of a real woman (Neary, 2011). Sybil Dorsett was a pseudonym for Shirley Mason, a young woman who formed an unusual attachment to her psychologist Connie Wilbur, becoming dependent on her both emotionally and financially (Neary, 2011). Mason was a very suggestible woman who was prone to fantasize (Carey, 2017). When she no longer felt like she was receiving the attention she deserved, she walked into Wilbur's office and announced, in a childlike voice, that she was named Peggy, a nine-year-old girl who stood up for Shirley since she was unable to do so herself (Neary, 2011). In total, Mason generated and revealed 16 personalities, ranging from babies to little boys to teenage girls (Neary, 2011).

Through both hypnosis and drugs, including sodium pentothal (Neary, 2011) and intravenous barbiturates (Carey, 2017), these personalities recanted the awful sexual and physical abuse Mason experienced at the hands of her mother (Carey, 2017). At one point, Mason wrote Wilbur a letter admitting that she was lying, but the doctor dismissed this as an attempt to avoid uncovering deeper trauma. Since Mason could not emotionally afford to lose Dr. Wilbur, she followed along with the doctor's suggestions (Neary, 2011). While the story ends with a happy reintegration of personalities, the real life of Shirley Mason did not mirror what was portrayed by her character Sybil. After Shirley was outed following the release of the 1973 book which did little to hide her true identity, she became heavily dependent on Dr. Wilbur. Shirley Mason lived the rest of her life in hiding as an addict (Carey, 2017).

The film became a pop phenomenon and created a tidal wave of MPD/DID cases. Before the release, there were only 200 cases in history, a number that increased to over 40,000 post-release (Brand & Pasko, 2017). Despite the film's success, the supposedly true story was exposed as fiction in Debbie Nathan's 2012 bestseller *Sybil Exposed: The Extraordinary Story*

*Behind the Famous Multiple Personality Case.* From a mound of papers, photos, and tapes, it was uncovered that Wilbur subjected Mason to years of electroshock therapy and a concoction of drugs, only under which she produced the rambling false memory-based narratives recounting the horrific child abuse (Brand & Pasko, 2017). The film created widespread interest in the disorder, not only in the general population, but also within the field of psychology. Interest was so great that it resulted in a group of psychiatrists and psychologists to successfully lobby for the addition of Multiple Personality Disorder (MPD) into the DSM (Carey, 2017). Regardless of its contribution to psychology, the eventual reveal that the case was fabricated only added more fuel to the fire in the questioning of the disorder's legitimacy.

*William "Billy" Milligan*

William Stanley Milligan, otherwise known as Billy, was arrested in 1977 and charged with the rape of four women, as well as the kidnapping and robbing of three of them, on The Ohio State University campus (Stuart, 1978). Billy was found to have 10 distinct personalities with their own names, aesthetic values, and IQs (Stuart, 1978), ranging from as low as 80 all the way up to 130 (Coles, 1981). By the time *The Minds of Billy Milligan* (Keyes, 1981) was published in 1981, the total number of personalities had climbed to 24. Written by Daniel Keyes, the book describes how the twenty-four people who lived inside of Billy battled for supremacy over his body. Adalana, the affection-starved lesbian, ultimately prevailed when she "used" Billy's body in the rapes, causing Billy to wake up in jail with no memory of how he got there (Keyes, n.d.). As his early life had many of the common predisposing factors, including violent physical and sexual abuse at the hands of his stepfather (Coles, 1981), he made legal history in 1978 as the first criminal defendant in the country to be found not guilty by reason of insanity due to Multiple Personality.

*Kenneth "The Hillside Strangler" Bianchi*

Kenneth Bianchi was a chronic liar. After having a child with his girlfriend Kelli Boyd, he set up a psychology practice with a fake degree (Biography.com Editors, 2014). He told Boyd he was dying of cancer, and then went on a four-month killing spree. Between 1977 and 1978, 10 women aged 12 to 28 were kidnapped, raped, tortured, and eventually killed. Their remains were disposed of in the hills of Los Angeles (Crime Museum, LLC, 2021). This unknown killer, dubbed "The Hillside Strangler" by the media, was eventually determined to be both Angelo Buono Jr. and his cousin Kenneth Bianchi. After moving to Washington state, Bianchi began to operate alone, murdering two college students before his eventual arrest (Crime Museum, LLC, 2021). During his interview, he claimed to have what was then known as Multiple Personality Disorder (Crime Museum, LLC, 2021).

Two months after pleading "not guilty," Bianchi changed his plea to "not guilty by reason of insanity," with his defense attorney insisting that Bianchi had amnesia about the two Washington state murders. He claimed that three different psychiatrists had evaluated Bianchi and diagnosed him with severe Multiple Personality Disorder. Under what was believed to be hypnosis, Bianchi created an alter named Steve Walker. Steve confessed, spoke freely about the crimes for months, implicated Buono, and gave a detailed account of the killings. At his competency hearing, two psychiatrists believed that he had multiple personalities and was unable to stand trial; two were certain that he was faking, and two could not be sure (McClary, 2008).

The lack of professional consensus provides evidence for the idea that humans can skillfully adopt the role of a person with more than one personality when it is believed to be advantageous (OpenEd CUNY, n.d.). One psychiatrist, Dr. Orne, observed that Bianchi lacked a history of dissociation, and that the presentation of his alternate personalities were both overly

dramatic and inconsistent (Simon, 2008). In addition, he informed Bianchi that people with MPD have at least three personalities, attempting to communicate that he would be more convincing with the addition of a third. On that same day, a new personality named Billy emerged (Kiesel, 1984). Upon searching Bianchi's apartment, police found over a dozen sophisticated psychology books, with one specifically discussing hypnotic techniques. This, in addition to the admission by Bianchi that he had seen *The Three Faces of Eve* (Johnson, 1957), the most famous movie about multiple personalities at the time (Kiesel, 1984), led all six psychologists to conclude that he was faking (McClary, 2008). Bianchi withdrew his insanity plea, pleaded guilty to both murder charges (McClary, 2008), and later admitted to falsifying the MPD (Simon, 2008).

## Methods

My primary sources of evidence were popular films centered around a main character with DID. The 5 films included one television show, titled *United States of Tara* (Spielberg, 2009), herein referred to as *Tara*. The oldest of the four movies I viewed was *The Three Faces of Eve* (Johnson, 1957), herein referred to as *Eve*, which was released in 1957, just five years after the first edition of the DSM was published (APA, 1952). I also watched the movies *Sybil* (Petrie, 1976), *Me, Myself, and Irene* (Farrelly & Farrelly, 2000), herein referred to as *Irene,* and the 2016 film *Split* (Shyamalan, 2016). *Tara* (Spielberg, 2009) is comprised of three seasons with twelve episodes each. Each episode is approximately 30 minutes. The 36 episodes combine to about 18 hours of run time, and this film was chosen for being a TV show. *Eve* (Johnson, 1957), which was picked for being the first movie about multiple personalities, is 91 minutes long. *Sybil* (Petrie, 1976) has a run time of 3 hours, 7 minutes, and was chosen for the resulting explosion in media coverage. *Me, Myself, and Irene* (Farrelly & Farrelly, 2000) is 1 hour, 57 minutes long, and was chosen for its genre as a comedy. Lastly, *Split* (Shyamalan, 2016) has a runtime of 1

hour, 57 minutes, and I chose this film because it is a horror/thriller.

*Film Details*

| | ***Eve*** | ***Sybil*** | ***Irene*** | ***Tara*** | ***Split*** |
|---|---|---|---|---|---|
| **Run Time** | 1 hour, 31 minutes | 3 hours, 7 minutes | 1 hour, 57 minutes | 36 30-minute episodes<br>Total: 18 hours | 1 hour, 57 minutes |
| **Reference** | YouTube | Amazon Prime Video | DVR Recorded | Hulu | Amazon Prime Video |

I began by watching each title in full, pausing often to take note of direct quotes. When watching these titles, I maintained a living document that contained my handwritten notes, which were primarily based on the following questions:

1. Is this a real story?
2. What is the diagnosis?
3. How is dissociation depicted?
4. How does each alter differ in physical appearance, including choice of clothing and hairstyle, tone of voice, dialect, and affect, mannerisms, capabilities, allergies, preferences and interests, and personality?
5. What caused the split?
6. If the split was caused by a traumatic experience, was it a result of childhood physical or sexual abuse?
7. Does the host have any memory of their childhood, or anything prior to their first dissociation?
8. Are there any stereotypes or negative language used surrounding anything related to the disorder?
9. Is there evidence of the host orienting to wholeness?
10. Does the host become integrated?

11. If the host becomes integrated, how does this occur?

12. If the host becomes integrated, which personality prevails?

At the completion of watching these five films, I had two full notebooks comprised of handwritten notes. I then went through the notes with a highlighter, weeded out less relevant information, and then transcribed what was left into typed notes. I then categorized these notes into one of four categories for each title: references to a specific alter, references to trauma, denial of DID and stereotypes, and other, which encapsulated references to DID that did not fit into one of the aforementioned categories. Upon doing this, I found six characteristics that were common to most, if not all, of the films. First, the cause of the split, which is usually some type of trauma, is revealed in all five of the films, with three of them aligning with the physical or sexual abuse outlined in the DSM. In all but one of the films, the character can be seen dissociating, and the actual diagnosis the character receives is either multiple personalities or DID. Every film contains some type of resistance against the validity of the diagnosis, such as the presence of stereotypes or explicitly calling the character "crazy" or "psycho." Lastly, four of the five films include both the prevail of one personality as well as a depiction of how the character becomes integrated, or the ways in which the alters "die."

I then obtained the DID criteria from the DSM-5 and turned it into a point system to rank the accuracy of each title. Accuracy ranking was done to quantify the qualitative data in order to definitively say whether a film was a good or bad depiction of the disorder, as well as whether one is a better depiction than another. To meet the minimum criteria for diagnosis, the character must receive four points in Criteria A, which includes one point in the first and third subsections, and two in the second. They much also receive one point each in Criteria B, Criteria C, Criteria D, and Criteria E. Therefore, to quality for diagnosis, a character only needs 8 points, but may

score up to 17. These scores translate into four levels of diagnosis based on the number of criteria met, which are as follows:

0-6 points: Does not meet criteria

7 points: Minimally meets criteria

8-12 points: Sufficiently meets criteria

13-16 points: Globally representative

The point system, as well as the score for each film analyzed, is as follows:

| **Criteria Section** | **Symptom** | | **Points Needed** | | **Movie** | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | *Minimum* | *Maximum* | *Eve* | *Sybil* | *Irene* | *Tara* | *Split* |
| Criteria A | Two or more distinct personality states | | 1 | 1 | X | X | X | X | X |
| | Discontinuity in: (and) | Sense of self | 2 | 2 | X | | X | X | X |
| | | Sense of agency | | | X | X | X | X | X |
| | Related alterations in: (and/or) | Affect | 1 | 7 | X | X | X | X | X |
| | | Behavior | | | X | X | X | X | X |
| | | Consciousness | | | X | X | X | X | X |
| | | Memory | | | X | X | X | X | X |
| | | Perception | | | X | X | X | X | |
| | | Cognition | | | X | X | X | X | X |
| | | Sensory-motor functioning | | | X | X | X | X | X |
| Criteria B | Recurrent gaps in the recall of: (and/or) | Everyday events | 1 | 3 | X | X | X | X | X |
| | | Important personal information | | | X | X | | X | X |
| | | Traumatic events | | | X | X | | X | X |
| Criteria C | The symptoms cause clinically significant: (and/or) | Distress | 1 | 2 | X | | | X | X |
| | | Impairment | | | X | X | X | X | X |
| Criteria D | The disturbance is not part a normal part of a broadly accepted cultural or religious practice. | | 1 | 1 | X | X | X | X | X |
| Criteria E | The symptoms are not attributable to the physiological effects of a substance or another medical condition. | | 1 | 1 | X | X | X | X | X |
| **TOTAL** | | | **8** | **17** | 17 | 15 | 14 | 17 | 16 |

**Current Films Reviewed**

After I completed watching all five of the films, I analyzed the notes I had recorded. From this, I wrote brief a synopsis of each film that describes the general plot. The synopses also include a description of the host, as well as all their alternate personalities. These synopses are as follows:

*The Three Faces of Eve*

*The Three Faces of Eve* (Johnson, 1957) tells the story of Eve White, a timid housewife who begins experiencing headaches and blackout spells. When she cannot recall attempting to strangle her baby, she begins to see a psychiatrist. It is at this point that she first transforms into Eve Black, a carefree party girl. She is eventually diagnosed with having multiple personalities. While under hypnosis, a third personality named Jane appears, who seems to be relatively stable. After uncovering the trauma that caused her to fracture, Jane suddenly remembers all the details of Eve's childhood. Both Eve Black and Eve White disappear, allowing Jane to live out the rest of her life as a fully integrated woman.

*Sybil*

*Sybil* (Petrie, 1976) is a three-hour film that claims to depict the real-life story of Sybil Dorsett, a shy young teacher who is terrified of both people and hands and is incapable of having fun. A practitioner by the name Dr. Connie Wilbur discovers that Sybil has multiple personalities after she came into the hospital for a cut that she did not remember getting. The main personalities that take control during the movie are Peggy, Vanessa, Vicky, and Marcia. Peggy is a terrified nine-year-old girl who has been hurt time and time again, causing her to act out and hurt Sybil in the process. Vanessa is a talented piano player who forms a relationship with the attractive neighbor, Richard. Vicky, short for Victoria Antoinette Shallot, is a confident 13-year-

old girl with blonde hair and a thin frame. She grew up in Paris and soars through life with a social ease, stepping in when Sybil lacks the strength to do something. With her uninterrupted memory, she seems to oversee all the other personalities. Marcia, a gloomy young girl who covers her straight brown hair with a scarf, is extremely suicidal, and has attempted to kill Sybil on multiple occasions. As Sybil lacks childhood memories, all her personalities take the form of children. After many rounds of hypnosis, she begins to recount the extreme childhood physical and sexual abuse she experienced at the hands of her mother. As a result of therapy, her personalities become integrated, and she lives the rest of her life as one.

*Me, Myself, and Irene*

*Me, Myself, and Irene* (Farrelly & Farrelly, 2000) is a 2000 comedy starring Jim Carrey. It portrays the story of Charlie, a Rhode Island police-officer who lets everybody walk all over him. Upon noticing his quick change in personality, his co-workers become concerned. He is sent to a team of practitioners to get evaluated. This is where he is told that, by not dealing with his problems, he created Hank, a confrontational wise guy who emerges to fight Charlie's battles. Despite his official diagnosis being "advanced illusionary schizophrenia" (not a real diagnosis) with "involuntary narcissistic rage" (also not a bona fide diagnosis), he portrays classic signs of having an alternate personality. This includes having two distinct personalities, as well as periods of time and actions that he cannot not recall. After constantly getting in trouble for Hank's actions on a trip with a woman named Irene, Charlie finally learns to stand up for himself. He overcomes his fear of water and permanently gets rid of Hank, allowing Charlie to live the rest of his life as his whole self.

*United States of Tara*

The three-season-long television show *United States of Tara* (Spielberg, 2009) depicts

the fictionalized story of Tara Craine, a wife, mother of two, and artist, as she struggles to live with DID. She originally has only three alternate personalities– Buck, a chain-smoking, overprotective Vietnam war vet; T, a 16-year-old troublemaker; and Alice, an old-school housewife based on Tara's foster-mother Mimi, who acts as a caretaker to all. Four more personalities appear throughout the show, resulting in a total of seven personalities, each serving a different role. Gimmie is a nocturnal, animalistic personality who is searching for answers about Tara's youth, while Chicken is an outward presentation of Tara's four-year-old self. Shoshana Schoenbaum emerges as Tara's new therapist after she reads a book based on a psychologist by the same name. In the end, each personality appears to say goodbye before being murdered by a personality named Bryce Craine, a manifestation of the abusive stepbrother who molested her as a young child. Eventually, Tara drowns Bryce, and she becomes fully integrated.

*Split*

The fictional horror movie *Split* (Shyamalan, 2016) follows Kevin Wendall Crumb, who has 23 alternate personalities. Barry, the most prominent and stable personality who has a love of fashion, has held down a job for ten years and frequently attends sessions with his therapist. Trouble arises when Dennis takes control and kidnaps three teenage girls after he and an alter named Patricia, a motherly figure who looks after the girls, conspire to overthrow the system. In addition to Patricia, a nine-year-old boy named Hedwig often checks in on them. He befriends Casey, one of the kidnapped girls, until she breaks his trust by attempting to contact the police. In the end, Kevin does not become integrated; rather, an 24$^{th}$ personality called the Beast emerges. This animalistic persona is capable of murder, and it kills two of the three girls and Kevin's therapist by eating their insides. He spares only Casey. Upon her rescue, police search the basement of the Philadelphia Zoo where he had been living and holding the girls captive. It is

revealed to the public that the suspect has DID, which is referred to as a controversial disorder, and the Beast ultimately evades the police.

## Results

### Expected Outcomes

Predating the DSM-5 (APA, 2013) criteria by 56 years, *Eve* (Johnson, 1957) was released just five years after the publication of the first DSM. The DSM-I (APA, 1952) did not include any diagnostic criteria, and the description of a dissociative reaction was limited. The disorder was considered relatively rare, with *Eve* (Johnson, 1957) being the earliest depiction of DID in film. As a result, I expected that *Eve* would not meet diagnostic criteria. In addition, *Sybil* (Petrie, 1976) predates the publication of the DSM-5 (APA, 2013) by 36 years. It was released during the time the DSM-II (APA, 1968) was in use, which also contained no diagnostic criteria. Because of this, I also did not expect Sybil to meet diagnostic criteria.

*Split* (Shyamalan, 2016) is the only film being analyzed that premiered after the publication of the DSM-5 (APA, 2013) and because of this, I initially expected that Kevin, the character from this film, would be the only one to meet current diagnostic criteria. Upon further consideration, since *Split* (Shyamalan, 2016) falls into the horror genre, it primarily focuses on the kidnapping of the three teenage girls rather than focusing on the character with DID. Consequently, I predicted that *Split's* (Shyamalan, 2016) Kevin would not meet the DSM-5 (APA, 2013) diagnostic criteria.

Since *Tara* (Spielberg, 2009) premiered on Showtime four years prior to the 2013 publication of the DSM-5, this originally led me to conclude that the main character Tara (Spielberg, 2009) would not meet diagnostic criteria; However, upon comparing the DSM-IV criteria, which was used in the depiction of DID throughout the three seasons of *Tara* (Spielberg,

2009), to that of the updated DSM-5 criteria (APA, 2013), I noted that no significant changes were made. The main difference is that the DSM-5 is more explicit about the "related alterations" that the individual experiences between each personality (APA, 2013, p. 292). Since the criterion that specifies this provides seven alterations but only requires one for diagnosis, these details would not change the diagnosis of an individual; rather, it should only provide more evidence for one. In addition, *Tara* (Spielberg, 2009) is a television show rather than a movie. *Tara* (Spielberg, 2009) has at least 15 more hours of screen-time than any of the movies, which means that all diagnostic criteria should receive coverage throughout the three seasons. Considering all of this evidence, I predicted that Tara would meet diagnostic criteria. Finally, *Irene* (Farrelly & Farrelly, 2000) also premiered at the time the DSM-IV was in still use. Given it is a comedy and the character is not officially diagnosed with DID, I did not expect Charlie in *Irene* (Farrelly & Farrelly, 2000) to meet diagnostic criteria.

**Findings**

From highest to lowest scores, *Eve* (Johnson, 1957) and *Tara* (Spielberg, 2009) had perfect scores at 17 points, *Split* (Shyamalan, 2016) earned 16, *Sybil* (Petrie, 1976) had 15, and *Irene* (Farrelly & Farrelly, 2000) received 13 points. All five characters met the criteria for diagnosis, and not just minimally. Every single character fell into the highest level of diagnosis, which claims that the film is globally representative of the disorder. These results contrast my expected findings, as I hypothesized that only *Tara* (Spielberg, 2009) would fall into this level of diagnosis. This expectation was due to the fact that *Tara* (Spielberg, 2009) is one of the more recent depictions of DID, and I anticipated the character to be the most well developed over the 30+ hours of the show. More specifically, I foresaw neither *Eve* (Johnson, 1957) nor *Sybil* (Petrie, 1976) meeting diagnostic minimums. I believed that these movies were simply too old to

depict criteria that was not included in the DSM at the time of their respective releases.

*Eve* (Johnson, 1957) received a perfect score, meaning that it checked every box of the possible criteria, while *Sybil* (Petrie, 1976) was near perfect. *Sybil* (Petrie, 1976) is a special case in that the movie does not depict the use of drugs, therefore allowing her to meet Criteria E. While the movie does not include this detail, real-life accounts contrast this, describing the intense drugs used on Shirley to elicit information from the unconscious. The drugs used have been reported to cause fantasies that seem real while the person is experiencing them, allowing for the person to form memory pathways for the drug-induced states after they have worn off (Carey, 2017). Since the drugs were not shown in the film, Sybil meets the diagnostic criteria; however, it is still important to clarify this point. Given these findings, I will provide at least one example from each film for each of the first fifteen diagnostic criteria contained within Criteria A, B, and C. As Criteria D and E are presumed to be true unless there is evidence otherwise, they will be omitted.

*The Three Faces of Eve*

Two or more distinct personality states

Eve White, Eve Black, and Jane.

Discontinuity in sense of self

Eve Black tells Eve White's husband, Ralph to make her a drink "straight."

Ralph: "I never seen you take a drink before, you ain't fooling me, you know. I know what you're trying to do."

Eve Black chugs the whole drink, and Ralph looks at her in shock.

Ralph: "You're trying to make me think you're the other one."

Eve Black: "What other one? You don't even know your own wife when you see her?"

Ralph: “You ain’t Evie. I ain’t never seen Evie do a thing like that in my whole life before.”

Discontinuity in sense of agency

Eve Black attempted to strangle Bonnie with the string of the blinds and Eve White keeps denying that it was her.

Eve White: “I’d die before I’d hurt Bonnie.”

Related alterations in affect

Eve White speaks at a whisper and is very delicate, only speaking when she is spoken to. Black's voice is loud and energetic and walks with confidence. She also sings and dances.

Dr. Luther: “Were you ever on stage, Miss Black?”

Eve Black: “No, not exactly on the stage. But I sang in nightclubs, a lot of them. Across the river’s one. The big apple. You ever been there? They’re crazy about me at the big apple. Every time I go in there, they ask me to stand up and sing. Of course, I have to be in the mood to do it, though, I have to have a couple of snorts first.”

Related alterations in behavior

Ralph had previously asked Eve White to move to Jacksonville with him, and she refused as she was fearful that Eve Black would try to hurt Bonnie again. Later on, Eve Black agrees to the move.

Eve Black: “I think you ought to ask me to go to Jacksonville with you.”

Ralph: “I don't think so.”

Eve Black: “Well you asked her.”

Ralph: “Yeah but I don't know if this is the same thing or not.”

Related alterations in consciousness

Eve White: “I’m hearing voices, too. Just one voice. She tells me to do things.”

Dr. Luther: “A woman’s voice? Can you recognize it in any way?”

Eve White: “No. it sounds familiar sometimes, but I don’t really recognize it.”

Dr. Luther: “What does this voice tell you to do?”

Eve White: “To do things like… leave Ralph, take Bonnie and run away. All kinds of terrible things like that.”

Eve White: “What if sometimes it… sounds like my own voice?”

Related alterations in memory

Ralph brings up how Eve White went to Atlanta the month prior to visit her cousin for five days, and she refused to come home because she was having too much fun. Ralph was forced to go up there to get her, causing Eve to curse him out and tell him that she’s never come home. In response, Eve White states that she hasn’t been to Atlanta in over a year.

Related alterations in perception

Dr. Luther: “So, you’re not Eve White?”

Eve Black: “I certainly am not.”

Dr. Luther: “If you’re not Eve white, who are you?”

Eve Black: “I’m Eve Black.”

Dr. Luther: “You mean that was your maiden name?”

Eve Black: “That’s still my name. I’ve never been married, that’s for laughs, getting married.”

Dr. Luther: “What about Ralph?”

Eve Black: “You think I’d marry a jerk like that?”

Dr. Luther: “And Bonnie isn’t your child?”

Eve Black: “Not while I’m in my right mind she isn’t.”

Related alterations in cognition

Black: “Is it Jane who's doing this to me? I wish I knew more about her. It's not like it used to be when I knew all about Eve White and she didn't know anything about me and there wasn't anybody else. That's the way I liked it. It's all changed now, hasn't it?”

Related alterations in sensory-motor functioning

Eve White dissociates while in Dr. Luther’s office. She opens her eyes as Eve Black, and immediately begins to scratch her legs.

Eve Black: “It’s these hose. They’re nylon and I’m allergic to nylon. I think I’ll take them off.”

Recurrent gaps in the recall of everyday events

Eve White: “The other day I was playing in the backyard with Bonnie and all of a sudden I got this splitting headache and then the next thing I knew, the next thing I was conscious of, it was the next morning.”

Recurrent gaps in the recall of important personal information

Dr. Luther hypnotizes Eve White, she opens her eyes, and looks around.

Woman: “Who are you?”

Dr. Luther: “Who do you think?”

Woman: “I have no idea.”

Dr. Luther: “May I ask who you are?”

Woman: “I don’t know that either.”

Recurrent gaps in the recall of traumatic events

Eve White can't remember anything from her childhood, so Dr. Luther asks Eve Black if she does.

Dr. Luther: “Do you remember anything about a blue China cup?”

Eve Black: “I don't remember anything about anything like that I told you.”

It is revealed that Eve White was forced to kiss her dead grandmother while she lay in her casket. Once this is remembered, she becomes integrated and gets her memories back.

The symptoms cause clinically significant distress

Ralph asks Eve White to come to Jacksonville with him, but she continues to say that she doesn’t want leave because she doesn’t want to be alone with Bonnie.

Eve White: “She tried to hurt Bonnie once before, she scared her.”

Ralph storms out of the room and Eve White begins to break down in tears.

The symptoms cause clinically significant impairment

Eve Black: “[Eve White] tried to kill herself last night. Something's wrong somewhere. With a razor blade. She’s feeling awfully low, and when I got what she had in her mind, it near about scared me half to death. Because you know, if somebody hadn't stopped her, I'd be gone too, you know what I mean. There wasn't anybody else there but me. So, when she went in the bathroom, and she locked the door…”

She holds out her left wrist to show Dr. Luther that it is bandaged up.

Eve Black: “… Look. She made one slash and then I got out and I made her drop the blade and I got it and threw it away. It was a close call. I know she meant it. Been me, I wouldn't have meant it. I might be trying to scare someone or fool them, but I wouldn't go that far. She was really going to kill herself if I hadn't stopped her.”

*Sybil*

Two or more distinct personality states

Sybil Dorsett, Peggy, Vicki(y), Vanessa, Hattie, Marcia, Clara, (H)ellen, Margie, Sid, Mike, Ruthie, Nancy, Mary, and Sybil Ann. The number of alters, as well as their names and the spellings, were unclear in the movie.

Discontinuity in sense of self

N/A

Discontinuity in sense of agency

Richard asks Sybil to go out with him, and Sybil says she doesn't go out at night. Her eyes slowly close and she looks down, and Vicki's voice is heard.

Vicky: "Sybil can't say yes. Vanessa, you go, you like music."

Vanessa is seen playing piano, and she looks over once her name is called.

Vicky: "You may go, Vanessa."

Related alterations in affect

Peggy's voice is shaky.

Marcia has a monotone voice and moves very stiffly, in manner that's almost robotic.

Vanessa's voice is happier/more energetic/airy, and she walks with her chest up and out, with pride and confidence.

Mary's voice is slow and raspy like an elderly woman, and she walk slowly with a limp.

Related alterations in behavior

Vicki: "Do you know, the other day she wanted to take a ride in the park with that attractive young man. She was afraid to take his hand. She's afraid of hands, so is Peggy. I had to go. I'm not afraid of hands. I'm not afraid of anything."

Later on, Vanessa is on a date with Richard. They are sitting on the subway, and she puts her hand on top of his. Later that night Richard and Sybil are saying goodbye, and he asks for a kiss.

Richard: “Your hand at least?”

He then grabs her hand, she yelps “Ooh!” and pulls it away.

Sybil is afraid of hands and wouldn’t have so easily have held Richard’s on the train.

Related alterations in consciousness

*Example 1:*

Sybil gets home after the incident with her class in Central Park where she ended up in the fountain.

Sybil screams: “How could you embarrass me in front of them all that way?”

A shaky voice replies: “Uhuhuhhh get away. Please get away.”

Sybil hits something and angrily says: “I will not get away. I will stand here till you explain yourself.”

Shaky voice: “I don’t even know what I did, I don’t–”

Sybil: “Don’t you plead ignorance of the law to me.”

Shaky voice: “Out, out, out, I had to get out!”

Sybil lifts her head from the wall she was leaning on and looks over her shoulder.

Sybil: “What?”

*Example 2:*

Sybil dissociates after she breaks her window and cuts her hand. The image pans to her apartment, which is wrecked. Painting supplies are spilled and spread out all over. She looks over at the easel, and gasps with a frightened look on her face. The painting

contains a lightbulb, music notes, and knives. Her hand begins to shake, and she whimpers as she lightly pushes the picture off the easel.

Related alterations in memory

Sybil is at Dr. Wilbur's office for her initial checkup.

Sybil: “I cut my wrist, and I don’t know how. And then I was here, talking to you. Have I hurt somebody? Have I done something bad?”

Related alterations in perception

Sybil was hysterical in the hotel room with Dr. Wilbur, until she looks out the window and suddenly stops.

Peggy: “I see… the knob. I see the knob. On the white house. On the white house, I see the knob, and the shades are pulled down. I live right there. I live right there.”

She begins to point out the window, poking on the glass.

Peggy: “201 West 4th street, Willow Corners, Wisconsin. I live right there. Right there. Right there.”

An image of a big, white, fenced in house, flashes on the screen on and off with the image of what she is actually looking at, which is a barbeque place.

Dr. Wilbur: “That’s Harlem.”

Related alterations in cognition

Vicky: “All [Sybil] eats is rotten fruit. That’s all she’s eaten all month long. Her daddy forgets to send her the check. Lots of times her daddy forgets to send the check, and that makes Peggy very, very mad. And she barges into the stores and smashes all the crystal, and Sybil has to pay for it. But I don’t care.”

Sybil would never waste money. When she was getting lunch with her father, she told

him that she is very frugal, and that if she gives up her luxuries, then she could get by on what he already sends her.

Related alterations in sensory-motor functioning

Vanessa is a great piano player.

Sybil is the only one that wears glasses.

Vicky speaks fluent French.

Peggy: “I got something to tell you. It’s about Sybil. She puts guck all over her hair because she has gray hair (giggles). I don’t, I’m natural.”

Recurrent gaps in the recall of everyday events

*Example 1:*

Sybil is standing in Dr. Wilbur’s office with her head leaning on the wall. She quickly lifts her head, with her eyes red as if she’d been crying. She goes to look at her watch, but Dr. Wilbur interrupts.

Dry Wilbur: “No! Without looking at your watch, tell me what you just said.”

Sybil: “Is it so important? I said, “is this your office?”

She walks across the office to get her glasses and put them back on.

Dr. Wilbur: “That was a half an hour ago, it’s nighttime now.”

*Example 2:*

Richard: “I knew you were an artist. I’ve seen you painting in the middle of the night.”

Sybil: “I don’t do that. I haven’t painted in a long time.”

Richard: “Yeah, you do. I watch you. From window to window, right across our backyards. You never have company, you eat by yourself, you still pay with dolls, and you watch me, too.”

Recurrent gaps in the recall of important personal information

Sybil: “I’m so awfully ashamed, doctor. I’ve always been like this, always, and I used to think that everybody was like this. That they would just naturally wake up and be someplace else or a whole lot older or wearing another dress. Once, I woke up, and I was two years older. Like when I was in the third grade and my grandmother died, and I wasn’t anyplace for two years. I just wasn’t anyplace, not anyplace at all.”

Recurrent gaps in the recall of traumatic events

Dr. Wilbur asks Sybil is asked to smell and identify different scents during her neurological exam.

Sybil: “Oh, disinfectant!”

She hunches over and begins to cry.

Dr. Wilbur: “I’s all right. What’s the matter? You smelled something like that before?”

The symptoms cause clinically significant distress

N/A

The symptoms cause clinically significant impairment

Sybil gets fired from her job after transitioning at Central Park and standing in the fountain.

*Me, Myself, and Irene*

Two or more distinct personality states

Charlie and Hank.

Discontinuity in sense of self

Charlie pulls into the train station and yells for Irene, but an officer grabs him tries to take him away.

Charlie: “Not now!”

He punches the officer, looks down at his hand, shocked but satisfied by his actions.

Charlie: “That was me!”

Discontinuity in sense of agency

*Example 1:*

Hank begins to choke Charlie.

Charlie: “He’s choking me! He’s choking me!”

His right-hand peels his left hand off of his neck and begins to pull the ring finger backwards.

Hank: “Ow, ow, ow, ow, ow! Charlie, don’t break it don’t break it!”

Charlie breaks his left ring finger and falls to the ground.

*Example 2:*

Charlie is about to jump across a gap of water to help Irene, but Hank stops him. Charlie’s fully extended right leg is being pulled back, while his left leg is bent in a running position. Charlie strains to jump, but Hank pulls him back, preventing him from doing so. Charlie turns around and screams “Hank!” as he grabs right leg with both of his hands and tries to pull his leg forwards.

Related alterations in affect

Hank has a deeper, smoother, raspier voice with a slight whisper to it, and is more confrontational and confident.

Hank: “You’ve seen Charlie in action. He’s like origami: folds under pressure.”

Related alterations in behavior

Previously, Charlie nicely asked the owner of a barbershop to move his car. Instead, the

owner throws his keys at Charlie and says, “park it out behind the grocery store will you, Charlie?”

Charlie agrees, but when Hank emerges later on, he drives the owner’s car through glass storefront.

Hank: “There you go, Dick. I parked it for you. And by the way, you’ve got a headlight out.”

He spits on a ticket he just wrote him and slaps it on the front of the car.

Related alterations in consciousness

Charlie notices the bandages on his nose in the mirror.

Charlie: “Hey, my nose! How’d that happen?”

Irene: “Hank wanted to do something nice for you, so he insisted that we go to a plastic surgeon.”

Charlie then notices bandages on his chin, too.

Charlie: “What, what is this?”

Irene: “Well, Hank thought you had a weak chin.”

Charlie: “What, I like my chin! I like my chin! It’s my chin! Mine!”

Related alterations in memory

Charlie wakes, and pees all over the bathroom.

Charlie: “Irene? Why am I peeing like I was up all-night having sex?”

Irene shoots up from bed with a horrified look, as she thought she had slept with Charlie the night before, but he has no recollection of it.

Related alterations in perception

Hank is driving a car he just stole. The right arm is controlling the steering wheel, while

the left arm wraps around to the back of his neck, and slams head into the wheel twice.

Hank: “Ever been bitch slapped?”

Hank uses the left hand to slap himself across the face 4 times.

The right hand grabs the left side of jacket and pulls it away from the open driver’s door, towards passenger seat.

Hank: “Arrivederci, deadwood!”

He throws himself out of the car, runs after it, and jumps back in.

He looks behind him, satisfied that Charlie is gone. When he looks in the rearview mirror and sees Charlie in the reflection, he gets angry.

Hank: “What the hell are you still doing here?”

Charlie: “You can’t just throw me away, Hank. We’re in this together!”

Related alterations in cognition

Irene explains that Hank had a good idea in thinking they should hide out in a cabin.

Charlie: “Oh yeah? what about water? Food?”

Irene tells Charlie that Hank got the supplies they needed.

Charlie pulls them out from the trunk, which contains a dildo, a bottle of wine, a rope, a shovel, a bag of limes, and some lawn darts.

Charlie: “Well he had a plan, all right.”

Related alterations in sensory-motor functioning

*Example 1:*

Charlie gets shot by an officer.

Charlie: “Hank, we’re shot!”

Hank: “Come on, you pussy. It’s just a flesh wound, look!”

Hank puts his finger on the injury, and Charlie winces and yells in pain. They continue running until Hank spots a red car with no top and the keys in the ignition.

Charlie: “No, I can’t go on, I think–.”

Charlie falls to the ground.

Charlie: “Oh! I think I’m gonna… faint”

Charlie faints.

Hank: “Do you mean to say I gotta carry your sorry ass? All right, come on then, wussy.”

Charlie’s limp body has his arm held out as if someone is pulling him up to help him stand up.

Hank then slumps over.

Hank: “Jesus you’re heavy!”

His body moves as if Hank is holding Charlie up with one arm over his shoulder as he helps him walk.

Recurrent gaps in the recall of everyday events

Charlie looks at the report after being analyzed by head doctors.

Charlie: “I don’t remember any of this.”

Recurrent gaps in the recall of important personal information

N/A

Recurrent gaps in the recall of traumatic events

N/A

The symptoms cause clinically significant distress

N/A

The symptoms cause clinically significant impairment

Charlie's boss calls him a “pretty big liability” and says he may have to let him go after his week vacation.

*United States of Tara*

Two or more distinct personality states

Tara, Buck, Alice, T, Gimmie, Shoshana, Chicken, and Bryce.

Discontinuity in sense of self

S1E10: When Marshall walks in on T kissing the boy he likes, Tara attempts to reconcile.

Tara: “That wasn’t me, I would never–.”

Discontinuity in sense of agency

S1E12: Tara is confronting her high school rapist, Trip, and Alice emerges.

Doctor: “So, Tara’s not inside listening? I’m here with Max, Tara, and we want to know that you’re safe.”

Alice: “I told you. There’s no Tara.”

Doctor: “I think there is, and she’s stronger than you think, Alice.”

Alice: “No, she isn’t. And she’s weak, and she *needs* me. That you would dare suggest that you know better than I do, just…”

Related alterations in affect

S1E2: Alice speaks in a light, airy voice.

S1E1: Buck has a southern accent.

S2E4: Shoshana has a New York accent.

Related alterations in behavior

S2E2: Tara doesn’t like women, but Buck does, and he forms a physical and romantic relationship with a woman named Pammy. After Tara runs into Pammy and realizes that

the two of them were sexually involved, she tells her that nothing will ever happen between them again. Later that night, Buck shows up at Pammy's apartment with flowers and says he couldn't stay away from her. He then gives Pammy a leg massage as she lay on the recliner. He then looks at her, says "thank you Lord," and puts his head up her skirt.

Related alterations in consciousness

S1E10: Tara tells her therapist that she could hear everything T was hearing before she transitioned at the tattoo parlor.

Tara: "I don't know what or why it's happening, but the feeling is incredible."

Therapist: "When host and alter share the same experience simultaneously, it's called co-consciousness."

Related alterations in memory

S2E4: Tara is reading Shoshana's (the actual therapist from New York) book. As she goes to reach for the rotary phone, she hears a voice, and her eyes close while she dials. She suddenly has a flashback, and she sees she and Charmaine as kids coming inside from the rain. In the flashback as Mimi talks to them, and then dials on rotary phone. Tara's eyes suddenly open, and she looks frightened at the clicking noises of the rotary phone. She gets up and leaves the room.

Related alterations in perception

*Example 1:*

S2E5: Tara drives to the police station to pick up Max, and she begins to hear Shoshana speak to her. When she looks over to the passenger seat and sees Shoshana (her alter) sitting there, she freaks out and drives her car into a sign on the side of the road.

*Example 2:*

S1E8: After Max tells Tara about the new alter, she immediately throws up, bends over, and comes back up as Alice, who announces she is pregnant. Max says this is impossible because Tara has an IUD. After Alice reveals to Max that the name of the new alter is Gimmie, Max wakes up in the middle of the night to find Alice crying on the floor of the bathroom.

Alice: "I lost our baby. I lost our little girl."

Max: "It's not a miscarriage, you got your period."

He then lays down on the floor and holds her as she cries.

Related alterations in cognition

S2E6: The family is hiding out in the basement from a tornado.

Alice: "This reminds me of those church look-ins I attended as a girl. No necking, children!"

Tara is neither religious, nor does she have any childhood memories.

Related alterations in sensory-motor functioning

S1E1: Buck wears glasses and is the only lefty.

S1E7: Buck smokes cigarettes, but they make Tara sick. She throws up after dissociating from Buck back to Tara.

S1E12: When bowling, Tara performs awfully, but says that the kids are getting pretty good. Max tells her that they learned from Buck.

Recurrent gaps in the recall of everyday events

S2E3: Tara: "I'm fucked. I just woke up, again, naked, again. Next that woman from the grocery store who has two kids and a La-Z-Boy. I don't know what Buck's been doing

over there, but it can't be good. It's been 2 weeks since Buck's been taking the body. 'I just want it for a few hours' he said. Yeah, a few hours day!"

Recurrent gaps in the recall of important personal information

S2E2: Tara sees Pammy, the waitress from the bar she and Max went to, at the grocery store. Pammy compliments her and insinuates that something happened between then, but Tara, having no recollection, shoots these advances down. They see each other again when putting the carts away.

Tara: "I don't know what happened between us."

Pammy: "You weren't that drunk. I've never been with a chick before."

Tara: "Neither have I!"

She says this in way that conveys she has still never been with a woman.

Recurrent gaps in the recall of traumatic events

S1E11: Tara: "My trauma happened when I was 16, so I didn't start switching until after that, but whenever I'd come back from a transition, I knew exactly how to cover and get by. I don't remember what happened at boarding school, but I do have vivid memories of a few weeks after. It was a month until summer break and I couldn't wait to get out. I'm such a total summer person. And I remember I wore my bathing suit under my clothes every day, and while everyone was going to class and going on with their lives, I just sat in my dorm window, waiting for summer to come. Next thing I remember is snow, everywhere. I was at my parents and six months had gone by an instant and it was just white."

The symptoms cause clinically significant distress

S2E2: Tara: "Oh, Jesus Christ it's happening again. It's happening. I'm- I'm losing time

again. It's happening again. I'm fucking freaking. I'm- I'm- I want to up my medication but I don't want Max to think there's anything wrong with me- Oh my God!! I thought I was better! We all thought I was better. I can't- I can't. Oh, I wanted to be better so badly!"

The symptoms cause clinically significant impairment

S3E2: Tara attends her first class, abnormal psychology, on her first day back at college. When she walks into the classroom, she confidently walks up to the platform.

Shoshana: "All right. Let's settle in and start with the discourse, people. I'm Dr. Shoshana Schoenbaum. Your beloved Dr. Hattaras is tending to a client in crisis, so I have the honor, and you have the privilege. Trust me, you will be stimulated."

Later on, Professor Hattaras walks in while Shoshana is teaching. He walks towards the front and Shohsana stops teaching to look at him.

Dr. Hattaras: "Go on."

The warm smile on Shoshana's face quickly changes to anger.

Dr. Hattaras: "I think one of us should take a seat."

Tara grabs her textbook and her purse and rushes out of the classroom.

*Split*

Two or more distinct personality states

Barry, Jade, Orwell, Kevin, Heinrich, Norma, Goddard, Dennis, Hedwig, Bernice, Patricia, Polly, Luke, Rakel, Felida, Ansel, Jalin, Kat, B.T., Samuel, Mary Reynolds, Ian, and Mr. Pritchard.

Discontinuity in sense of self

Barry is about to leave his therapist's home.

Therapist: “Don't you want your sketches, Barry? You're usually very protective of them.”

Discontinuity in sense of agency

Dennis: “We've taken charge. We're the only ones who can protect Kevin. He's very weak. He doesn’t know how powerful we can be.”

Related alterations in affect

Hedwig has as lisp.

Barry seems to have a Philadelphia accent.

Dennis’s voice is much lower and demanding, and he wears glasses

Patricia’s voice is higher, and woman-like.

Related alterations in behavior

Barry walks into his therapist’s office.

Therapist: “Who are you? You’ve emailed me for an unscheduled appointment two days in a row. I think Orwell or Jade, or Samuel or Heinrich had the light for a moment and emailed me. And you're here to tell me everything's okay.”

Barry then reaffirms that it’s him.

Therapist: “It doesn’t seem like Barry. Barry is an extraverted leader.”

Related alterations in consciousness

Dennis goes to the train station. When he is there, he opens his eyes, squints, and takes his glasses off.

Patricia: “Thank you, Dennis.”

In the next scene, Patricia is standing on the edge of a platform as a train pulls in. She then opens her eyes, and puts the glasses back on, effectively dissociating into Dennis

again.

Related alterations in memory

Casey says Kevin's full name, allowing him to dissociate back into himself.

Kevin: "Who are you? Wh-what's happening? What did I do? Did I hurt you?"

He sees his therapist laying on the ground, dead.

Kevin: "Who did that?"

Related alterations in perception

N/A

Related alterations in cognition

Therapist: "I think I'm talking to Dennis. But he's been banned from the light because, among other things, he has a proclivity to watch young girls dance, which he knows himself is wrong and has fought against with little success. I've guessed this because you've adjusted the chocolate dish twice since you came in here, and I understand you have OCD."

Related alterations in sensory-motor functioning

Jade: "I hate my insulin shots. No one else around here has to take them. Why do I have to have diabetes?"

Recurrent gaps in the recall of everyday events

Barry: "I have a very bad feeling I'm losing time."

Recurrent gaps in the recall of important personal information

Kevin: "I swear, I was on a bus. I don't remember anything after that, I– this is still September 18, 2014, right?"

Casey shakes her head no.

Recurrent gaps in the recall of traumatic events

Dennis: “I want to talk about Kevin and what his mother did to him. I remember it all. Kevin's mother had rather malevolent ways of punishing a 3-year-old.”

The symptoms cause clinically significant distress

Upon realizing that he killed his therapist, Kevin takes a deep breath and tells Casey where he has a gun hidden.

Kevin: “Kill me. Then kill me”

The symptoms cause clinically significant impairment

In the past, he has had trouble holding a job now. He has managed at his work for ten years, but now, he is kidnapping and killing young girls.

## Discussion

I found that all five characters reviewed met the minimum criteria to receive a diagnosis of DID in the DSM-5, despite the fact that each film has received criticism for its false portrayal or for “sensationalizing” the disorder. One reason for inaccurate depictions is overdiagnosis, often attributed to the popularity of films that portray characters with multiple personalities. These films, based on exaggerated symptoms, then become the face of DID, rather than the trials of true patients with DID. For example, individuals who suffer from DID fear finding out what they did while they were not in control of their thoughts or behaviors. Because of this, distress or impairment may occur when patients become aware of these episodes, or when the actions that occurred during these periods of amnesia interfere with the patient’s day-to-day life. As a result, patients may try to hide memory loss due to feelings of being out of control or the inability to explain themselves. On the other hand, patients who are faking symptoms might exaggerate or

over-explain these memory lapses. Because of this, practitioners may take patients at face value and over-diagnose DID. This overdiagnosis is a result of indiscriminate diagnostic criteria.

All but one film, *Split* (Shyamalan, 2016), were released prior to the publication of the most recent edition and is arguably the most widely criticized film for its confusing and harmful diagnostic portrayal; however, at a time when the diagnosis had been rarely seen, was not well understood, and virtually unknown to the general public, *Eve* (Johnson, 1957) managed to depict a character that met DSM-5 criteria. And yet the film was released when the first edition of the DSM was only five years old. Practitioners at that time had very little upon which to base a diagnosis. Understandably, neither did filmmakers, yet the film capture all the current criteria for DID. Many practitioners were unfamiliar with dissociative disorders and how to make a proper diagnosis. Because of the popularity of the film, it is conceivable that patients might present with a myriad of confusing or exaggerated symptoms. These patients then left appointments with a diagnosis of DID. In turn, the patients presented a false example of DID to the world. In general, a diagnostic system should become more refined and discerning over time. Since the DSM-5 contains the most updated criteria, theoretically, it should be the most discriminating; however, I find this to be untrue. Of all the diagnostic manuals, the DSM-5 contains the broadest criteria. Films from the original diagnostic manual era were prescient in their depiction of the details of DID as we know it today. It is clear that the controversy surrounding the misrepresentation of the disorder in the media may not be the result of inaccurate or bad depictions, but rather that of indiscriminate diagnostic criteria.

The problem with the diagnostic criteria is that it is one of inclusion rather than exclusion. While many disorders contain diagnostic criteria that includes the word “not,” which specifies both what is and what is not a symptom, DID does not. By-specifying what is not a

symptom, the range of behaviors and emotional states to determine the diagnosis are narrowed. Because the criteria for DID lacks this ruling out process, symptoms are too easily included. Patients are given multiple opportunities to have the same criterion checked off in order to meet a diagnostic minimum. For example, memory loss may fit into three separate criteria in the DSM. This includes Criteria A, under related alterations in memory; Criteria B, under recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events; and in Criteria C, causing clinically significant distress or impairment. Since there are no clear parameters regarding what type of memory loss counts in each of these three criteria, one example can be used throughout the diagnostic process. These overlapping criteria may be a cause for over-diagnosis.

Other diagnoses in the DSM-5 do contain explicit diagnostic criteria which have been fine-tuned to differentiate the criteria. One example of this is the criteria for Posttraumatic Stress Disorder (PTSD). PTSD Criterion A states, under section four, "does not apply to exposure" that occurs through four different media examples, including television and movies (APA, 2013, p. 271). This is further specified, stating that while the criteria do not apply to these four circumstances, it does apply if the exposure is "work related" (APA, 2013, p. 271). One of the reasons that the diagnostic criteria is so specific is due to large scale research following shared disasters, or collective trauma events (Mills, 2021), such as the September 11$^{th}$ attacks on the Twin Towers. The aftermath of these types of traumas are heavily researched, both on those clinically diagnosed with PTSD, and those who feel guilt for having "near-misses" (Mills, 2021). Near misses are the people who missed their flight that morning or woke up late and didn't make it to work on time. While they may experience PTSD-like symptoms, they cannot be diagnosed with PTSD since they did not directly experience the tragedy (Mills, 2021).

There is also likely an implicit bias in DID research, as it largely originates from only a small number of DID treatment centers (Paris, 2012) rather than having a large-scale event from which research on the disorder originates. These research centers for DID also run expensive inpatient treatments, so the research may be biased, since the centers have a significant financial interest in seeing high rates of DID diagnoses. As such, more patients might seek out their services, which means a more stringent diagnostic criteria would be harmful to business. Due to this bias in current methodology, independent research is needed to study DID patients and their similarities which could potentially lead to a more discriminating diagnostic criteria.

So that a better representation of DID is seen in the media, changes need to be made in the any next editions of the DSM to create an updated, more explicit diagnostic criteria. These changes may include specifying between the four different types of memory losses, which are related alterations in memory, recurrent gaps in the recall of everyday events, lack of recall for important personal information, and inability to remember traumatic events. Specification of the criteria are necessary to ensure that each criterion can be met only by one specific symptom, and this specific symptom should not also fit into another category within the same diagnostic criteria. Other changes in future DSM criteria should take into account not only what is a symptom, but also what is not a symptom. This specificity may require the inclusion of definitions for Criteria A concepts such as consciousness, perception, and cognition.

As it stands, consciousness can include a patient waking up and not knowing where they are or where they have been but finding evidence of having done things they do not remember doing. While this description could be a change in consciousness, it could also be a memory problem as in gaps in the recall of everyday events. In addition, alterations in cognition are similar to discontinuity in sense of self as they both involve ways of thinking and the actions that

follow. These two criteria are in different categories, again showing how one example may check off two different boxes, leading a patient one step closer to a misdiagnosis. Through the improved specification of diagnostic criteria, patients will need to meet more stringent benchmarks in order to receive a diagnosis. This will change the narrative surrounding DID patients. False diagnoses will likely decrease, and movies based on fictional symptoms will no longer be the face of DID.

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