What is Dissociative Identity Disorder?

- A psychobiological response to traumas suffered in a specific time window in early childhood,
- A dissociative disorder,
- A complex posttraumatic stress syndrome.

How does DID develop?

- An important step in childhood development - the formation of a central, integrated consciousness - is impeded or prevented by chronic trauma.
- The child uses radical denial and splitting to cope with the traumas, imagining that the traumas happened to "someone else".
- The child's fantasy capabilities and imagination give the different personality states their individual characteristics.
- The extremely inconsistent and contradictory behavior of attachment figures and their denial of the trauma suffered by the child additionally foster the dissociative coping strategy. [19]:6-7

What is the cause?

Dissociative Identity Disorder is caused by "overwhelming experiences, traumatic events, and/or abuse occurring in childhood", particularly when traumas begin before age 5. [4]:293, [1]:122 The child's repeated, overwhelming experiences usually occur alongside disturbed or disrupted attachment between the parent/caregiver and the child. Dissociative Identity Disorder is often, but not always, caused by early child abuse (including neglect and the failure to respond to the child). [1]:122-123 Other early and chronic traumatization can cause it, e.g., medical trauma, involving multiple painful and prolonged medical procedures at an early age. [4]:294

Early childhood trauma causes Dissociative Identity Disorder to develop by preventing the child from forming a cohesive or unified sense of self, known as a core personality during their earliest years. Instead the prolonged trauma causes the different "behavioral states" present from birth to become increasingly dissociated (disconnected) from each other; over time these develop into alternate identities. It is believed that developing multiple identities protects the child by keeping trauma memories and emotions contained with specific identities, rather than overwhelming the child completely. [1]:122-123
Key Facts

1. Dissociative Identity Disorder was previously called Multiple Personality Disorder (MPD), but has always been classified as a dissociative disorder; not a personality disorder. [3][5][6]
2. Only around 6% of people with DID make their diagnosis obvious on an ongoing basis (R. P. Kluft, 2009). [1]
3. Dissociative Identity Disorder is not rare, but relatively common, affecting around 1-3% of the population [1].
4. Most people with DID have a mix of dissociative and posttraumatic symptoms, as well as non-trauma related symptoms.[2]
5. Amnesia in people with DID can take many different forms, including amnesia for significant events in the past OR for events in everyday life. Amnesia is not limited to traumatic or stressful events. [4]:293

Is Multiple Personality Disorder the same as Dissociative Identity Disorder?

In 1994, Multiple Personality Disorder was renamed to Dissociative Identity Disorder in the American DSM-IV psychiatric manual. [24]:529 The World Health Organization still uses the name Multiple Personality Disorder in it’s ICD manual, which has not had a significant update since 1992; the next update, known as the ICD-11, is expected to used the newer name. [2], [6] Most books and research now use the new name Dissociative Identity Disorder.

There were various reasons for the name change, the DSM-IV stated:

"it is a disorder characterized by the presence of two or more identities or personality states that recurrently take control of the individual's behavior accompanied by an inability to remember important personal information ... it is a disorder characterized by identity fragmentation rather than a proliferation of separate personalities" [24]:529

What is like to have DID?

Jessica explains what it is like to have a diagnosis of Dissociative Identity Disorder, and to live with alter personalities.

DSM-5 Diagnostic Criteria

The newest guide used in psychiatry to diagnose mental disorders is the DSM-5, released by the APA in 2013.[3] The DSM-5 gives the following diagnostic criteria for Dissociative Identity Disorder:

Code 300.14

"A. Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption of marked discontinuity in sense of self and sense
of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.

B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The disturbance is not a normal part of a broadly accepted cultural or religious practice. Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play.

E. The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures)." [3]:292

**Differential Diagnosis**

The DSM 5 lists the following alternative diagnoses, which may be considered/ruled out during the Dissociative Identity Disorder diagnostic process. Any of these can be co-morbid with Dissociative Identity Disorder.

- **Other Specified Dissociative Disorder** (formerly Dissociative Disorder Not Otherwise Specified)
- Major Depressive Disorder (often just called "depression"). Depression is very common in people with DID but both depressed mood and depressive thoughts fluctuate because they are present in some alters but not others. Because of this Other specified depressive disorder may be diagnosed along with DID. [4]:296
- **Bipolar Disorders** - especially Bipolar II Changes in mood occur in Dissociative Identity Disorder due to switching between alters (alters often have different mood states to each other). Bipolar II does not involve full-blown mania.
- **Posttraumatic Stress Disorder** There is now a dissociative subtype of PTSD and some overlapping features between DID and PTSD. PTSD is commonly comorbid with DID, but key differences exist as well. Complex PTSD is diagnosed as just PTSD in the DSM-5 (it is not considered a separate disorder). Differences between DID and Complex PTSD are described in the Dissociative Identity Disorder treatment guidelines for Adults; Complex PTSD is very common in people with Dissociative Identity Disorder, and dissociation is a symptom of both.
- **Psychotic Disorders** (including Schizophrenia). Hearing voices (which come from alter personalities), and symptoms of partial flashbacks like feeling touched when nobody is there may be mistaken for psychotic hallucinations. The passive influence of alters causes many psychotic-like symptoms, but without any loss of contact with reality.
- **Personality Disorders** (especially Borderline Personality Disorder (BPD)). BPD has both transient stress-related dissociative symptoms and identity disturbance within its diagnostic criteria. Psychological tests can be used to determine if Dissociative Identity Disorder is present, and whether a personality disorder is also present. Self-injury and self-destructive behavior is also common in both DID and BPD. [1]:129, 137
- **Substance/medication-induced disorders** (e.g., Alcohol or drug addiction or side effects of another drug) Certain substances can cause episodes of amnesia and altered behavior (e.g. alcohol) or other dissociative experiences - in DID these occur during times when no substance has been used. Substance use disorders are common in people with DID. [4]:297-298
- **Conversion Disorder** (Functional Neurological Symptom Disorder). These disorders are common in people with DID, particularly psychogenic non-epileptic seizures (PNES), which can cause amnesia during the seizure only. [4]:297-298
- Seizure Disorders - especially Complex Partial Seizures. EEG tests can differentiate between seizure disorders and seizure-like symptoms in DID. Dissociative symptoms are far greater in people with DID. [4]:297
- **Factitious Disorder and Malingering** Both of which involve intentionally and knowingly pretending to have DID, e.g., by repeatedly giving false information to professionals. This is very different to having doubts about symptoms, or wondering if you 'made
it all up'. Psychological tests, observation, and corroborating history can be used to help diagnose. [3]:296-297 Malingerers have a clear motive, e.g. to avoid responsibility for a crime (despite the fact the diagnosis is rarely accepted for an 'insanity' defense).

See also: Common Misdiagnoses and Dissociative Identity Disorder

**Symptoms described in the DSM-5**

Dissociative Identity Disorder has a wide variety of symptoms, the primary symptoms that occur in all people with DID are described in the DSM psychiatric manual. The key characteristic of Dissociative Identity Disorder is the presence of **at least two distinct personality states** (described in some cultures as an experience of "possession"). The presence of **reoccurring periods of amnesia** is the next most important characteristic, sometimes referred to as **recurrent lapses in memory** which go beyond ordinary forgetting. [3]:291-292 The remaining diagnostic criteria require symptoms to cause **distress and/or impaired functioning** in at least one area of life, and state that DID can only be diagnosed if no other condition provides a better explanation for symptoms. A mix of **secondary symptoms** are found in DID, particularly those caused by the passive influence of alters intruding into awareness, but no single secondary symptom is present in everyone with Dissociative Identity Disorder, and these do not form part of the diagnostic criteria.

**Distinct Personality States**

A person with Dissociative Identity Disorder has "distinct personality states", this phrase refers to distinct (different, separate) identities that appear to be different personalities, they are often called alternate personalities, alternate identities, or "alters". Other terms sometimes used instead of "alters" include dissociative parts (of the personality), Apparently Normal Part of the personality (ANP), and Emotional Part of the personality (EP).[1], [4]:193 Alters are only overt (obvious) in a small minority of people with DID in clinical situations. A change introduced in the DSM-5 makes it possible to diagnose DID without the diagnosing clinician directly observing a switch between alters: instead DID can be diagnosed if the person **self-reports** their presence and effects, or if another person describes observing a switch between alters. Two clusters of symptoms indicate the presence of alters if they are not observed, these are described in the DSM-5's extended description of Dissociative Identity Disorder:

- Sudden alterations or discontinuities in **sense of self** and **sense of agency** (Criteria A),
- and **recurrent dissociative amnesias** (Criteria B). [3]:291-292

**Sense of Self and Agency**

The terms "sense of self" and "sense of agency" are used in the DSM's Dissociative Identity Disorder Criterion A, which describes the presence of **distinct personality states**, better known as **alter personalities**. It is the discontinuities (switches) between alters, as well as their presence that this criteria describes.

A discontinuity in a person's **sense of self** can affect any part of someone's functioning. Attitudes, outlooks and personal preferences like preferred foods or clothes may change suddenly and inexplicably, and then change back again. This happens because alter personalities have different attitudes, outlooks and preferences, so a very sudden change without explanation occurs when an alter has either taken control or is strongly influencing the person. When that alter is no longer active, everything changes back (until the next time the same alter is active). During these times, a person may find have bought clothes they would never choose to wear, or a very outgoing person may suddenly become shy and introverted with no apparent reason.

Discontinuity in a person's **sense of agency** means not feeling in control of, or as if you don't "own" your feelings, thoughts or actions. For example, experiencing thoughts, feelings or actions that seem as if they are **not mine** or belong to someone else. This is not the delusional belief that they belong to an outside person, it is the perception that their own speech, thoughts, and/or behavior do not feel like they belong to them and may make no sense to them. Emotions and impulses are often described as puzzling to the person. This happens in Dissociative Identity Disorder because some of the thoughts, feelings or actions of **alter personalities** intrude into their conscious awareness, even when they are not aware they have any alter personalities, or have
amnesia for their actions.[3]:298 This is known as **passive influence** or **partially dissociated intrusions** of alter identities into conscious awareness (see below).

A person with DID may also experience a **fully dissociated intrusion**, and may say things like:
- I have no control, I watch what happens, but can't stop it [3]:293
- I find myself "coming to" in the downtown area where I live, but I won't remember where I parked the car [14]:63
- I have found myself crying uncontrollably and sucking my thumb, but I can't explain why [14]:63
- Sometimes I've had people call me by a name I don't recognize, and I don't know who they are [14]:15

A similar depersonalized experience can happen briefly during times of severe stress, especially in people with **Borderline Personality Disorder**, except that the person perceives the behavior as "out of character" rather than like another person; but in Dissociative Identity Disorder there may not be any obvious stressor causing the change, the actions and words may not relate to any prior distress, and the duration can be considerably longer (hours, days, or more). In DID, this happens because an alter personality has taken control, so attitudes, outlook and personal preferences change at the same time - leaving a feeling as if someone totally different in control of your body. This change in control is known as **switching**, only in Dissociative Identity Disorder can a person switch, because no other diagnosis has alter personalities that control (of the body) can be switched to.

Rapidly switching moods (within minutes or hours) are commonly caused by the presence of alters which have different moods, these changes in moods can be puzzling and lead to a misdiagnosis of **Bipolar Disorder**, type 2, however mood changes in Bipolar Disorder do not switch back and forth as rapidly.[3]:296

The combined changes in "sense of self" and "sense of agency" can cause a person to find themselves feeling like they are watching passively while someone else controls their body; they hear themselves speaking words they would never normally speak and that may not make sense to them, and which they are **powerless to stop**. The person has become a **depersonalized observer** of themselves.

Some people describe this combined change of "sense of self" and "sense of agency" as feeling like an **experience of possession**, in a non-religious sense, or having their body "hijacked". A person with DID may find that their body feels totally different during this time (e.g., like a small child, the opposite gender, huge and muscular), or may feel as if they are suddenly younger or older.[3]:298

**Recurrent Amnesia: Criterion B**

In DID, **total amnesia for the actions of alter personalities is not necessary** - it is possible for a person to be aware of many of their actions at the time, known as **co-consciousness**, or remember some of what happened later. If a person does have total amnesia the changes in a person's speech, mood and behavior may be **witnessed by others** and reported back to them, but they may deny this "odd behavior" because they have no memory of it, which can lead others to incorrectly assume they are **repeatedly lying**.

Several different types of amnesia can occur in people with Dissociative Identity Disorder, the common types are:
- **"gaps in past memory of personal life events"** (e.g., periods of childhood or adolescence; some important life events, such as the death of a grandparent, getting married, giving birth); this amnesia does not need to be restricted to traumatic events
- **"lapses in dependable memory"** (e.g., of what happened today, remembering how to do well-learned skills like how to do their job, drive, read, etc); this refers to the whole person - for example having a child alter who does not know how to read would prevent the person from remembering how to read when that alter was in control of the body
- **"discovery of evidence of their everyday actions and tasks that they do not recollect doing"** (e.g., finding unexplained objects in their shopping bags or among their possessions; finding perplexing writings or drawings that they must have created; discovering injuries; "coming to" in the midst of doing something). Dissociative **fugues**, which involve travel to an unusual place without any memory of the
journey or its purpose, are common. People find themselves “coming to” at the beach, hiding in a closet a home, in a nightclub, or in bed without any memory of the “lost” time. [3]:293

Some people with Dissociative Identity Disorder don’t match the classic view presented in the book and film Sybil, and the numerous media portrayals of DID since, because the amnesia in DID does not need to involve having no memory of what alters do when they are in control, a person can remember or be aware of what happens at the time but still have DID.[17]:4, [17]:19 People with total amnesia for the actions of alter personalities may refer to the periods of amnesia as blackouts or losing time, and may not be aware that they have alter personalities, this degree of amnesia does occur in some people with DID but has never been a required diagnostic criteria. Other people with DID may have internal conversations with their alters and are able to describe them, which is something asked about in the Structured Clinical Interview for Dissociative Disorders. [14]:22, [14]:66 If no recurrent (reoccurring) gaps in memory for the past or present occur but all the other criteria are met then the similar diagnosis of Other Specified Dissociative Disorder Presentation 1 can be given instead.[3]:292 The three common types amnesia found in DID can be assessed using diagnostic screening and/or a clinical interview for Dissociative Disorders.

Passive Influence of Alters

The passive influence of alters cause many common secondary symptoms Dissociative Identity Disorder, symptoms that are often described as confusing and frightening, and can make a person feel like they are going crazy.[17]:8 People with DID normally have some of these symptoms, but all of them are optional rather than needed for diagnosis. While none of these symptoms are unique to Dissociative Identity Disorder, understanding why they happen and that they are common in DID can be very helpful.

Examples of passive influences:

- Hearing a child’s voice - when no child is visible
- **Speech insertion** - saying things you don’t remember saying, or didn’t intend to say
- **Thought insertion** - strong thoughts seem to come out of nowhere and don’t feel like yours
- **Thought withdrawal** - your thoughts may suddenly seem to get taken away
- **Internal conversations** or hearing voices arguing, internal struggle
- **Hearing voices that are threatening, harsh or tell you to do self-destructive acts**
- Intrusive or “made” feelings or emotions - unexpected surges of feelings that are puzzling
- Intrusive or “made” impulses or “made” actions - some impulses or behavior doesn’t feel like yours, you may be or may not be fully aware of it at the time, you may be told of things you did by others or find you have self-injured
- Temporary loss of well rehearsed knowledge or skills, e.g. forgetting where you live or how to drive or do your job (amnesia)
- **Self-alteration** - suddenly, inexplicably feeling that your body, thoughts, or urges belong to someone else or are not yours (when not feeling depersonalized/detached from self, that occurs without switching to an alter)
- **Self-puzzlement** - you don’t understand why you feel and behave as you do [17]:4, 14, [18]:231-232

The symptoms marked with * are known as Schneiderian first-rank symptoms (FRS) and were historically used to diagnose Schizophrenia, but are actually more common in DID. In DID they not given delusional explanations because they do not have a psychotic origin in people (except in the uncommon case that a psychotic disorder also exists). Schizophrenia is a very common misdiagnosis for DID.

An influential study of 220 people with Dissociative Identity Disorder found that most people experienced several of the symptoms above, although no single symptom was experienced by everyone, and none are actually diagnostic criteria. These symptoms can be understood as the result of alter personalities partially intruding into a person’s conscious awareness.[17]:8, 14 For example, hearing a child’s voice can be caused by the voice of a very young alter personality intruding into conscious awareness without fully taking over control.

ICD-10 and ICD-11 Criteria
The last edition of the International Classification of Diseases, the diagnostic guide published by the World Health Organization is the ICD-10, published in 1992. The draft ICD-11 beta criteria for Dissociative Identity Disorder classifies it as a Mixed Dissociative Disorder, and proposes this definition:

**ICD 11 draft criteria**

**Code 7B36**

"Dissociative identity disorder is characterized by the presence of two or more distinct, nonintegrated or incompletely integrated subsystems of the personality (dissociative identities), each of which exhibits a distinct pattern of experiencing, interpreting, and relating to itself, others, and the world. At least two dissociative identities are capable of functioning in daily life, recurrently take executive control of the individual's consciousness and functioning and include a substantial set of sensations, affects, thoughts, memories, and behaviours. The symptoms are not consistent with a recognized neurological disorder or other health condition. The disturbance is sufficiently severe to cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning."

Alternative names:
- Multiple Personality
- Multiple Personality Disorder

*Last updated August 2016.*

**Differences between the ICD-10 and Draft ICD-11 for DID**

Several significant changes have been made, including recognizing each alter identity/dissociative part of the personality as a "subsystem of the personality" rather than a complete personality. It also recognizes that some alters may be *partially integrated* with each other, for example co-consciousness (sharing memory and/or feelings in the present). The ICD-11 states that at least two identities must be able to function in *daily life*, it is unclear how much functioning is needed: does it refer to time in control, or is it looking for two Apparently Normal Parts (hosts)? The name has also changed from Multiple Personality, and it has been given greater prominence.

**ICD 10 Diagnostic Criteria**

**Code F44.81**

In the World Health Organization's ICD diagnostic manual, Dissociative Identity Disorder is still referred to as Multiple Personality, and classified as one of several *Other dissociative [conversion] disorders* within code F44.8. The diagnostic criteria are:

"A. The existence of two or more distinct personalities within the individual, only one being evident at a time.
B. Each personality has its own memories, preferences and behaviour patterns, and at some time (and recurrently) takes full control of the individuals behaviour.
C. Inability to recall important personal information, too extensive to be explained by ordinary forgetfulness.
D. Not due to organic mental disorders (F0) (e.g. in epileptic disorders) or psychoactive substance-related disorders (F1) (e.g. intoxication or withdrawal).
E. The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures)."

**Diagnostic Tests and Interviews**

Screening tools, like the Dissociative Experiences Scale and SDQ-20 cannot give a definite diagnosis for Dissociative Identity Disorder, they are designed to rule out people unlikely to have a Dissociative Disorder, and to highlight those who may benefit from a clinical interview like the Dissociative Disorders Interview Schedule or Structured Clinical Interview for Dissociative Disorders, which can give a definitive diagnosis for Dissociative Identity Disorder or another Dissociative Disorder (or rule them out). [7]:26

The *Dissociative Experiences Scale (DES)* is a self-assessment screening tool (a questionnaire) that is useful
for identifying people who experience a high degree of dissociation. It is available in many languages. A definite diagnosis should only be made by a qualified clinician. This can be done using a clinical interview based on the Dissociative Experiences Scale, or by using one of the two clinical interviews developed for Dissociative Disorders, the SCID-D or DDIS (described below). [1]:126-127,[11]:21, [12], [14]

The Somatiform Dissociation Questionnaire (SDQ-20) is another self-assessment screening tool for Dissociative Identity Disorder and other Dissociative Disorders. [1]:127 It is a questionnaire that measures physical symptoms historically found to be common in people with Dissociative Disorders, including DID and Other Specified Dissociative Disorder. Symptoms assessed include sensory disturbances (e.g., tunnel vision, psychogenic blindness, auditory distancing, numbness/insensitivity to pain), other conversion disorder symptoms (e.g., psychogenic paralysis and non-epileptic seizures), genital symptoms (difficulty urinating, genital pain that does not occur during intercourse), and more.[1]:127, [28] The SDQ-20 was developed Dutch clinicians and researchers in the late 1990s. [1]:127 Average scores have been published for the DID, OSDD (formerly known as DDNOS), Somatoform Disorders, Eating Disorders, Schizophrenia, Anxiety Disorders, major Depression, mixed psychiatric disorders, Bipolar disorder, and a non-psychiatric group. [7]:25 The SDQ-20, and the shorter SDQ-5, are available online in multiple languages, along with their scoring instructions. [7]:36 Somatoform Dissociation is “manifested in the loss of the normal integration of somatoform components of experience, bodily reactions and functions ... it is a disturbance of mental function”. [29] This has been shown to be higher in Dissociative Identity Disorder than in people from any other diagnostic group, including those diagnosed with Somatoform Disorders, and it also correlates with trauma history, especially physical and sexual trauma occurring from ages 0-6 (both self-reported and corroborated trauma).[29]:722, [30]:25

Dissociative Disorders Interview Schedule (DDIS), developed by Dr Colin A. Ross et al.[13] This uses some observation from a clinician, and is a structured interview. No special training is needed to carry this out and it can be downloaded without charge from the Ross Institute. It has been updated for the DSM-5. [13]

Structured Clinical Interview for Dissociative Disorders - Revised (SCID-D), is regarded as the gold-standard diagnostic tool for Dissociative Identity Disorder. [15]:102 It is a semi-structured clinical interview that uses observation from a trained clinician. It was developed primarily by Dr Marlene Steinberg and can accurately assess all Dissociative Disorders. [12], [14] It can distinguish between all Dissociative Disorders and dissociative or identity symptoms present in Borderline Personality Disorder, Schizophrenia, PTSD, major Depression, and Acute Stress Disorder. Each domain of dissociative symptoms is assessed: amnesia, depersonalization, derealization, identity confusion and identity alteration, and then rated for severity (absent, mild, moderate, or severe). This interview can only be carried out after specific training, and includes the interviewer noting subtle indicators of dissociation, including intra-interview amnesia, also known as micro-amnesias, eye movements, trance states, changes in demeanor and mood, avoidance or uncertainty in answering certain questions. [14]:80 148 The questions are open-ended to elicit detailed answers. Questions avoid “leading or intrusive” wording, but many people may still have emotional reactions to certain questions. [14]:80, 148

Clinicians wishing to use the SCID-D can receive training from International Society for the Study of Trauma and Dissociation (ISSTD), or affiliate organizations worldwide. The SCID-D has not yet been updated to reflect the DSM-5 diagnostic criteria.[14] (Last checked May, 2016)

Another tool based on self-report, the Multidimensional Inventory of Dissociation (MID), also exists.[1]:126, [15] This ignores normal experiences of dissociation, and assesses only pathological dissociation.[15] It is only available to clinicians and uses an Excel-based scoring system, who can request a copy from author Paul F.Dell. It can reliably help a clinician diagnose Dissociative Identity Disorder and Other Specified Dissociative Disorder (DDNOS), and problematic Borderline Personality Disorder traits. It includes over 200 questions, and produces a series of graphs and total scores for different aspects of dissociation.[15]

Treatment

The Adult Treatment Guidelines for Dissociative Identity Disorder were first produced over 20 years ago, they were developed by expert consensus and guided by large-scale clinical research. The current Adult version, from 2011, is free to download from the International Society for the Study of Trauma and Dissociation. [1] The treatment guidelines for Dissociative Identity Disorder also cover similar forms of Dissociative Disorder Not
Otherwise Specified (DDNOS), which is now known as Other Specified Dissociative Disorder. [1]

Research shows that treatment based on the treatment guidelines, which focuses primarily on outpatient psychotherapy, improves symptoms, increases functioning and reduce the rates of hospitalization.[1], [9]:169 Poor outcomes were found when treatment did not follow the guidelines, for example treatment which did not directly engage alter identities and seek to reduce amnesia,[9]:169 or when treatment was focused on “memory recovery”. [9]:180 Harm was far more likely to occur when DID was not treated at all. [9]:169 Treating Dissociative Identity Disorder did not only consistently improve dissociative symptoms, it also improved patients' general distress and depression.[9]:175

Psychotherapy

Psychotherapy (talking therapy) is the primary method of treatment for Dissociative Identity Disorder, and has the most evidence-based research showing significant improvements with psychotherapy which adheres to the treatment guidelines. No specific type of psychotherapy is recommended. [1], [9] Psychotherapy for Dissociative Identity Disorder follows the basic principles of general psychotherapy,[1] with additional of techniques which address dissociative symptoms, for example guidance on working with alters. Treating Dissociative Identity Disorder is not primarily based around uncovering trauma memories, hypnotism, or trauma exposure techniques. A recent study that compared experts in the treatment of Dissociative Disorders to community clinicians found that experts spent more time on techniques for the containment of trauma memories than uncovering them.[8]:4 Experts in treating DID also spent more time on grounding and safety interventions.[8]:4

The goal of treatment is integrated functioning, which means a workable form of integration or harmony among identities.[1]

Is Integration Essential?

Integration in DID refers to the process of someone gradually getting closer and more connected to other parts of themselves, so that alter identities are not as dissociated (disconnected) from the person, or from each other. [1]:133 Many people use the word integration to refer solely to fusion, which is the permanent merging of alters within a person with Dissociative Identity Disorder. Full integration, known as final fusion, into a single identity is not essential for healing to take place: it is only part of a long-term process, with many improvements to daily life occurring on the way. Some people mistakenly believe that the only goal of treatment for Dissociative Identity Disorder is simply to have a single identity rather than multiple identities. [1]:133 However, this simplistic view does not take into account the work of addressing the traumatic experiences that caused multiple identities in the first place, or recovery from the other co-morbid disorders that people with DID typically have. While some people do choose final fusion as their goal, and this outcome is seen by some professionals (e.g., Kluft), as the most stable over the longer term, not everyone wants to achieve this, or is able to achieve this. Reasons for not integrating fully include serious and long-term situational stress, avoiding addressing unresolved and painful life issues or traumatic memories, lack of money for treatment, comorbid physical or mental disorders which don't improve as treatment progresses, advanced age, and/or significant investment in either alters themselves or in having DID. [1]:133-134

An alternative goal for treatment involves achieving a workable form of harmony between alter identities, known as resolution, and this is actually a more common outcome than full integration. Resolution involves achieving a cooperative arrangement between the person’s identities, which is a sufficiently integrated (i.e., connected) and co-ordinated way of functioning that promotes "optimal functioning". [1]:133-134 International treatment studies have shown that long-term psychotherapy helps people with Dissociative Identity Disorder achieve significant and sustainable improvements in their overall mental health as well as their DID symptoms, regardless of whether they eventually reach final fusion, and whether they are treated by a Dissociative Disorders specialist or a “community clinician”.

Note: The international treatment guidelines for Dissociative Identity Disorder in Adults state that therapists should not try to ignore or “get rid" of any alters: integration involves merging/fusing together which is the opposite.
Previous treatment studies have shown full integration (final fusion) was achieved for between 1 in 3 and 1 in 6 of people, but do not generally state how many people chose not to fully integrate.

See also: Healthy Multiplicity

**Dissociative Identity Disorder treatment - integration, fusion or a co-operative arrangement**

Medication and DID

Although psychotropic (psychiatric) medication is not a primary treatment for complex dissociative disorders, most DID patients do take some form of medication. This typically targets the comorbid conditions, including...
PTSD, mood disorders (e.g., depression), and any obsessive-compulsive symptoms.[1] The use of antidepressants is particularly common. People with DID or other complex posttraumatic conditions may only partially respond to medication, in DID there is the further complication of potential amnesia for whether other alters have refused to take medication or taken too much. The DID treatment guidelines for adults state that alters may report different responses to the same medication, possibly due to physiological differences, physical symptoms which have a psychological cause (somatoform symptoms), and/or the alters' experience of separateness.[1]

**Healthy Multiplicity**

Healthy multiplicity is achieved when a person has multiple senses of identity, but does not have clinically significant distress or impairment as a result of their dissociative identities. A person who meets all the diagnostic criteria for Dissociative Identity Disorder except Criteria C (distress or impaired life) may be referred to as a healthy multiple, and does not have any dissociative disorder since all of them require distress or impaired functioning. The presence of alters alone is not enough to classify someone as having a "mental disorder". [3]

**History of DID**

Dissociative Identity Disorder is sometimes incorrectly believed to be a "new" diagnosis, but it has a long history of recognition, and has been part of the Diagnostic and Statistical Manual for Mental Disorders since its first edition was published in 1952.[21] Before this, Dissociative Identity Disorder was also described in earlier diagnostic manuals,[22],[23]:377,[26] and for hundreds of years in books and writing, including those by many famous "physicians" and scientists including Sigmund Freud, Pierre Janet, and Morton Prince (founder of the Journal of Abnormal Psychology). Dissociative Identity Disorder has retained the same diagnostic code, DSM code 300.14, for almost 50 years.[3],[22-24]

**Historical Names for Dissociative Identity Disorder**

The history of Dissociative Identity Disorder in diagnostic manuals parallels that of Posttraumatic Stress Disorder, with both becoming a separate diagnosis with the publication of the DSM-III in 1980. DID has historically been described alongside other Dissociative Disorders, including Amnesia, Fugue and Depersonalization, which are not subject to suggestions that they are either a "new" or "controversial" diagnosis.

- Hysteria - Statistical Manual for the Use of Institutions for the Insane, 1918 (Grob, p.426)
- Dissociated Personality - DSM-I, 1952)
- Hysterical neurosis, dissociative type - DSM-II, 1968 - "multiple personality" listed as a symptom
- Multiple Personality - DSM-III, 1980
- Multiple Personality Disorder - DSM-III-R, 1987
- Dissociative Identity Disorder (Multiple Personality Disorder) - DSM-IV, 1994
- Dissociative Identity Disorder - DSM-5, 2013

**DSM-I (1952): Dissociated personality. Code 000-x02**

"Dissociative reaction This reaction represents a type of gross personality disorganization, the basis of which is a neurotic disturbance, although the diffuse dissociation seen in some casts may occasionally appear psychotic. The personality disorganization may result in aimless running or "freezing." The repressed impulse giving rise to the anxiety may be discharged by, or deflected into, various symptomatic expressions, such as depersonalization, dissociated personality, stupor, fugue, amnesia, dream state, somnambulism, etc. The diagnosis will specify symptomatic manifestations. These reactions must be differentiated from schizoid personality, from schizophrenic reaction, and from analogous symptoms in some other types of neurotic reactions. Formerly, this reaction has been classified as a type of "conversion hysteria"."[21]:34

**DSM-II (1968): Hysterical neurosis, dissociative type. Code 300.14**

300.1 Hysterical neurosis
This neurosis is characterized by an involuntary psychogenic loss or disorder of function. Symptoms characteristically begin and end suddenly in emotionally charged situations and are symbolic of the underlying conflicts. Often they can be modified by suggestion alone. This is a new diagnosis that encompasses the former diagnoses "Conversion reaction" and "Dissociative reaction" in DSM-I. This distinction between conversion and dissociative reactions should be preserved by using one of the following diagnoses whenever possible.

300.14 Hysterical neurosis, dissociative type

"In the dissociative type, alterations may occur in the patient's state of consciousness or in his identity, to produce such symptoms as amnesia, somnambulism, fugue, and multiple personality." [22]:40


This version of the DSM was the first to include diagnostic criteria for mental disorders, rather than only a description. Other changes in this update include moving all Dissociative Disorders to a new section, renaming Traumatic Neurosis to PTSD, and changing it to a separate diagnosis. The description of Dissociative Identity Disorder covers two pages, ending with these criteria:

"A. The existence within the individual of two or more distinct personalities, each of which is dominant at a particular time.
B. The personality that is dominant at any particular time determines the individual's behavior.
C. Each individual personality is complex and integrated with its own unique behavior patterns and social relationships". [23]:259

The role of childhood trauma was recognized as follows: "Onset of Multiple Personality may be in early childhood or later. The disorder is rarely diagnosed until adolescence," and "Child abuse and other forms of severe emotional trauma in childhood may be predisposing factors." It was recognized as more common in females, with diagnosis commonly occurring in late adolescence, or young adult females. Differences between alter personalities mentioned included reports of "being of the opposite sex, of a different race or age, or from a different family than the original personality," and that they may have different responses to "physiological and psychological measurements". The diagnosis was described as "apparently extremely rare". [23]:257-258

The description stated that each personality had "unique memories, behavior patterns, and social relationships.." and that switches between identities were "sudden and often associated with psychosocial stress". Limited amnesia and a typical lack of awareness of alter personalities was described:

"Usually the original personality has no knowledge or awareness of the existence of any of the other personalities (subpersonalities). When there are more than two subpersonalities in one individual, each is aware of the others to varying degrees. The subpersonalities may not know each other or be constant companions. At any given moment one personality will interact verbally with the external environment, but none or any number of the other personalities may actively perceive (i.e., "listen in on") all that is going on." [23]:257-259

The disorder was recognized as not occurring alone, with medically unexplained physical symptoms being common (diagnosed as Somatoform Disorders), as well as "Psychological Factors Affecting Physical Condition". Differential Diagnosis are listed as Psychogenic Amnesia, Psychogenic Fugue, and Psychotic Disorders, e.g., Schizophrenia spectrum disorders, plus Malingering (intentionally faking illness for an obvious gain).[23]:257-259


Multiple Personality is now officially called Multiple Personality Disorder, changes include recognizing self-injury, self-harm and addiction to medication as common, and adding Borderline Personality Disorder as a differential diagnosis. The diagnostic criteria are given below.

"A. The existence within the person of two or more distinct personalities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self.
B. At least two of these personalities or personality states recurrently take full control of the person's behavior."
The term “personality” is defined for the first time, and “personality state” is introduced:

The essential feature of this disorder is the existence within the person of two or more distinct personalities or personality states. Personality is here defined as a relatively enduring pattern of perceiving, relating to, and thinking about the environment and one’s self that is exhibited in a wide range of important social and personal contexts.

Personality states differ only in that the pattern is not exhibited in as wide a range of contexts. In classic cases, there are at least two fully developed personalities; in other cases, there may be only one distinct personality and one or more personality states. In classic cases, the personalities and personality states each have unique memories, behavior patterns, and social relationships; in other cases, there may be varying degrees of sharing of memories and commonalities in behavior or social relationships.


“A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

B. At least two of these identities or personality states recurrently take control of the person’s behavior.

C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

D. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures). NOTE: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.” [24]:529


Several changes were made, including adding a new criteria:

“The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.”

This change means that a person who has alter identities (and some amnesia), is no longer automatically considered to have a mental health disorder. A person can only be diagnosed if they experiences distress or difficulties in life as a result. See DSM-5 criteria. [3]

**References**


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