

#DID: The Role of Social Media in the Presentation of Dissociative Symptoms in Adolescents

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The recent social media–led and –centered movement encouraging mental health awareness, disclosure, and discussion, primarily among adolescents,¹ can have significant benefits, including reducing mental health stigma, providing peer and social support, and disseminating information. Conversely, mental health disclosure online provides a catalyst for spreading misinformation and cyberbullying. It may also present opportunities for monetary and other forms of secondary gain; for example, some TikTok dissociative identity disorder (DID) influencers have vast numbers of followers and include donation links to their Venmo and PayPal accounts. At the time of this writing, TikTok hashtags “#did,” “#didsystem,” and “#dissociativeidentitydisorder” have amassed hundreds of thousands of views.

An increasing number of young people have been presenting to our clinical high-risk program with self-described DID and report learning about mental health symptoms on social media platforms such as TikTok. These reports have increased in the context of the COVID-19 pandemic–related rise in social isolation and mental health diagnoses in youth.² Given that the reported symptoms of the youth who have presented to our clinic diverge in several respects from the literature on DID, we aim to provide clinical recommendations for understanding and assessing dissociative experiences in the context of current social media culture. A nuanced understanding of self-reported dissociative symptoms in this context is critical for accurate diagnosis and patient-centered care.

CLINICAL PRACTICE RECOMMENDATIONS

1. Youth-serving providers may benefit from familiarity with social media and popular media portrayals of and terms for dissociative disorders as well as other mental health disorders common in their clinical practice.

The DID online community on TikTok and elsewhere includes unique presentations and terminology. Clinicians may benefit from reading recent accounts published in the popular press as well as seeking out hashtags and viewing content on dominant social media platforms. Some of current terms used online are already established in the DID literature, such as an “alter,” or alternative identity,³ and some are specific to the online community and stray from established terminology. Online-based terms include a “system,” which is the name of a person and all their alters. The “host” is the main person/alter, and “switching” occurs when one alter/host appears and takes over the person’s body. Some TikTok users describe that their alters have roles, such as “caretaker,” “protector,” or “little.” Common variations of alters in the TikTok DID community are “fictives” and “factives,” which are terms for alters based on fictional and nonfictional characters, respectively. People reporting DID online often report seeking a state of “multiplicity,” in which different alters would theoretically live and coexist in harmony within the host’s body. In terms of how DID is portrayed online, videos are often presented to “introduce” different alters—describing name and other identity characteristics, role in the system, and personality traits—and capture the moments in which they switch between alters. It is also noteworthy that some individuals on TikTok who describe themselves as a system do not describe their experiences in terms of distress, mental health symptoms, and/or impairment; rather, they describe their identity as a state of “plurality,” or plural identity.⁴ In these cases, understanding experiences as a function of developmentally normative identity formation may be more useful than pathologizing symptoms. Given that exploration of identity is a common part of adolescence,⁵ clinicians working with this age group should routinely ask questions to learn how patients understand and define their own identities.

2. Knowledge of the established literature on dissociative disorders can facilitate differential diagnosis, shed light on possible etiologies, and assist in psychoeducation.

DID remains understudied and controversial in terms of its etiology.⁶ Nevertheless, there are several ways in which these online accounts of dissociative disorders diverge from the existing literature and the diagnostic criteria as outlined in *DSM-5*:⁷ First, DID is a disorder of adulthood and has not been reported in the literature to occur in children and adolescents.⁶ Distress and impairment, which are hallmarks of dissociative disorders, are not always seen in online reporters. Integration of alters into the primary personality is thought to be the ideal clinical outcome/gold standard of treatment, and it is unknown if attaining multiplicity is a possible or a functional state of being.¹ Individuals with DID do not typically exhibit rapid switching between personalities or have awareness of their own multiple personalities before extensive treatment and successful integration.³ Finally, recent and online presentations of DID may not report the critical context of a complex trauma history, which is considered a key feature of DID.³

3. Assessment of dissociative symptoms may be enhanced by a consideration of symptoms, comorbidity, and the cultural and social context of the patient, ideally with the input from collateral reporters.

Specifically, providers may wish to do the following:

- Assess for DID and trauma using established assessment tools, eg, gold standard clinical interviews as well as measures such as the Dissociative Experiences Scale,⁸ Dissociation Questionnaire,⁹ and Childhood Trauma Questionnaire (CTQ).¹⁰
- Assess for medical conditions and comorbid disorders that may better account for dissociative symptoms. Providers should assess for conditions that could better account for dissociative symptoms, such as neurological disorders, head injuries, and substance use.^{3,7} Common comorbidities could include mood, anxiety, psychotic, posttraumatic stress, and personality disorders.
- Inquire about any potential unsafe or self-destructive behaviors the patient might report when they are an alter and collaboratively incorporate these in safety planning.
- Evaluate possible benefits or upsides of these experiences including potential secondary gain, such as social support or validation, increased online engagement, and financial incentives. Suggested questions could include: “What are the upsides, if any, of having (these symptoms)?”; “What do you like about (these symptoms)?”; and/or “Are there any ways in which (they) are helpful in your life?”
- Assess the patient’s use of social media and its role in obtaining mental health and help-seeking information. Providers should inquire about degree and frequency of interaction with social media platforms their patients use, including TikTok and YouTube (including whether they observe, post content, or both). This can include assessing attachments to influencers or online personalities that may be involved in the DID/mental health online community as well as attachment to fictional characters and other celebrities that they may follow online. Next, it can be helpful to assess a patient’s mental health knowledge and degree to which they use online platforms to seek help with personal difficulties using open-ended questions such as: “Where do you go online to get support for your personal problems?” and/or “What do you know about symptoms/experiences like yours and people who have them?” Note if a patient uses any terminology primarily used in online spaces (eg, system, fictives/factives). Assess what they understand these terms to mean, and how their experiences relate to those of online influencers/personalities.
- Obtain a detailed timeline of reported dissociative symptoms, including initial onset, nature, and dynamic changes. Document specific examples of self-reported distress and impairment in functioning. Providers should incorporate information about the onset and timing of changes in social media use to establish whether dissociative symptoms occurred before, during, and/or after changes in social media use patterns.
- Seek to understand the patient’s social network and supports. Questions could aim to understand who the patient’s closest friends and/or romantic partner are; how they met them; and how, when, and where they interact with them (including online and virtual spaces). Additionally, it may be helpful to ask if any loved ones have symptoms similar to those they may describe. Lastly, it can help to understand whether a patient has discussed these symptoms with social supports and, if so, how these disclosures were received.
- Ask patients what their ideal goals for these symptoms would be and why. Is their goal for symptoms to go away or improve? Do they seek multiplicity or integration? If experiences are not distressing or impairing, do they define their identity in terms of plurality?

CLINICAL VIGNETTE

The following fictitious example illustrates some of the above recommendations and their incorporation into assessment and treatment planning.

“Sam” is a 14-year-old cisgender male patient who was evaluated due to his parents’ concerns of dissociation and depression. Sam endorsed symptoms of major depressive disorder without any psychosis and does not have history of trauma. He reported that when he “zones out” 8 to 10 named alters, who are fictives of his favorite videogame and anime characters, “take over (his) body.” During the evaluation, Sam displayed inconsistencies while describing the specifics of his experiences (duration, frequency, and distress). He confided that he and his friends, who also have alters, learned about DID on TikTok and that these personalities developed after encountering TikTok influencers with some of the same fictives. Further assessment of Sam revealed that these alters were not distressing and served a significant role in Sam’s social support network. Namely, he reported that he and his friends highly valued the videogame and anime characters comprising their alters and that he and his friends engage in cosplay at local conventions in which they dress up and roleplay these same characters. Sam began treatment for his depression, which included cognitive-behavioral therapy and a selective serotonin reuptake inhibitor. After making progress on primary therapy goals related to his depression, he was provided with psychoeducation about DID. He and his therapist agreed that Sam’s experiences seemed inconsistent with DID and generated alternative hypotheses. Sam began to understand the fictives as aspects of his own identity best expressed through creative and social outlets.

CONCLUSION

Evaluating and including self-reported dissociative symptoms in diagnostic formulations and treatment planning is challenging. It remains unclear, in the absence of new literature, if these experiences are best understood as malingering, a novel culture-bound syndrome, a new iteration of dissociative disorders, an expression of

developmentally normative identity seeking, or an expression of distress related to a comorbid disorder. Clinicians can help youth who report concern or identification with a DID diagnosis by providing psychoeducation and describing specific ways a patient’s symptoms are or are not consistent with known literature. It can be invalidating to challenge a patient’s interpretation of their experiences. In cases with diagnostic uncertainty, a clinical attitude of genuine curiosity and open-mindedness about unknown aspects of the human psyche and shortcomings of mental health diagnostic categories are useful. As in the case of the treatment of psychotic disorders, clinicians must also walk a fine line to avoid collusion and/or reinforcing beliefs that may be unhelpful. Instead, clinicians can support their patients by reflecting the emotions underlying their experiences, by working together to reduce distress and improve coping skills, and by supporting behaviors consistent with the patient’s goals and values.

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