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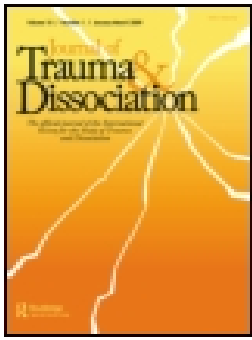


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Dissociative Identity Disorder: Diagnostic Accuracy and DSM-5 Criteria Change Implications

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ABSTRACT

The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) revised the diagnostic criteria for dissociative identity disorder (DID) to more accurately reflect the symptom profile of DID patients. No study has examined how this change affects clinical diagnosis of DID. The present study examined clinician reports of patient symptoms in relation to DSM-IV-TR and DSM-5 DID diagnostic criteria. Data were analyzed from 169 clinicians who participated in the Treatment of Patients with Dissociative Disorders Network Study with a patient they assigned a DID diagnosis. Clinicians evaluated their patients with respect to DSM-IV-TR and DSM-5 DID diagnostic criteria. Researchers determined a clinician-assigned DID diagnosis as “accurate” when the patient’s reported dissociative symptoms matched DSM-IV-TR and/or DSM-5 criteria for DID. Most of the clinicians (95.27%) accurately diagnosed DID. Of those accurately diagnosed, 83.85% of patients met DSM-IV-TR and DSM-5 DID criteria, 9.94% only met DSM-IV-TR DID criteria, and 6.21% only met DSM-5 DID criteria. Further examination of responses suggested that possible idiomatic responses to the negative wording of the DSM-5 exclusionary criteria might have accounted for the DSM-IV-TR appearing to fit for a greater number of cases in this study. Changes in the DSM criteria for DID did not substantially change the frequency or accuracy of assigned DID diagnoses, but the removal of the requirement in DSM-5 that self-states regularly take control of an individual’s behavior slightly increased the number of individuals meeting criteria for DID.

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Dissociation; dissociative identity disorder; dissociative disorder; diagnosis; accuracy; training

The latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) updated the diagnostic criteria for dissociative identity disorder (DID). To improve clinical utility, experts revised the criteria to more accurately reflect research on the complex clinical profile of DID (Spiegel et al., 2011). Updates to the DSM-5 criteria included the following: (a) more domains in which there can be a lack of identity integration, (b) more specific diagnostic criteria for dissociative

amnesia, (c) inclusion of culturally diverse manifestations of dissociation (e.g., possession), (d) acceptance of *self*-reports of personality states and (e) removal of the requirement that two or more self-states recurrently take control of behavior. To date, no study has examined whether these changes affect the frequency or accuracy with which clinicians make DID diagnoses.

There are assessment instruments with good psychometric properties available to diagnose DID (e.g., Structured Clinician Interview for DSM-IV – Dissociative Disorders; Marlene Steinberg, 1994; M. Steinberg, 2001). However, there are many barriers that impede diagnosis of individuals with dissociative disorders (DD), especially DID. This includes widespread myths about DD/DID, inaccurate portrayals of DD/DID in media and psychology textbooks, lack of clinician training, and skepticism of the validity and etiology of DD/DID. The complex symptom profile of DID patients can make it challenging for clinicians to deconstruct potential comorbid diagnoses or other symptoms (e.g., suicidal and/or self-destructive behaviors). This contributes to these patients suffering years of misdiagnosis and lack of proper treatment (Leonard et al., 2005; Perniciaro, 2014). DID patients spend between 6 and 12.5 years in mental health treatment and receive an average of 4 prior diagnoses before the correct diagnosis is ascertained (Loewenstein, 2018).

The lack of available training resources that focus on trauma is well-documented (Cook et al., 2017; Courtois & Gold, 2009). Only 20% of academic training programs and graduate internships for psychology professionals offer trauma-specific training seminars, workshops, or classes, and fewer still educate trainees about dissociation and DD/DID (e.g., Bride et al., 2009; Cook et al., 2017). An analysis of graduate psychopathology textbooks revealed that the textbooks did not provide adequate information about empirically supported research related to trauma and dissociation (Brand, Kumar et al., 2019). Many textbooks lacked coverage about dissociation in general, provided biased coverage of dissociation with minimal empirical support (e.g., primarily discussing fantasy-based models of dissociation), and/or failed to review trauma-based dissociation research. The failure to educate clinicians-in-training on the epidemiological, neurobiological, clinical, and treatment outcome research on DID (see Loewenstein, 2018, for an overview) perpetuates the lack of accurate understanding of this population, contributes to underdiagnosis and incorrect treatment, and leaves new clinicians susceptible to the many misunderstandings they may encounter.

Clinicians' lack of training, exposure and familiarity with dissociative disorders lead to misdiagnosis of individuals with DD/DID (Dorahy et al., 2005; Hayes & Mitchell, 1994; Perniciaro, 2014). Dorahy et al. (2005) found that fewer than 25% of doctoral-level clinicians accurately diagnosed a hypothetical patient demonstrating multiple DD symptoms in a vignette. Perniciaro (2014) found that only 60% of the licensed clinicians correctly diagnosed a case vignette of a patient with symptoms that met all diagnostic criteria for DID

and noted that clinical experience treating DID and lower levels of skepticism about DID were positively correlated with accuracy of diagnosis. Based on inaccurate beliefs that DID is rare and/or iatrogenically created (reviewed in Brand et al., 2016), there is skepticism among mental health professionals about the etiology and prevalence of DID. Not surprisingly, Hayes and Mitchell (1994) found that clinicians' degree of skepticism about DID directly correlated with clinicians' misdiagnosis of DID. At the level of the consumer, DID patients report feeling misunderstood and disbelieved by skeptical service providers (Leonard et al., 2005).

Lack of training and/or awareness of DD/DID diagnoses leads to primary diagnosis of co-morbid disorders (e.g., mood disorders, and PTSD) or misdiagnosis (e.g., psychosis, as DID patients commonly describe auditory hallucinations; Spiegel et al., 2011). In fact, the majority of DD patients receive multiple mental health diagnoses before receiving an accurate DD diagnosis (Putnam et al., 1986). DD patients often present to treatment with transdiagnostic symptoms that manifest similar to other disorders, particularly borderline personality disorder, schizophrenia, bipolar disorder, and PTSD (e.g., Brand & Lanius, 2014; Dorahy et al., 2014; Lyssenko et al., 2018; Rodewald et al., 2011; Yargiç et al., 1998). This complex symptom profile further complicates the diagnostic process of identifying and accurately diagnosing DD.

Unless there is specific treatment of the DD/DID, comorbid disorders generally do not definitively improve (Brand et al., 2012; Jepsen et al., 2014; Sar et al., 2013). DD experts recommend a phasic treatment model with a foundation of patient safety and stabilization (Brand et al., 2012; International Society for the Study of Trauma and Dissociation, 2011). In the Treatment of Patients with Dissociative Disorders (TOP DD) studies, Brand and colleagues (Brand, Schielke et al., 2019; Bride et al., 2009) found that a DD/DID diagnosis and DD/DID-specific treatment resulted in significant decreases in dissociative and co-occurring symptoms from baseline, including self-injury, suicide attempts, PTSD symptoms, etc., and increases in ability to regulate emotions and improved overall adaptive functioning (B. Brand et al., 2009, p. 2013; Brand, Schielke et al., 2019). Not surprisingly, accurate diagnosis can substantially change the treatment approach, and in turn, lead to improved treatment outcomes for patients.

Present study

We assessed the impact on clinical diagnosis of DID with changes to the diagnostic criteria for DID in DSM-5. We analyzed data collected during the 2019 TOP DD Network study (Brand, Schielke et al., 2019) to examine accuracy of DID diagnosis by using clinicians' descriptions of patients' symptoms and aligning these with DID diagnostic criteria. We classified a clinician-assigned DID diagnosis "accurate" when the patient's reported dissociative symptoms

matched DSM-IV-TR and/or DSM-5 criteria for DID. The authors hypothesized that (1) the majority of clinicians would accurately diagnose their patient with DID, (2) the majority of DID-diagnosed patients would meet DID criteria in both versions of the DSM, and (3) more patients would meet DID criteria in the DSM-5 than in the DSM-IV-TR (American Psychiatric Association, 2000).

Method

Procedure

The present study used data from the TOP DD Network study (Brand, Schielke et al., 2019), which examined the efficacy of a multi-modal, web-based psychoeducational intervention program for DD patients and their clinicians. The study was approved by the institutional review board at the first and third authors' university; participants provided written informed consent. Clinicians were primarily recruited through professional trauma and dissociation conferences and listservs, so were more likely to have familiarity with assessment and treatment of DD/DID.

Participants

While 291 clinician-patient dyads enrolled in the TOP DD Network study (Brand, Schielke et al., 2019), the present analyses include only therapists ($n = 169$) who reported diagnosis of a DID patient. The clinicians were mostly female (79.29%), white (94.67%), and had spent an average of 10.19 years treating DD patients prior to enrolling in the study ($SD = 7.79$, range 0.5–34). See Tables 1–2 for additional clinician demographic and training information, respectively. The patients about whom the therapists reported data were primarily female (93.49%) and white (82.25%), with an average age of 40.94 years old ($SD = 10.96$, range 19–65).

Measures

Demographics and training. Clinicians reported their demographic information and their training experiences, including degree(s) earned, dissociation workshops attended, and training in trauma and DD during graduate school. Clinicians were asked to report on their level of perceived comfort and preparedness for treating DD patients on a Likert scale ranging from 1 (*not at all*) to 5 (*completely*).

Patient diagnosis and symptoms. Clinicians were asked to report their patient's DD diagnosis and, from a list of DSM-IV-TR and DSM-5 DID diagnostic criteria, indicate which symptoms their patient experienced. The clinicians indicated *yes* or *no* to each symptom following the prompt, "Please

Table 1. Clinician Demographics and Characteristics (n = 169).

| Baseline characteristic | | % | n | M | SD | Range |
|---|---------------------------------------|-------|-----|-------|------|---------|
| Gender | Female | 79.29 | 134 | | | |
| | Male | 20.71 | 35 | | | |
| Race / ethnicity | Caucasian | 94.67 | 160 | | | |
| | Latino or Hispanic | 1.18 | 2 | | | |
| | Asian | 1.18 | 2 | | | |
| | Black | 0.00 | 0 | | | |
| | Other | 2.96 | 5 | | | |
| | | | | | | |
| Degree(s) | Social work (master's or doctoral) | 21.89 | 37 | | | |
| | Family therapy (master's or doctoral) | 6.51 | 11 | | | |
| | Psychology or related 2-year degree | 13.02 | 22 | | | |
| | Psychology Ph.D. or Psy.D. | 27.22 | 46 | | | |
| | Medical doctor M.D. | 13.02 | 22 | | | |
| | Other therapist degree | 25.44 | 43 | | | |
| Country | United States | 52.66 | 89 | | | |
| | Norway | 15.98 | 27 | | | |
| | Australia | 8.88 | 15 | | | |
| | United Kingdom | 7.10 | 12 | | | |
| | Canada | 5.33 | 9 | | | |
| | Netherlands | 2.37 | 4 | | | |
| | Sweden | 2.96 | 5 | | | |
| | India | 1.18 | 2 | | | |
| | Spain | 0.59 | 1 | | | |
| | New Zealand | 0.59 | 1 | | | |
| | Israel | 0.59 | 1 | | | |
| | Other | 1.78 | 3 | | | |
| | | | | | | |
| Years treating dissociative patients | | | | 10.19 | 7.79 | <1 – 34 |
| Comfort treating DD patients (1–5) ^a | | | | 3.97 | 1.04 | 2–5 |
| Perceived preparedness treating DD (1–5) ^a | | | | 3.89 | 0.99 | 2–5 |

Note. Ph.D. = doctor of philosophy; Psy.D = doctor of psychology.

^aPreparedness and degree of comfort measured on a 1 to 5 scale (1 = Not at all, 3 = Fairly, 5 = Completely)

Table 2. Clinician Training Experiences (n = 169).

| Methods of learning about treating dissociative patients | % | n |
|--|-------|-----|
| Specialized training in <i>trauma</i> as a student/resident/intern/postdoc | 35.50 | 60 |
| Specialized training in <i>dissociative disorders</i> as a student/resident/intern/postdoc | 31.36 | 53 |
| Supervision/consultation with a trauma disorders/DD specialist(s) | 67.46 | 114 |
| Work(ed) within a trauma-focused unit, center, or practice | 37.87 | 64 |
| Graduated from ISST-D's (or similar professional organization's) training for treating DDs | 26.04 | 44 |
| Learned by reading one or more books about DD patients | 76.92 | 130 |
| Learned only by treating DD patients | 30.18 | 51 |
| Other | 23.67 | 40 |

indicate whether or not your client is accurately described by the following criteria.” When querying the DSM-IV-TR criteria specifically, the prompt stated, “Please indicate whether or not your client is accurately described by the following criteria not due to the direct physiological effects of a substance or a neurological or other general medical condition.”

Table 3. DSM Criterion Endorsed by Participants with Inaccurate Diagnosis or Accurate Diagnosis in only DSM-IV-TR or DSM-5.

| DSM version | Criterion | Correct Diagnosis | | Inaccurate Diagnosis |
|-------------|-------------|------------------------------------|--------------------------------|----------------------|
| | | DSM-IV-TR only (<i>n</i> = 16) | DSM-5 only (<i>n</i> = 10) | (<i>n</i> = 8) |
| DSM-IV-TR | Criterion A | 16 | 9 | 3 |
| | Criterion B | 16 | 4 | 4 |
| | Criterion C | 16 | 7 | 4 |
| DSM-5 | Criterion A | 16 | 10 | 3 |
| | Criterion B | 10 | 10 | 4 |
| | Criterion C | 16 | 10 | 7 |
| | Criterion D | 15 | 10 | 4 |
| | Criterion E | 14 | 10 | 4 |

Note. Responses in bold reflect the number of participants who endorsed each diagnostic criterion in the DSM edition(s) in which the participant does not meet all diagnostic criteria.

Analyses

Data analysis was completed using SPSS Version 26. The first author coded whether each patient’s clinician-reported symptoms matched the DID diagnostic criteria according to the DSM-IV-TR only, DSM-5 only, both DSM-IV-TR and DSM-5, or neither DSM-IV-TR nor DSM-5. Individuals were classified as “correctly diagnosed” when the clinician-reported symptoms were consistent with DID and “inaccurately diagnosed” if clinician-reported symptoms did not meet all DID diagnostic criteria. For example, we classified a patient as “inaccurately diagnosed” if a clinician reported that the patient was diagnosed with DID, but did not report episodes of amnesia or inability to recall important personal information (DSM-IV-TR criterion C; DSM-5 DID criterion B). We computed descriptive statistics to examine the number of correctly and inaccurately diagnosed patients, and the DSM diagnostic criteria that each patient’s symptoms matched, if any. Using post hoc descriptive statistics, we examined ascertainment of specific diagnostic criteria in cases that only met diagnostic criteria for DID in one version of the DSM (i.e., DSM-IV-TR only or DSM-5 only) and cases identified as inaccurately diagnosed.

Results

Comparison of clinician-reported DID diagnoses and clinician-reported patient symptoms showed that 95.27% (*n* = 161) of patients were correctly diagnosed and 4.73% (*n* = 8) of patients were inaccurately diagnosed. Of the 161 correctly diagnosed patients, 83.85% (*n* = 135) met both DSM-IV-TR and DSM-5 criteria for DID, 9.94% (*n* = 16) only met DSM-IV-TR DID criteria, and 6.21% (*n* = 10) only met DSM-5 DID criteria.

Accurately diagnosed

DSM-IV-TR only

Among the patients who met all diagnostic criteria for DID in the DSM-IV-TR but not in the DSM-5 ($n = 16$), all clinician participants reported that their patient met DSM-5 Criterion A (i.e., disruption of identity with two or more personality states) and Criterion C (i.e., impairment and/or distress). 37.50% ($n = 6$) of the clinicians did not endorse that their patient experienced DSM-5 Criterion B (dissociative amnesia). Most (62.50%, $n = 10$) of the patients who met DID diagnostic criteria per the DSM-IV-TR but not the DSM-5 were due to the clinician responding “no” to DSM-5 criteria, indicating that the patient’s symptoms were *not* a normal part of cultural or religious practices and/or were *not* due to the effects of substances or another medical condition. Of these, 43.75% ($n = 7$) did not endorse DSM-5 Criterion D or E; 12.50% ($n = 2$) did not endorse Criterion E (symptoms were not due to the effects of a substance or other medical condition); 6.25% ($n = 1$) did not endorse Criterion D (symptoms were not a part of normative cultural practice).

DSM-5 only

Among the patients who met all diagnostic criteria for DID in the DSM-5 but not the DSM-IV-TR ($n = 10$), 10% ($n = 1$) of clinicians did not endorse DSM-IV-TR Criterion A (two or more distinct self-states as worded in the DSM-IV-TR), 60% ($n = 6$) did not endorse Criterion B (self-states regularly take control of the patient’s behavior), and 30% ($n = 3$) did not endorse Criterion C (inability to recall personal information unrelated to ordinary forgetfulness). When assessing for symptoms that were congruent with DSM-IV-TR criteria, Criterion D was automatically endorsed as part of the question prompt (i.e., the question asked which symptoms the patient experienced that were *not* related to substances or other medical conditions).

Inaccurately diagnosed group

Among the eight patients who were inaccurately diagnosed in relation to reported symptom profiles, clinicians reported that each patient experienced some form of dissociative symptomology (e.g., self-states, amnesia, or mixed dissociative symptoms). Per DSM-IV-TR diagnostic criteria, 62.50% ($n = 5$) of clinicians who inaccurately diagnosed their patient did not endorse Criterion A, 50% ($n = 4$) did not endorse Criterion B, and 50% ($n = 4$) did not endorse Criterion C, implying that their patient did not experience these symptoms. Per DSM-5 diagnostic criteria, 62.5% ($n = 5$) of clinicians did not endorse Criterion A, 50% ($n = 4$) did not endorse Criterion B, 12.5% ($n = 1$) did not endorse Criterion C, and 50% ($n = 4$) did not endorse both Criterion D and E. Two clinicians indicated that their patient experienced multiple self-states that regularly take control of their behavior but did not have amnesia, which would mean that an accurate

diagnosis would be Dissociative Disorder Not Otherwise Specified (DDNOS, DSM-IV-TR) or Other Specified DD (OSDD, DSM-5), and two clinicians indicated that their patient experienced episodes of amnesia but no self-states.

Discussion

This study examined the diagnostic accuracy of DID diagnoses ascertained by clinicians in the TOP DD Network study. As hypothesized, most clinicians accurately diagnosed DID in their patients. Most patients who met DSM-IV-TR diagnostic criteria for DID also met DSM-5 diagnostic criteria for DID. Surprisingly, less patients met DID criteria in the DSM-5 than in the DSM-IV-TR.

Diagnostic accuracy

In contrast to the results of the vignette-based studies (Dorahy et al., 2005; Perniciaro, 2014), 95.27% clinicians in this study correctly diagnosed their patient with DID. However, we recruited clinicians primarily through trauma- and dissociation-specific conferences and online platforms. This would indicate clinician interest in DD/DID and selection for more experienced clinicians with this population. In the vignette-based studies, most clinicians reported that they had previously treated zero to six dissociative patients. In contrast, in this study, clinicians reported working with dissociative patients for an average of about ten years – a quite experienced group. Only 36% of these clinicians reported specialized trauma training as part of their graduate training. However, in addition to attending trainings on DD/DID, more than 60% showed independent interest in DD/DID through reading books about dissociation/DD and/or seeking supervision/consultation with a trauma or DD/DID specialist.

All eight inaccurately diagnosed patients experienced some form of dissociative symptomology (e.g., identity disruption, dissociative amnesia, and/or mixed dissociative symptoms) that caused significant impairment and/or distress. However, based on the clinicians' report of symptoms, these patients did not meet full diagnostic criteria for DID in either classification system. These patients reported dissociative symptoms that did not meet DSM-5 criteria for a specific DD and are better classified as OSDD or the dissociative subtype of PTSD. In DSM-5, the two defining features of DID are identity disruption and experiences of amnesia. In two cases of inaccurately diagnosed patients, the patient experienced multiple self-states but did not report amnesia. In two other cases, the patient experienced episodes of amnesia but did not describe multiple self-states. The other four patients who were inaccurately diagnosed presented with an array of symptoms that mapped onto DSM-IV-TR and DSM-5 dissociative diagnostic criteria, but each patient was missing one or more symptoms from both versions of the DSM diagnostic criteria for DID.

As treatment proceeds, it is common for patients diagnosed with OSDD to meet the full diagnostic criteria for DID. This was the case in most patients diagnosed with Dissociative Disorder NOS (DDNOS) by DSM-IV-TR criteria, and those of prior DSM versions (Spiegel et al., 2011). The DSM 5 work group that reviewed diagnostic criteria for DID was particularly concerned with reducing the frequency of DDNOS diagnosis. The latter had accounted for at least 40% of all DSM-IV-TR DD diagnoses – an unacceptably high rate (Spiegel et al., 2011).

The potential diagnostic impact of DSM-5 DID criteria changes

As predicted, the majority (83.85%) of DID-diagnosed patients met DID criteria in both versions of the DSM. Objectively, results from this study found that slightly fewer patients met diagnostic criteria for DID using the DSM-5 ($n = 145$) as compared to the DSM-IV-TR ($n = 151$), with 16 patients meeting DID criteria only using the DSM-IV-TR and 10 patients meeting DID criteria only using the DSM-5.

Exploratory analysis revealed that 10 DSM-IV-TR accurate-DID diagnosis of patients failed to meet DSM-5 diagnostic criteria because clinicians answered “no” in response to the DSM-5 criteria that the patients’ symptoms were *not* related to the physiological effects of substances, *not* due to other medical conditions, or *not* a normative part of cultural or religious practices (i.e., criteria D and E). Rather than endorsing the diagnostic criteria with a “yes” to *confirm* that a patient’s symptoms are *not* caused by these other factors, clinicians may have selected “no” under the impression that this response would indicate that their patient’s symptoms were *not* caused by these other factors (i.e., “no, they are not due to those factors”). Such a response would be consistent with an informal manner of stating agreement with a negative statement that is common in various parts of North America. Taking this possibility into account, 96.45% of patients would have been accurately diagnosed, 90.06% would have met criteria in both versions of the DSM, and only 3.73% ($n = 6$) patients would have solely met DSM-IV-TR diagnostic criteria, resulting in the DSM-5 criteria fitting for a greater number of cases than those of the DSM-IV-TR.

Also, in some cases, there are patterns of endorsement that appear attributable to the changes in the DSM-5. For example, one clinician endorsed that the patient experienced two or more self-states by DSM-5 criteria, but not by DSM-IV-TR criteria. The DSM-5 criteria no longer require that self-states to regularly “take control of the patient’s behavior,” which allowed six additional patients to meet DSM-5 diagnostic criteria for DID, but not by DSM-IV-TR criteria. The DSM-5 work group eliminated the DSM-IV-TR criterion for states to “recurrantly take control,” which is not consistent with the phenomenology of DID, as well as being difficult for clinicians to apply to actual DID patients. This change in diagnostic criteria appears to have worked as intended by increasing diagnosis

of DID and hypothetically decreasing that of OSDD (DDNOS in DSM-IV-TR). Also, differences in the criterion phrasing for dissociative amnesia across the two iterations of the manual accounted for 37.50% of the cases were found to meet DSM-IV-TR but not DSM-5 DID criteria. In the DSM-5, individuals can self-report experiencing dissociative states (Criterion A). In many cases, DID is covert, meaning that it can be challenging for an assessor to initially identify self-states beyond the self-report of DID patients (Spiegel et al., 2011). While this change is reflective of the phenomenology and experience of DID, it must also be considered that the risk of false-positive diagnoses of DID may increase. Clinicians should use evidence-based tools (e.g., structured interviews) for assessing and diagnosing DID to minimize this risk.

Implications

The findings of this study have important implications for assessment and diagnosis of DID. Overall, the DSM-5 diagnostic criteria for DID appear to have improved clinical utility for the identification of DID. In particular, elimination of the DSM-IV-TR “B” criterion that identity states “recurrently take control of the person’s behavior” improved ascertainment and user-friendliness in clinical diagnosis of DID. On the other hand, some clinicians failed to indicate that their patient’s symptoms were *not* related to substances, medical conditions, or cultural and religious practices. The inverse, negated wording style might have led to confusion and inaccurate responses. Negated, inverse-wording can result in errors due to lack of attention or misunderstanding (Van Sonderen et al., 2013). To reduce possible confusion and inaccurate responses, clinical and research instruments should be phrased in as clear a manner as possible to prevent clinicians or patients from misunderstanding the prompt or criteria. This issue should be given attention in future editions of the DSM. Also, in DSM 5, the amnesia criteria were changed to better reflect the differing patterns of dissociative amnesia in patients diagnosed with DID, compared with those with Dissociative Amnesia (DA; Dell, 2013). In the former, amnesia occurred both for past life history and ongoing amnesia for current life experience. In the latter, amnesia primarily manifested as retrospective gaps and/or fragmentation in autobiographical memory (Dell, 2013). Clinicians should be made more aware of this important research-based change in the DSM-5 amnesia criterion.

Limitations and future directions

There are limitations to the present study. The patients’ diagnoses were not assessed using standardized diagnostic instruments. Rather, diagnostic accuracy was determined by clinicians’ reports of patients’ symptoms based on checklists of criteria directly from the DSM-IV-TR and DSM-5. Thus, there are no data to help understand how each clinician arrived at the diagnosis for their patient.

Recruitment was done primarily through trauma- and DD-specific conferences and listservs. This created a sample of clinicians with clear interest in and experience with DD patients. Thus, the results of the study may not be generalizable to all mental health professionals, many of whom have little or no familiarity with post-traumatic and/or DD. Finally, due to variations in group sizes between accurately and inaccurately diagnosed patients, the authors were unable to statistically compare clinician training or demographic information to assess for variables that could contribute to the accuracy or inaccuracy of diagnoses. Some of the differences in diagnostic patterns may be due to clinicians in some countries primarily using International Classification of Diseases (ICD) diagnostic criteria for psychiatric disorders and being less familiar with the DSM system. Future research should continue to investigate how clinicians' clinical and training experiences and beliefs and stigma about DID influence both the assessment and diagnosis of DID (Hayes & Mitchell, 1994; Perniciaro, 2014). Furthermore, research should seek to better understand how the method of assessing for DID influences the accuracy of DID diagnoses. Research should also consider socio-cultural factors that could potentially affect diagnosis of the DD; this includes accounting for the diagnostic manual and accompanying diagnostic criteria utilized in various parts of the world, considering the ways in which dissociation may manifest (e.g., feeling possessed), and understanding cultural norms surrounding seeking treatment and/or disclosing mental health symptoms.

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Data Availability Statement

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