Dissociative identity disorder: a review of the diagnosis that divides

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The diagnosis of dissociative identity disorder (DID) has been associated with controversy and remains an area of dispute among clinicians to this day. This review explores the evolution of the diagnosis and how it is currently described and understood in the International Classification of Diseases (ICD-11) and Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Also considered, are recent implications for clinical practice, treatment recommendations and the potential for any medicolegal issues to emerge.

Initially acknowledged as 'multiple personality disorder'; 1980 was the first time dissociative identity disorder (DID) was officially written into the DSM (DSM-III). An ongoing debate has since existed within the literature, with two main hypotheses competing to explain the origins of dissociation.[1] The more popular trauma model (TM) assumes dissociation is a result of severe trauma during childhood, absent support networks and formation of a disorganised attachment style.[2,3] It considers dissociation a result of repeated experiences of trauma at a young age, a so-to-speak survival strategy in which traumatic memories retreat into the subconscious. Thus, memories are unavailable to conscious awareness but later emerge as delineated, separate personalities or *alters*. This mechanism is thought to act as a coping strategy for stressful or triggering experiences throughout an individual's life.[4,5]

Further research reveals that patients diagnosed with DID can have smaller amygdala and hippocampal volumes in comparison with healthy subjects. Such neuroanatomical changes have also been observed in stress-related psychiatric diagnoses such as post-traumatic stress disorder (PTSD) and borderline personality disorder with childhood abuse and depression.[6] This finding potentially strengthens evidence to suggest trauma as a root cause.

Perhaps the less discussed model within the literature is the sociocognitive model, also referred to as the fantasy or non-trauma model. It argues dissociation to be a patient enactment, possibly due to sociocultural influences or iatrogenic outcome of suggestive psychotherapy.[3,7] Early popular culture such as Robert Louis Stevenson's *Jekyll and Hyde* and Mary Shelley's *Frankenstein* emerged in the 1800s, illustrating how a person might experience life with DID, raising public awareness of the condition.[4] According to Drajer and Boon (1999), from as early as 1995 patients began self-diagnosing for other gains after reading information in literature provided or via the internet. Other literature suggests self-diagnosis is not consciously pursued.[8] More recent research concludes there is less scientific evidence to support the sociocognitive model but it might, in fact, appeal more to clinicians.[9] This could be partly due to the inadequate or incorrect nature of the information available to us regarding dissociative disorders or an unconscious reluctance on our part to tolerate the severity of abuse and trauma that patients report.[1]

Little is currently known about professionals' attitudes towards this diagnosis within the UK, and despite attempts to investigate incidence and prevalence, concrete figures have yet to be established. Despite this, it is considered that DID is not necessarily rare simply because of low diagnosis rates.[10] While classification for this diagnosis across time has been poor, changes within ICD-11 instill hope. The most recent update of distinguishing partial DID from full DID itself should help future research and clinical practice.[11] Tyrer (2019) acknowledges research may have placed too much focus on the TM, with insufficient evidence from available substantial cohort studies. Instead, an integrated and more holistic approach could offer a way forward when reflecting on the roots of this diagnosis for our patients.[12]

Discussion

DID and current classification

DID is currently recognised in both ICD-11 and the DSM-5 (see Table 1 for essential criteria). Literature suggests diagnostic criteria within DSM-IV and ICD-10 did not offer enough clarity in guidance. The description of DID in the ICD-10 starts: 'This disorder is rare, and controversy exists about the extent to which it is

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iatrogenic or culture-specific', which already throws into question the validity of making a diagnosis, potentially creating a barrier for clinicians.[8]

The biggest shift in ICD-11, is the distinction between partial and full dissociation. In both DSM-IV and ICD-10, dissociation was recognised with the title 'multiple personality disorder', in which two or more distinct personality states or *alters* recurrently took control of a patient's daily functioning. Evidence later emerged suggesting a significant proportion of patients experienced alter personality states did not recurrently assume control of functioning, which was subsequently reflected in changes to both DSM-5 and ICD-11.[13,14]

Introduction of the diagnosis 'partial DID' (ICD-11), outlined non-dominant personality states making more occasional and transient appearances, *eg* during heightened stress or when engaging with self-harming behaviours (rather than assuming control of functioning).[11,15] DSM-5 introduced the criterion 'recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting' instead of the criterion of different distinct personalities assuming control.[14] When considering this new stipulation, for full DID, ICD-11 states there is no requirement for dissociative amnesia to make a diagnosis, but acknowledges that 'substantial episodes of amnesia are typically present at some point during the course of the disorder'.[15] Whereas for partial DID, dissociative amnesia is stated to be absent or limited to the brief episodes where an alter assumes control during self-harm or extreme emotion.[14] It remains unclear how recent changes to diagnostic criteria will impact on rates of diagnosis. Considering the lack of current data on both

Table 1: ICD-11 and DSM-5 essential diagnostic criteria[15,16]

Essential diagnostic criteria ICD-11 [Code 6864]	Essential diagnostic criteria DSM-5
1. Disruption of identity characterised by the presence of two or more distinct personality states (dissociative identities), involving marked discontinuities in the sense of self and agency. Each personality state includes its own pattern of experiencing, perceiving, conceiving, and relating to self, the body, and the environment.	A. Disruption of identity characterised by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behaviour, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual
2. At least two distinct personality states recurrently take executive control of the individual's consciousness and functioning in interacting with others or with the environment, such as in the performance of specific aspects of daily life (eg parenting, work), or in response to specific situations (eg those that are perceived as threatening)	B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting
3. Changes in personality state are accompanied by related alterations in sensation, perception, affect, cognition, memory, motor control and behaviour. There are typically episodes of amnesia inconsistent with ordinary forgetting, which may be severe	C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
4. The symptoms are not better accounted for by another mental disorder (eg schizophrenia or other primary psychotic disorder)	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
5. The symptoms are not due to the effects of a substance or medication on the central nervous system, including withdrawal effects (eg blackouts or chaotic behaviour during substance intoxication), and are not due to a disease of the nervous system (eg complex partial seizures) or to a sleep-wake disorder (eg symptoms occur during hypnagogic or hypnopompic states)	E. The symptoms are not attributable to the physiological effects of a substance (eg blackouts or chaotic behaviour during alcohol intoxication) or other medical condition (eg complex partial seizures
6. The symptoms result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort	

incidence and prevalence rates in the UK, it would be of interest to follow how future clinical practice is affected.

Current evidence for treatment

Early psychoanalysts believed the aim of therapy was to achieve 're-association' between the conscious mind and internal conflicts of the unconscious mind brought about by early life traumas.[17] Many have since focused on addressing identity fragmentation to reconstitute the whole self by allowing individuals to relate to others and build trusting relationships to achieve a sense of belonging and reinforce the reconstituted identity.[18]

Other developments include use of trauma-focused cognitive behavioral therapy (CBT) and dialectical behavioural therapy (DBT);[19] Similarly, more DID-targeted modalities include the three stages of the tactical integration model, which focuses on establishing stability, then addresses traumatic memories until full integration is achieved. Full integration is achieved through mapping personalities, then engaging them separately while inviting them to work together in clusters that are later 'blended' until absorbed into the unified host personality.[20,21]

Ego state therapy emerged as a form of hypnotherapy that was combined with eye movement desensitisation and reprocessing (EMDR) therapy as a key approach to trauma processing by addressing development of distinct ego identities.[22,23] EMDR has seen developments that tailor this modality to the treatment of DID by using stabilisation, affect management and grounding individuals to reprocess and reintegrate their traumatic experiences. The Wreathing protocol adds to this by outlining an approach to regroup and integrate the remaining disassociated elements of personality at the end of EMDR therapy.[24]

Distressing material may arise when exploring distinct identities, including repressed memories and traumas, therefore, a therapeutic alliance often transcends the choice of modality and is the main ingredient to a successful therapy.[25]

There remains little empirical evidence to compare and measure the effectiveness of different therapeutic interventions for DID mainly due to difficulties in distinguishing the endpoint of treatment.[26,27] For some, a successful course of therapy may mean the complete subsiding of symptoms, for others, it may be a notable improvement in frequency of dissociative experiences. Many psychotherapists have advocated for learning to live with many selves. This idea advocates for the focus of therapy to be a means of empowering individuals to be comfortable in shifting back and forth between a number of selves and equipping them with the skills to navigate this experience.[28]

There are no established guidelines specifically for the pharmacological treatment of DID, however, medications have been found to be useful in treating the underlying features of DID as well as comorbidities. Atypical antipsychotics have a role in managing pseudohallucinations, which tend to arise as internal voices. Opioid antagonists have been identified in reducing stress-induced analgesia through its mediation of mu and kappa systems, which have been thought to precipitate DID experiences.[29] Other studies explore use of antidepressants such as SSRIs, monoamine oxidase inhibitors, anticonvulsants and anxiolytics to manage hyperarousal and mood instability. However, care must be taken when using benzodiazepines as they have been known to exacerbate dissociative experiences.[30,31]

Clinical implications for practice

Frequently seen comorbidities in DID include borderline personality disorder, PTSD and depressive disorders (DSM-5).[32] Patients with DID also show an increased risk of self-injurious behaviour and suicide attempts.[33] Differentiating DID from other conditions can be challenging and is most effectively done by taking a thorough clinical history and gaining a deep understanding of a patient's subjective experience. Many symptoms, such as mood fluctuations, amnesia, perceptual abnormalities and anxiety, may also be present in other conditions.

Rating scales, such as the Dissociative Disorder Interview Schedule (DDIS) and Disassociation Experiences Survey (DES), can help measure the severity of dissociative symptoms but cannot be relied upon solely to differentiate DID from other conditions.[34] Some studies have used structural analysis of social behaviour (SASB) and found it to be effective in differentiating between DID and other mental disorders.[35] The Trauma and Dissociation Symptoms Interview (TDSI) has been found to be effective in identifying dissociative disorders in relation to the criteria set out by the DSM-5 and ICD-11.[36]

Despite a lack of concrete empirical data on treatments available, there remains a vast arsenal of therapeutic modalities to choose from, which must be tailored to the needs of individual patients. The optimal form of care for patients with DID is an interdisciplinary and holistic one. Studies of inpatient units in the US with specialised DID treatment programs show the combination of individual and group therapies as well as activity that fosters a sense of belonging to a group can help reinforce relationships, sense of identity and promote

safe disclosure whereby traumatic experiences can be explored with a greater sense of stability and reduced distress.[17,37]

Medico-legal implications

Scepticism has long surrounded this diagnosis when adopted by defendants, particularly when claiming a non-dominant personality state is responsible for committing a serious crime. Pleading not guilty by reason of insanity for this reason has been heavily questioned, with debate as to whether evidence from assessment by forensic experts should be considered in a court of law. In part, this questioning centres around thinking DID symptoms could be easily malingered, with a concerning overlap between this and dissociative phenomena.[4,38,39]

The conception of DID as a mental illness amounting to insanity enough to excuse criminal behaviour was first encountered in 1978, with the case of Billy Milligan (State versus Milligan). Billy Milligan was convicted of serial incidents of rape. The court, however, considered that due to the lack of one integrated personality Billy Milligan was insane, and not culpable for these crimes. The public outrage that followed led to subsequent cases using DID defences becoming largely unsuccessful.

It is important to acknowledge dissociative states are usually related to a person's mental state at the time of a crime, and in the case of DID these mind sets are often transient.[41] Considering this, we can accept the presence of heightened emotional states having the potential to impact on a defendant's memory, but also conclude that complete amnesia would be unlikely to occur and be able to use this reasoning to fully remove criminal responsibility. It seems courts have opted not to admit DID evidence from forensic experts into their consideration in most cases due to scientific evidence failing to meet set reliability standards, deeming 'expertise' as more of a pseudoscience.[38] Subsequently, a defence of not guilty by reason of insanity due to presence of DID is now rarely successful.[40]

Conclusion

Despite avid dispute across time, it appears with recent research that a more holistic approach is now coming to the fore, encouraging us to not place focus on just one cause or treatment pathway for DID but instead to step back and consider each person on an individual basis. A new distinction in ICD-11 may allow clinicians to have more confidence in diagnosis, and therefore tailor treatment options to each person they are managing.

While seemingly there remains a way to go in terms of offering clarity, some progress is being made to try to dispel controversies and empower clinicians to consider each patient's subjective experience to decide how best we can work alongside them, offering optimal support when customising a management plan.

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Declaration of interests

None.

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