NCBI Bookshelf. A service of the National Library of Medicine, National Institutes of Health.

StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-.

Dissociative Identity Disorder

Authors

Paroma Mitra[1]; Ankit Jain.

Affiliations

[1] New York University School of Medicine

Last Update: May 16, 2023.

Continuing Education Activity

Dissociative identity disorder (DID) is a psychiatric disorder diagnosed in about 1.5% of the global population. This disorder is often misdiagnosed and often requires multiple assessments for an accurate diagnosis. Patients often present with self-injurious behavior and suicide attempts. This activity reviews the evaluation and treatment of dissociative identity disorder and explains the role of an interprofessional team in caring for patients diagnosed with dissociative identity disorder (DID). This activity also reviews the association between DID and suicidal behavior.

Objectives:

- Describe the constellation of behavioral symptoms that lead to a diagnosis of dissociative identity disorder.
- Review risk factors for the development of a diagnosis of dissociative identity disorder.
- Explain the different modalities of evidence-based treatment for dissociative identity disorder.
- Outline some interprofessional strategies that can improve patient outcomes in patients with dissociative identity disorder.

Access free multiple choice questions on this topic.

Introduction

Dissociative identity disorder (DID) is a disorder associated with severe behavioral health symptoms. DID was previously known as Multiple Personality Disorder until 1994. Approximately 1.5% of the population internationally has been diagnosed with dissociative identity disorder.[1] Patients with this diagnosis often have several emergency presentations, often with self-injurious behavior and even substance use.[2]

Of note, DID has been observed and described in several countries and associated with terms such as "outer world possession" and "possession by demons."[3] Several case reports have been described with those terms; however, trauma and its association came with DID much later.

Etiology

Dissociative identity disorder is typically associated with severe childhood trauma and abuse.[4] Dalenberg and his team have detailed the role of trauma in the development of dissociative disorder and dismissed the previous model, which was based on fantasy and often associated with suggestibility, cognitive distortions, and fantasy. However, newer research tends to describe a combination of both severe traumas (which may be in any form physical/emotional/sexual)as well as some effects of cognitive suggestion. Stress experienced by an individual secondary to trauma has been seen to contribute to the formation of an accurate understanding of the trauma being unreal, even posttraumatic dissociation such as leaving one's body, etc., and poor sleep. However, in the fantasy theory-it has been seen that people with high levels of vulnerability, predisposition of psychological symptoms, media influences, and likely social isolation and vulnerability.[5]

Several prominent psychologists, such as Kluft, have broken down the theory behind DID-in-sum. The theory describes predisposing factors for dissociation, which include an ability to dissociate, overwhelming traumatic

experiences that distort reality, creation of alters with specific names and identities, and lack of external stability, which leads to the child's self-soothing to tolerate these stressors. These four factors must be present for DID to develop.[6]

Epidemiology

Dissociative disorders show a prevalence of 1% to 5% in the international population. Severe dissociative identity disorder is present in 1% to 1.5% of this population. Patients may spend up to 5 to 12.5 years in treatment before being diagnosed with dissociative identity disorder.[7] Patients with DID come with increased rates of non-suicidal self-injurious behavior and suicide attempts.[8]

Pathophysiology

The DID person, per the *International Society for the Study of Trauma and Dissociation,* is described as a person who experiences separate identities that function independently and are autonomous of each other. The International Society describes alternate identities or "alters" as independent identities with distinct behaviors and memories distinct from others and may even differ in language and expressions used. Signs of a switch to an altered state include trance-like behavior, eye blinking, eye-rolling, and changes in posture.

The major hypothesis by Putnam et al. is that "alternate identities result from the inability of many traumatized children to develop a unified sense of self that is maintained across various behavioral states, particularly if the traumatic exposure first occurs before the age of 5." [9] The theories have been studied by groups in the inpatient unit services in the 1990s.

History and Physical

The way to diagnose dissociative identity disorder is via detailed history taken by both psychiatric practitioners and experienced psychologists. Often, persons with DID are misdiagnosed with other personality disorders, most commonly borderline personality disorder, as elements of dissociation are prominently seen and even amnesia. Longitudinal assessments over long periods and careful history-taking are often required to complete diagnostic evaluations. History is often gathered from multiple sources as well. Neurological examinations are often required to rule out autoimmune encephalitis, often requiring electroencephalograms, lumbar punctures, and brain imaging.

Dissociative Disorders are classically characterized as disrupting normal consciousness/memory/identity and behavior. The disorders are classically broken down into "positive " and "negative " symptoms -positive symptoms are often associated with "new personalities, derealization," and negative symptoms are symptoms such as autism and paralysis.[10] Dissociative identity disorder is part of the larger dissociative disorders spectrum; however, it has more specific criteria outlined by the Diagnostic And Statistical Manual Edition-5.

The Diagnostic and Statistical Manual (DSM-5)criteria for DID include at least two or more distinct personalities. Each personality varies in behavior, sense of consciousness, memory, and perception of the outside world. Persons with DID experience amnesia, distinct gaps in memory, and recollections of daily and traumatic events. They cannot be directly related to substance use or part of cultural norms or practices. Importantly, these symptoms must cause a notable lack of daily functioning.[11][10]

Evaluation

As explained above, a detailed history from multiple sources and multiple longitudinal assessments over time is of the essence. However, some evaluation tools have been developed to diagnose DID. Some of these are below:

- Dissociative Experiences Scale - a 28-item self-report instrument whose items primarily tap the absorption of outside information, use of imagination depersonalization, derealization, and amnesia.[12]
- Dissociation Questionnaire - 63 questions that measure identity confusion and fragmentation, loss of control, amnesia, and absorption.

- Difficulties in Emotion Regulation Scale (DERS) - 36-question subjective questions around challenges in goal-directed work, impulsivity, emotional responses to situations, ability to self-regulate emotions, etc.[13]

Treatment / Management

Some treatment approaches for dissociative identity disorder include basic structures from work with personality disorders in a three-pronged approach:

- Establishing safety, stabilization, and symptom reduction;
- Confronting, working through, and integrating traumatic memories
- Identity integration and rehabilitation.[14]

The first step focuses on the safety of patients with DID, as many present with suicidal ideation and self-injurious behavior.[8] It is important to mitigate that risk. The second phase focuses on working with traumatic memories and includes tolerating, processing, and integrating past trauma. This may focus on continuing to re-access traumatic memories with different alternate identities and may help share memories. The third and final treatment phase focuses on the patient's relationship to self as a whole and to the rest of the world. Through all the phases of treatment, a strong therapeutic alliance and trust are encouraged

The most common approach is via psychodynamic psychotherapy steps, broken down above. Recent approaches include trauma-focused cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT).[15] There are no controlled clinical trials for CBT. The reason DBT skills are used is essentially secondary to some of the overlapping symptoms between borderline personality disorder and DID. Even with varying therapy approaches, some core treatment features include more education, emotional regulation, managing stressors, and daily functioning.

Another mode of treatment is the use of hypnosis as therapy. According to the literature, DID patients are more hypnotizable than other clinical populations.[16] There have been some studies as recent as 2009 that have shown efficacy in the use of hypnosis to treat DID.[17] Many DID patients are considered autohypnotic. Some techniques include accessing alternate identities not present in the session, an intervention that can facilitate the emergence of identities critical to the therapeutic process.[6]

Another mode of treatment has been the use of *Eye Movement Desensitization and Reprocessing* (*EMDR*). The guidelines, however, advocate for EMDR to be used as part of integrative treatment. EMDR processing is recommended only when the patient is generally stable and has adequate coping skills.EMDR interventions for symptom reduction and containment, ego strengthening, work with alternate identities, and, when appropriate, the negotiation of consent and preparation of alternate identities.[18]

Psychopharmacology is not the primary treatment for DID. Medications may be used to target certain symptoms reported. The most commonly used medications include medications for mood disorders and PTSD (post-traumatic stress disorder).[19] The challenges of using psychopharmacological medications remain as different alters may report different symptoms. Some alters may report compliance, and some may not. The literature review has shown that many medications have been used for DID, including antipsychotic medications, mood stabilizers, and even stimulants; however, no medication has been effective in the treatment of DID.[20]

Differential Diagnosis

As mentioned above, the most common differential diagnosis includes borderline personality disorder, histrionic personality disorder, and even primary psychotic disorders such as schizophrenia and schizoaffective disorders. As mentioned, patients with DID often present with symptoms of dissociation and amnesia, which are also seen in patients with borderline personality disorder. Often, patients' symptoms are considered symptoms of psychosis as alters as mistaken as hallucinations, which often precipitate the use of antipsychotic medications. Given that trauma is a focus, post traumatic stress disorder is also a differential diagnosis.

The most common differential diagnosis is borderline personality disorder.[21] Borderline personality disorder is also associated with extensive trauma, which often presents with micropsychotic and dissociative symptoms.

Pertinent Studies and Ongoing Trials

There have been case studies and case reports formerly reported in the '90s and early 2000s. Some more treatment interventions have been described in naturalistic and longitudinal studies that continue to inform outcomes.[7]

Prognosis

Unfortunately, Dissociative identity disorder is a medical condition often diagnosed later in life. Often, patients are misdiagnosed with other diagnoses as described above and treated with medications and even therapies that may not directly address DID. Once in treatment, this tends to be lifelong as DID patients continue to require reality-based and grounding interventions. Safety planning with DID patients is lifelong. The prognosis without treatment and correct diagnosis is poor.

Complications

The patients remain at increased risk of self-injurious behavior given the presence of alters as well as latent trauma.[22] There have been newer research studies that have described suicidal ideation, especially during dissociation, which describes decreased pain tolerance and more emotional dysregulation. Most treatment interventions advocate for safety planning and reality testing before the use of more advanced psychotherapy techniques

Inpatient hospitalizations and day treatment programs may also be recommended for patients who struggle with thoughts of self-injurious behavior, poor impulse control, or acute mood dysregulation. Medications may be added for mood stabilization.

Deterrence and Patient Education

Patient education must focus on informing patients on the correct diagnosis when it is determined. Family members are encouraged to be educated about the nature of this illness, including the presence of alters, as well as safety and grounding techniques. Another vital aspect is to maintain a strong therapeutic alliance with the treatment team and engage in maintaining safety techniques.

Education may be done with multiple alters that do not communicate with each other, and this must be recognized. On the other hand, DID patients often do not want their diagnosis shared publicly, and their privacy must be respected.

Enhancing Healthcare Team Outcomes

Dissociative identity disorder requires treatment by an interprofessional healthcare team - this will often consist of medical specialists such as a psychiatrist, mid-level practitioners, nursing staff, specialized therapists, trauma counselors, peer counselors, and therapists who all communicate and collaborate. A psychiatrist and primary care physician complete the team. Maintaining a strong therapeutic alliance with the patient and involved family members continues to be of utmost importance. DID patients require frequent check-ins and follow-up appointments and an almost daily focus on safety planning and reality-based interventions.

Review Questions

- Access free multiple choice questions on this topic.
- Click here for a simplified version.
- Comment on this article.

References

1. Brand BL, Schielke HJ, Putnam KT, Putnam FW, Loewenstein RJ, Myrick A, Jepsen EKK, Langeland W, Steele K, Classen CC, Lanius RA. An Online Educational Program for Individuals With Dissociative Disorders and Their Clinicians: 1-Year and 2-Year Follow-Up. J Trauma Stress. 2019 Feb;32(1):156-166. [PMC free article: PMC6590319] [PubMed: 30698858]
2. Spiegel D, Lewis-Fernández R, Lanius R, Vermetten E, Simeon D, Friedman M. Dissociative disorders in DSM-5. Annu Rev Clin Psychol. 2013;9:299-326. [PubMed: 23394228]

3. van Duijl M, Nijenhuis E, Komproe IH, Gernaat HB, de Jong JT. Dissociative symptoms and reported trauma among patients with spirit possession and matched healthy controls in Uganda. Cult Med Psychiatry. 2010 Jun;34(2):380-400. [PMC free article: PMC2878595] [PubMed: 20401630]
4. Lynn SJ, Lilienfeld SO, Merckelbach H, Giesbrecht T, McNally RJ, Loftus EF, Bruck M, Garry M, Malaktaris A. The trauma model of dissociation: inconvenient truths and stubborn fictions. Comment on Dalenberg et al. (2012). Psychol Bull. 2014 May;140(3):896-910. [PubMed: 24773505]
5. Candel I, Merckelbach H. Peritraumatic dissociation as a predictor of post-traumatic stress disorder: a critical review. Compr Psychiatry. 2004 Jan-Feb;45(1):44-50. [PubMed: 14671736]
6. Kluft RP. An overview of the psychotherapy of dissociative identity disorder. Am J Psychother. 1999 Summer;53(3):289-319. [PubMed: 10586296]
7. Brand BL, Loewenstein RJ, Spiegel D. Dispelling myths about dissociative identity disorder treatment: an empirically based approach. Psychiatry. 2014 Summer;77(2):169-89. [PubMed: 24865199]
8. Foote B, Smolin Y, Neft DI, Lipschitz D. Dissociative disorders and suicidality in psychiatric outpatients. J Nerv Ment Dis. 2008 Jan;196(1):29-36. [PubMed: 18195639]
9. Ross CA, Anderson G, Fleisher WP, Norton GR. The frequency of multiple personality disorder among psychiatric inpatients. Am J Psychiatry. 1991 Dec;148(12):1717-20. [PubMed: 1957936]
10. Spiegel D, Loewenstein RJ, Lewis-Fernández R, Sar V, Simeon D, Vermetten E, Cardeña E, Dell PF. Dissociative disorders in DSM-5. Depress Anxiety. 2011 Sep;28(9):824-52. [PubMed: 21910187]
11. Brand BL, Sar V, Stavropoulos P, Krüger C, Korzekwa M, Martínez-Taboas A, Middleton W. Separating Fact from Fiction: An Empirical Examination of Six Myths About Dissociative Identity Disorder. Harv Rev Psychiatry. 2016 Jul-Aug;24(4):257-70. [PMC free article: PMC4959824] [PubMed: 27384396]
12. Dubester KA, Braun BG. Psychometric properties of the Dissociative Experiences Scale. J Nerv Ment Dis. 1995 Apr;183(4):231-5. [PubMed: 7714511]
13. Hallion LS, Steinman SA, Tolin DF, Diefenbach GJ. Psychometric Properties of the Difficulties in Emotion Regulation Scale (DERS) and Its Short Forms in Adults With Emotional Disorders. Front Psychol. 2018;9:539. [PMC free article: PMC5917244] [PubMed: 29725312]
14. Frankel FH. Adult reconstruction of childhood events in the multiple personality literature. Am J Psychiatry. 1993 Jun;150(6):954-8. [PubMed: 8494076]
15. Putnam FW, Loewenstein RJ. Treatment of multiple personality disorder: a survey of current practices. Am J Psychiatry. 1993 Jul;150(7):1048-52. [PubMed: 8100401]
16. Frischholz EJ, Lipman LS, Braun BG, Sachs RG. Psychopathology, hypnotizability, and dissociation. Am J Psychiatry. 1992 Nov;149(11):1521-5. [PubMed: 1415819]
17. Ross CA. Re: The effects of hypnosis on dissociative identity disorder. Can J Psychiatry. 2000 Apr;45(3):298-9. [PubMed: 10779893]
18. Fine CG, Berkowitz AS. The wreathing protocol: the imbrication of hypnosis and EMDR in the treatment of dissociative identity disorder and other dissociative responses. Eye Movement Desensitization Reprocessing. Am J Clin Hypn. 2001 Jan-Apr;43(3-4):275-90. [PubMed: 11269630]
19. Loewenstein RJ. Rational psychopharmacology in the treatment of multiple personality disorder. Psychiatr Clin North Am. 1991 Sep;14(3):721-40. [PubMed: 1946032]
20. Dorahy MJ, Brand BL, Sar V, Krüger C, Stavropoulos P, Martínez-Taboas A, Lewis-Fernández R, Middleton W. Dissociative identity disorder: An empirical overview. Aust N Z J Psychiatry. 2014 May;48(5):402-17. [PubMed: 24788904]
21. Brand BL, Lanius RA. Chronic complex dissociative disorders and borderline personality disorder: disorders of emotion dysregulation? Borderline Personal Disord Emot Dysregul. 2014;1:13. [PMC free article: PMC4579511] [PubMed: 26401297]
22. Rabasco A, Andover MS. The interaction of dissociation, pain tolerance, and suicidal ideation in predicting suicide attempts. Psychiatry Res. 2020 Feb;284:112661. [PubMed: 31708251]

Disclosure: Paroma Mitra declares no relevant financial relationships with ineligible companies.

Disclosure: Ankit Jain declares no relevant financial relationships with ineligible companies.

Bookshelf ID: NBK568768 PMID: 33760527