fragmentation of identity may vary with culture (e.g., possession-form presentations) and circumstance. Thus, individuals may experience discontinuities in identity and memory that may not be immediately evident to others or are obscured by attempts to hide dysfunction. Individuals with dissociative identity disorder experience a) recurrent, inexplicable intrusions into their conscious functioning and sense of self (e.g., voices; dissociated actions and speech; intrusive thoughts, emotions, and impulses), b) alterations of sense of self (e.g., attitudes, preferences, and feeling like one's body or actions are not one's own), c) odd changes of perception (e.g., depersonalization or derealization, such as feeling detached from one's body while cutting), and d) intermittent functional neurological symptoms. Stress often produces transient exacerbation of dissociative symptoms that makes them more evident.

The residual category of other specified dissociative disorder has seven examples: chronic or recurrent mixed dissociative symptoms that approach, but fall short of, the diagnostic criteria for dissociative identity disorder; dissociative states secondary to brainwashing or thought reform; two acute presentations, of less than 1 month's duration, of mixed dissociative symptoms, one of which is also marked by the presence of psychotic symptoms; and three single-symptom dissociative presentations—dissociative trance, dissociative stupor or coma, and Ganser's syndrome (the giving of approximate and vague answers).

Dissociative Identity Disorder

Diagnostic Criteria **300.14 (F44.81)**

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 in identity involves 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).

Diagnostic Features

The defining feature of dissociative identity disorder is the presence of two or more distinct personality states or an experience of possession (Criterion A). The overtness or covertness of these personality states, however, varies as a function of psychological motivation, current level of stress, culture, internal conflicts and dynamics, and emotional resilience. Sustained periods of identity disruption may occur when psychosocial pressures are severe and/or prolonged. In many possession-form cases of dissociative identity disorder, and in a small proportion of non-possession-form cases, manifestations of alternate identities are highly overt. Most individuals with non-possession-form dissociative identity disorder do not overtly display their discontinuity of identity for long periods of time; only a small minority present to clinical attention with observable alternation of

identities. When alternate personality states are not directly observed, the disorder can be identified by two clusters of symptoms: 1) sudden alterations or discontinuities in sense of self and sense of agency (Criterion A), and 2) recurrent dissociative amnesias (Criterion B).

Criterion A symptoms are related to discontinuities of experience that can affect any aspect of an individual's functioning. Individuals with dissociative identity disorder may report the feeling that they have suddenly become depersonalized observers of their "own" speech and actions, which they may feel powerless to stop (sense of self). Such individuals may also report perceptions of voices (e.g., a child's voice; crying; the voice of a spiritual being). In some cases, voices are experienced as multiple, perplexing, independent thought streams over which the individual experiences no control. Strong emotions, impulses, and even speech or other actions may suddenly emerge, without a sense of personal ownership or control (sense of agency). These emotions and impulses are frequently reported as ego-dystonic and puzzling. Attitudes, outlooks, and personal preferences (e.g., about food, activities, dress) may suddenly shift and then shift back. Individuals may report that their bodies feel different (e.g., like a small child, like the opposite gender, huge and muscular). Alterations in sense of self and loss of personal agency may be accompanied by a feeling that these attitudes, emotions, and behaviors—even one's body—are "not mine" and/or are "not under my control." Although most Criterion A symptoms are subjective, many of these sudden discontinuities in speech, affect, and behavior can be witnessed by family, friends, or the clinician. Non-epileptic seizures and other conversion symptoms are prominent in some presentations of dissociative identity disorder, especially in some non-Western settings.

The dissociative amnesia of individuals with dissociative identity disorder manifests in three primary ways: as 1) gaps in remote 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); 2) lapses in dependable memory (e.g., of what happened today, of well-learned skills such as how to do their job, use a computer, read, drive); and 3) 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, wherein the person discovers dissociated travel, are common. Thus, individuals with dissociative identity disorder may report that they have suddenly found themselves at the beach, at work, in a nightclub, or somewhere at home (e.g., in the closet, on a bed or sofa, in the corner) with no memory of how they came to be there. Amnesia in individuals with dissociative identity disorder is not limited to stressful or traumatic events; these individuals often cannot recall everyday events as well.

Individuals with dissociative identity disorder vary in their awareness and attitude toward their amnesias. It is common for these individuals to minimize their amnestic symptoms. Some of their amnestic behaviors may be apparent to others—as when these persons do not recall something they were witnessed to have done or said, when they cannot remember their own name, or when they do not recognize their spouse, children, or close friends.

Possession-form identities in dissociative identity disorder typically manifest as behaviors that appear as if a "spirit," supernatural being, or outside person has taken control, such that the individual begins speaking or acting in a distinctly different manner. For example, an individual's behavior may give the appearance that her identity has been replaced by the "ghost" of a girl who committed suicide in the same community years before, speaking and acting as though she were still alive. Or an individual may be "taken over" by a demon or deity, resulting in profound impairment, and demanding that the individual or a relative be punished for a past act, followed by more subtle periods of identity alteration. However, the majority of possession states around the world are normal, usually part of spiritual practice, and do not meet criteria for dissociative identity disor-

der. The identities that arise during possession-form dissociative identity disorder present recurrently, are unwanted and involuntary, cause clinically significant distress or impairment (Criterion C), and are not a normal part of a broadly accepted cultural or religious practice (Criterion D).

Associated Features Supporting Diagnosis

Individuals with dissociative identity disorder typically present with comorbid depression, anxiety, substance abuse, self-injury, non-epileptic seizures, or another common symptom. They often conceal, or are not fully aware of, disruptions in consciousness, amnesia, or other dissociative symptoms. Many individuals with dissociative identity disorder report dissociative flashbacks during which they undergo a sensory reliving of a previous event as though it were occurring in the present, often with a change of identity, a partial or complete loss of contact with or disorientation to current reality during the flashback, and a subsequent amnesia for the content of the flashback. Individuals with the disorder typically report multiple types of interpersonal maltreatment during childhood and adulthood. Nonmaltreatment forms of overwhelming early life events, such as multiple long, painful, early-life medical procedures, also may be reported. Self-mutilation and suicidal behavior are frequent. On standardized measures, these individuals report higher levels of hypnotizability and dissociativity compared with other clinical groups and healthy control subjects. Some individuals experience transient psychotic phenomena or episodes. Several brain regions have been implicated in the pathophysiology of dissociative identity disorder, including the orbitofrontal cortex, hippocampus, parahippocampal gyrus, and amygdala.

Prevalence

The 12-month prevalence of dissociative identity disorder among adults in a small U.S. community study was 1.5%. The prevalence across genders in that study was 1.6% for males and 1.4% for females.

Development and Course

Dissociative identity disorder is associated with overwhelming experiences, traumatic events, and/or abuse occurring in childhood. The full disorder may first manifest at almost any age (from earliest childhood to late life). Dissociation in children may generate problems with memory, concentration, attachment, and traumatic play. Nevertheless, children usually do not present with identity changes; instead they present primarily with overlap and interference among mental states (Criterion A phenomena), with symptoms related to discontinuities of experience. Sudden changes in identity during adolescence may appear to be just adolescent turmoil or the early stages of another mental disorder. Older individuals may present to treatment with what appear to be late-life mood disorders, obsessive-compulsive disorder, paranoia, psychotic mood disorders, or even cognitive disorders due to dissociative amnesia. In some cases, disruptive affects and memories may increasingly intrude into awareness with advancing age.

Psychological decompensation and overt changes in identity may be triggered by 1) removal from the traumatizing situation (e.g., through leaving home); 2) the individual's children reaching the same age at which the individual was originally abused or traumatized; 3) later traumatic experiences, even seemingly inconsequential ones, like a minor motor vehicle accident; or 4) the death of, or the onset of a fatal illness in, their abuser(s).

Risk and Prognostic Factors

Environmental. Interpersonal physical and sexual abuse is associated with an increased risk of dissociative identity disorder. Prevalence of childhood abuse and neglect in the

United States, Canada, and Europe among those with the disorder is about 90%. Other forms of traumatizing experiences, including childhood medical and surgical procedures, war, childhood prostitution, and terrorism, have been reported.

Course modifiers. Ongoing abuse, later-life retraumatization, comorbidity with mental disorders, severe medical illness, and delay in appropriate treatment are associated with poorer prognosis.

Culture-Related Diagnostic Issues

Many features of dissociative identity disorder can be influenced by the individual's cultural background. Individuals with this disorder may present with prominent medically unexplained neurological symptoms, such as non-epileptic seizures, paralyses, or sensory loss, in cultural settings where such symptoms are common. Similarly, in settings where normative possession is common (e.g., rural areas in the developing world, among certain religious groups in the United States and Europe), the fragmented identities may take the form of possessing spirits, deities, demons, animals, or mythical figures. Acculturation or prolonged intercultural contact may shape the characteristics of the other identities (e.g., identities in India may speak English exclusively and wear Western clothes). Possession-form dissociative identity disorder can be distinguished from culturally accepted possession states in that the former is involuntary, distressing, uncontrollable, and often recurrent or persistent; involves conflict between the individual and his or her surrounding family, social, or work milieu; and is manifested at times and in places that violate the norms of the culture or religion.

Gender-Related Diagnostic Issues

Females with dissociative identity disorder predominate in adult clinical settings but not in child clinical settings. Adult males with dissociative identity disorder may deny their symptoms and trauma histories, and this can lead to elevated rates of false negative diagnosis. Females with dissociative identity disorder present more frequently with acute dissociative states (e.g., flashbacks, amnesia, fugue, functional neurological [conversion] symptoms, hallucinations, self-mutilation). Males commonly exhibit more criminal or violent behavior than females; among males, common triggers of acute dissociative states include combat, prison conditions, and physical or sexual assaults.

Suicide Risk

Over 70% of outpatients with dissociative identity disorder have attempted suicide; multiple attempts are common, and other self-injurious behavior is frequent. Assessment of suicide risk may be complicated when there is amnesia for past suicidal behavior or when the presenting identity does not feel suicidal and is unaware that other dissociated identities do.

Functional Consequences of Dissociative Identity Disorder

Impairment varies widely, from apparently minimal (e.g., in high-functioning professionals) to profound. Regardless of level of disability, individuals with dissociative identity disorder commonly minimize the impact of their dissociative and posttraumatic symptoms. The symptoms of higher-functioning individuals may impair their relational, marital, family, and parenting functions more than their occupational and professional life (although the latter also may be affected). With appropriate treatment, many impaired individuals show marked improvement in occupational and personal functioning. However, some remain highly impaired in most activities of living. These individuals may only respond to treatment very slowly, with gradual reduction in or improved tolerance of

their dissociative and posttraumatic symptoms. Long-term supportive treatment may slowly increase these individuals' ability to manage their symptoms and decrease use of more restrictive levels of care.

Differential Diagnosis

Other specified dissociative disorder. The core of dissociative identity disorder is the division of identity, with recurrent disruption of conscious functioning and sense of self. This central feature is shared with one form of other specified dissociative disorder, which may be distinguished from dissociative identity disorder by the presence of chronic or recurrent mixed dissociative symptoms that do not meet Criterion A for dissociative identity disorder or are not accompanied by recurrent amnesia.

Major depressive disorder. Individuals with dissociative identity disorder are often depressed, and their symptoms may appear to meet the criteria for a major depressive episode. Rigorous assessment indicates that this depression in some cases does not meet full criteria for major depressive disorder. Other specified depressive disorder in individuals with dissociative identity disorder often has an important feature: the depressed mood and cognitions *fluctuate* because they are experienced in some identity states but not others.

Bipolar disorders. Individuals with dissociative identity disorder are often misdiagnosed with a bipolar disorder, most often bipolar II disorder. The relatively rapid shifts in mood in individuals with this disorder—typically within minutes or hours, in contrast to the slower mood changes typically seen in individuals with bipolar disorders—are due to the rapid, subjective shifts in mood commonly reported across dissociative states, sometimes accompanied by fluctuation in levels of activation. Furthermore, in dissociative identity disorder, elevated or depressed mood may be displayed in conjunction with overt identities, so one or the other mood may predominate for a relatively long period of time (often for days) or may shift within minutes.

Posttraumatic stress disorder. Some traumatized individuals have both posttraumatic stress disorder (PTSD) and dissociative identity disorder. Accordingly, it is crucial to distinguish between individuals with PTSD only and individuals who have both PTSD and dissociative identity disorder. This differential diagnosis requires that the clinician establish the presence or absence of dissociative symptoms that are not characteristic of acute stress disorder or PTSD. Some individuals with PTSD manifest dissociative symptoms that also occur in dissociative identity disorder: 1) amnesia for some aspects of trauma, 2) dissociative flashbacks (i.e., reliving of the trauma, with reduced awareness of one's current orientation), and 3) symptoms of intrusion and avoidance, negative alterations in cognition and mood, and hyperarousal that are focused around the traumatic event. On the other hand, individuals with dissociative identity disorder manifest dissociative symptoms that are not a manifestation of PTSD: 1) amnesias for many everyday (i.e., nontraumatic) events, 2) dissociative flashbacks that may be followed by amnesia for the content of the flashback, 3) disruptive intrusions (unrelated to traumatic material) by dissociated identity states into the individual's sense of self and agency, and 4) infrequent, full-blown changes among different identity states.

Psychotic disorders. Dissociative identity disorder may be confused with schizophrenia or other psychotic disorders. The personified, internally communicative inner voices of dissociative identity disorder, especially of a child (e.g., "I hear a little girl crying in a closet and an angry man yelling at her"), may be mistaken for psychotic hallucinations. Dissociative experiences of identity fragmentation or possession, and of perceived loss of control over thoughts, feelings, impulses, and acts, may be confused with signs of formal thought disorder, such as thought insertion or withdrawal. Individuals with dissociative identity disorder may also report visual, tactile, olfactory, gustatory, and somatic hallucinations, which are usually related to posttraumatic and dissociative factors, such as partial

flashbacks. Individuals with dissociative identity disorder experience these symptoms as caused by alternate identities, do not have delusional explanations for the phenomena, and often describe the symptoms in a personified way (e.g., "I feel like someone else wants to cry with my eyes"). Persecutory and derogatory internal voices in dissociative identity disorder associated with depressive symptoms may be misdiagnosed as major depression with psychotic features. Chaotic identity change and acute intrusions that disrupt thought processes may be distinguished from brief psychotic disorder by the predominance of dissociative symptoms and amnesia for the episode, and diagnostic evaluation after cessation of the crisis can help confirm the diagnosis.

Substance/medication-induced disorders. Symptoms associated with the physiological effects of a substance can be distinguished from dissociative identity disorder if the substance in question is judged to be etiologically related to the disturbance.

Personality disorders. Individuals with dissociative identity disorder often present identities that appear to encapsulate a variety of severe personality disorder features, suggesting a differential diagnosis of personality disorder, especially of the borderline type. Importantly, however, the individual's longitudinal variability in personality style (due to inconsistency among identities) differs from the pervasive and persistent dysfunction in affect management and interpersonal relationships typical of those with personality disorders.

Conversion disorder (functional neurological symptom disorder). This disorder may be distinguished from dissociative identity disorder by the absence of an identity disruption characterized by two or more distinct personality states or an experience of possession. Dissociative amnesia in conversion disorder is more limited and circumscribed (e.g., amnesia for a non-epileptic seizure).

Seizure disorders. Individuals with dissociative identity disorder may present with seizurelike symptoms and behaviors that resemble complex partial seizures with temporal lobe foci. These include déjà vu, jamais vu, depersonalization, derealization, out-of-body experiences, amnesia, disruptions of consciousness, hallucinations, and other intrusion phenomena of sensation, affect, and thought. Normal electroencephalographic findings, including telemetry, differentiate non-epileptic seizures from the seizurelike symptoms of dissociative identity disorder. Also, individuals with dissociative identity disorder obtain very high dissociation scores, whereas individuals with complex partial seizures do not.

Factitious disorder and malingering. Individuals who feign dissociative identity disorder do not report the subtle symptoms of intrusion characteristic of the disorder; instead they tend to overreport well-publicized symptoms of the disorder, such as dissociative amnesia, while underreporting less-publicized comorbid symptoms, such as depression. Individuals who feign dissociative identity disorder tend to be relatively undisturbed by or may even seem to enjoy "having" the disorder. In contrast, individuals with genuine dissociative identity disorder tend to be ashamed of and overwhelmed by their symptoms and to underreport their symptoms or deny their condition. Sequential observation, corroborating history, and intensive psychometric and psychological assessment may be helpful in assessment.

Individuals who malinger dissociative identity disorder usually create limited, stereotyped alternate identities, with feigned amnesia, related to the events for which gain is sought. For example, they may present an "all-good" identity and an "all-bad" identity in hopes of gaining exculpation for a crime.

Comorbidity

Many individuals with dissociative identity disorder present with a comorbid disorder. If not assessed and treated specifically for the dissociative disorder, these individuals often receive prolonged treatment for the comorbid diagnosis only, with limited overall treatment response and resultant demoralization, and disability.

Individuals with dissociative identity disorder usually exhibit a large number of comorbid disorders. In particular, most develop PTSD. Other disorders that are highly comorbid with dissociative identity disorder include depressive disorders, trauma- and stressor-related disorders, personality disorders (especially avoidant and borderline personality disorders), conversion disorder (functional neurological symptom disorder), somatic symptom disorder, eating disorders, substance-related disorders, obsessive-compulsive disorder, and sleep disorders. Dissociative alterations in identity, memory, and consciousness may affect the symptom presentation of comorbid disorders.

Dissociative Amnesia

Diagnostic Criteria **300.12 (F44.0)**

A. An inability to recall important autobiographical information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting.

   Note: Dissociative amnesia most often consists of localized or selective amnesia for a specific event or events; or generalized amnesia for identity and life history.

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

C. The disturbance is not attributable to the physiological effects of a substance (e.g., alcohol or other drug of abuse, a medication) or a neurological or other medical condition (e.g., partial complex seizures, transient global amnesia, sequelae of a closed head injury/traumatic brain injury, other neurological condition).

D. The disturbance is not better explained by dissociative identity disorder, posttraumatic stress disorder, acute stress disorder, somatic symptom disorder, or major or mild neurocognitive disorder.

Coding note: The code for dissociative amnesia without dissociative fugue is **300.12 (F44.0).** The code for dissociative amnesia with dissociative fugue is **300.13 (F44.1).**

Specify if:

300.13 (F44.1) With dissociative fugue: Apparently purposeful travel or bewildered wandering that is associated with amnesia for identity or for other important autobiographical information.

Diagnostic Features

The defining characteristic of dissociative amnesia is an inability to recall important autobiographical information that 1) should be successfully stored in memory and 2) ordinarily would be readily remembered (Criterion A). Dissociative amnesia differs from the permanent amnesias due to neurobiological damage or toxicity that prevent memory storage or retrieval in that it is always potentially reversible because the memory has been successfully stored.

Localized amnesia, a failure to recall events during a circumscribed period of time, is the most common form of dissociative amnesia. Localized amnesia may be broader than amnesia for a single traumatic event (e.g., months or years associated with child abuse or intense combat). In *selective amnesia,* the individual can recall some, but not all, of the events during a circumscribed period of time. Thus, the individual may remember part of a traumatic event but not other parts. Some individuals report both localized and selective amnesias.

Generalized amnesia, a complete loss of memory for one's life history, is rare. Individuals with generalized amnesia may forget personal identity. Some lose previous knowledge about the world (i.e., semantic knowledge) and can no longer access well-learned skills

(i.e., procedural knowledge). Generalized amnesia has an acute onset; the perplexity, disorientation, and purposeless wandering of individuals with generalized amnesia usually bring them to the attention of the police or psychiatric emergency services. Generalized amnesia may be more common among combat veterans, sexual assault victims, and individuals experiencing extreme emotional stress or conflict.

Individuals with dissociative amnesia are frequently unaware (or only partially aware) of their memory problems. Many, especially those with localized amnesia, minimize the importance of their memory loss and may become uncomfortable when prompted to address it. In *systematized amnesia,* the individual loses memory for a specific category of information (e.g., all memories relating to one's family, a particular person, or childhood sexual abuse). In *continuous amnesia,* an individual forgets each new event as it occurs.

Associated Features Supporting Diagnosis

Many individuals with dissociative amnesia are chronically impaired in their ability to form and sustain satisfactory relationships. Histories of trauma, child abuse, and victimization are common. Some individuals with dissociative amnesia report dissociative flashbacks (i.e., behavioral reexperiencing of traumatic events). Many have a history of self-mutilation, suicide attempts, and other high-risk behaviors. Depressive and functional neurological symptoms are common, as are depersonalization, auto-hypnotic symptoms, and high hypnotizability. Sexual dysfunctions are common. Mild traumatic brain injury may precede dissociative amnesia.

Prevalence

The 12-month prevalence for dissociative amnesia among adults in a small U.S. community study was 1.8% (1.0% for males; 2.6% for females).

Development and Course

Onset of generalized amnesia is usually sudden. Less is known about the onset of localized and selective amnesias because these amnesias are seldom evident, even to the individual. Although overwhelming or intolerable events typically precede localized amnesia, its onset may be delayed for hours, days, or longer.

Individuals may report multiple episodes of dissociative amnesia. A single episode may predispose to future episodes. In between episodes of amnesia, the individual may or may not appear to be acutely symptomatic. The duration of the forgotten events can range from minutes to decades. Some episodes of dissociative amnesia resolve rapidly (e.g., when the person is removed from combat or some other stressful situation), whereas other episodes persist for long periods of time. Some individuals may gradually recall the dissociated memories years later. Dissociative capacities may decline with age, but not always. As the amnesia remits, there may be considerable distress, suicidal behavior, and symptoms of posttraumatic stress disorder (PTSD).

Dissociative amnesia has been observed in young children, adolescents, and adults. Children may be the most difficult to evaluate because they often have difficulty understanding questions about amnesia, and interviewers may find it difficult to formulate child-friendly questions about memory and amnesia. Observations of apparent dissociative amnesia are often difficult to differentiate from inattention, absorption, anxiety, oppositional behavior, and learning disorders. Reports from several different sources (e.g., teacher, therapist, case worker) may be needed to diagnose amnesia in children.

Risk and Prognostic Factors

Environmental. Single or repeated traumatic experiences (e.g., war, childhood maltreatment, natural disaster, internment in concentration camps, genocide) are common ante-