

Dissociative Identity Disorder diagnostic guide

For ACC ISSC suppliers, providers and assessors

Dissociative Identity Disorder diagnosis requires specialised clinical expertise.

It is strongly recommended that therapists have training for diagnosing and treating this disorder, e.g. through programs available from the International Society for the Study of Trauma and Disassociation, www.isst-d.org.

Best practice DID clinical diagnosis:

- Make direct enquiry and describe specific situations where dissociative symptoms have been evident.
- Include in interview data behavioural descriptions to evidence the reported symptom/problem area.
- Utilise multiple modes and methods of assessment, i.e. self-report and behavioural observation; if using psychometrics, use both quantitative and qualitative analysis, etc.

This summary aims to assist you to diagnose adult Dissociative Identity Disorder (DID; see Appendix 1 for definition) in your mental health assessment of ACC clients. The summary sets out the difficulties in DID diagnosis, and outlines best practice diagnostic criteria.

This summary is adapted from the International Society for the Study of Trauma and Dissociation (ISSTD) Guidelines for Treating Dissociative Identity Disorder in Adults (2011)¹. It focuses on the DID diagnosis section only (pp. 115-132) and reproduces key excerpts relevant to difficulties in diagnosing DID.

Diagnosing DID is difficult

The difficulties in diagnosing DID result primarily from lack of education among clinicians about dissociation, dissociative disorders, and the effects of psychological trauma. This leads to limited clinical suspicion about dissociative disorders, misconceptions about their clinical presentation, and difficulty recognizing the signs and symptoms even when they occur spontaneously (e.g., auditory hallucinations are more common in DID than schizophrenia, but such symptoms are seen as markers of schizophrenia or often Borderline Personality Disorder (BPD) in a trauma population).

1. International Society for the Study of Trauma and Dissociation (2011). Guidelines for Treating Dissociative Identity Disorder in Adults, Third Revision. *Journal of Trauma & Dissociation*, 12(2), 115-187.

Instead of showing visibly distinct alternate identities, the typical DID patient presents a polysymptomatic mixture of dissociative and posttraumatic stress disorder (PTSD) symptoms within a matrix of ostensibly non-trauma-related symptoms (e.g., depression, panic attacks, substance abuse, somatoform symptoms, eating-disordered symptoms). The prominence of these latter, highly familiar symptoms often leads clinicians to diagnose only these comorbid conditions.

Standard diagnostic interviews and mental status examinations often **do not include questions about dissociation**, posttraumatic symptoms, or a history of psychological trauma.

Patients with DID **rarely volunteer information** about dissociative symptoms (e.g., due to shame, previous dismissal, difficulty describing subjective experience). The absence of focused inquiry about dissociation prevents the clinician from diagnosing the disorder.

Prevalence: Clinical studies in North America, Europe, and Turkey have found that generally between 1% to 5% of patients in general inpatient psychiatric units; in adolescent inpatient units; and in programs that treat substance abuse, eating disorders, and obsessive-compulsive disorder meet DID diagnostic criteria, particularly when evaluated with structured diagnostic instruments. Many of the patients in these studies had not previously been clinically diagnosed with a dissociative disorder. It is likely that the rate of DID in the sensitive claims ACC client population will be at least this high, especially when the trauma is early, prolonged and severe in nature.

Cultural influences: Pathological alterations of identity and/or consciousness may present within cultures as spirit possession and other culture-bound syndromes. Clinicians should recognise these cultural influences as ways for patients with DID to articulate their 'not self'.

Controversy over DID diagnosis

There has historically been concern about the validity of DID as a diagnosis. The ISSTD guidelines (2011) report that peer reviewed research in at least 26 countries indicates that DID is a valid cross-cultural diagnosis having validity comparable or exceeding that of other accepted psychiatric diagnoses. There has been concern about a socio-cognitive model, i.e. where clinicians influence patients to enact DID symptoms. There is no research that shows that the complex phenomenology of DID can be created by suggestion or hypnosis. There is considerable evidence that patients present with DID predating any interaction with clinicians. There is also an extensive body of literature studying the psychophysiology and psychobiology which adds to diagnostic validity. DID is nearly universally associated with a history of significant traumatisation most often first occurring in childhood and involving a care-giving figure. Despite its empirical foundation, the debate regarding DID legitimacy has continued.

DID diagnostic considerations

The essential manifestation of pathological dissociation is a partial or complete disruption of the normal integration of a person's psychosomatic functioning. Specifically, dissociation can unexpectedly disrupt, alter, or intrude upon a person's consciousness and experience of body, world, self, mind, agency, intentionality, thinking, believing, knowing, recognizing, remembering, feeling, wanting, speaking, acting, seeing, hearing, smelling, tasting, touching, and so on. These disruptions are typically experienced by the person as startling, autonomous intrusions into his or her usual ways of responding or functioning, or frank omissions from normal psychosomatic operations (e.g., amnesia, anaesthesia, conversion paralysis).

Dissociative Identities

A person with DID experiences himself or herself as having separate alternate identities that have relative psychological autonomy from one another. At various times, these subjective identities may take executive control of the person's body, mind and behaviour and/or influence his or her experience and behaviour from "within."

Taken together, the dissociative identities make up the identity or personality of the human being with DID, so they are not seen as multiple people but one person with multiple dissociative identities. Each identity has its own autonomous sense of self, autobiographical memories, emotional range and beliefs. Some may be very elaborated, others quite rudimentary.

The most common dissociative intrusions include hearing voices, depersonalization, derealization, unwilled and foreign ("made") thoughts, urges, desires, emotions, and actions.

Clinicians should attend to the unique, personal language with which patients with DID characterise their dissociative identities. Patients commonly refer to themselves as having parts, parts inside, aspects, facets, ways of being, voices, multiples, selves, ages of me, people, persons, individuals, spirits, demons, others, and so on. It can be helpful to use the terms that patients use to refer to their identities.

Diagnostic Interview

At a minimum, the patient should be asked about episodes of amnesia, fugue, depersonalization, derealization, identity confusion, and identity alteration. DID diagnostic instruments (e.g., SCID.D) and self-report screening measures (e.g., DES-II) may be useful for assessment (see Appendix 2).

Additional useful areas of inquiry are: spontaneous age regressions; autohypnotic experiences; hearing voices; passive-influence symptoms such as “made” thoughts, emotions, or behaviours (i.e., those that do not feel attributable to the self); and somatoform dissociative symptoms, such as bodily sensations related to strong emotions and past trauma.

Behavioural manifestations of dissociation need to be considered, such as alterations in posture, presentation of self, dress, style of speech, interpersonal relatedness, skill level, and sophistication of cognition, writing style as well as fixed gaze and eye fluttering.

Complications arising in DID diagnosis

Mistrust and reluctance to reveal inner feelings

The process of diagnosing severe dissociative disorders is complicated by people's early trauma and attachment difficulties and the resultant mistrust of others, especially authority figures. Traumatized patients may be very reluctant to reveal an inner, hidden world to a clinician who may be seen as such a figure.

Furthermore, the diagnostic process demands that the person reflect upon and report experiences that have been dissociated because they elicit such strong, negative, and contradictory feelings.

Unless clinicians take the time to develop a collaborative relationship based on increased levels of trust, the data from diagnostic interviews and self-report measures are unlikely to yield valid, useful information.

Denial and Disavowal

The presence of dissociative identities and other dissociative symptoms is commonly denied and disavowed by persons with DID. This kind of denial is consistent with the defensive function of disavowing both the trauma and its related emotions and the subsequent dissociated sense of self. Not surprisingly, persons with DID often present with avoidant personality disorder and as depleted and depressed.

Trauma history

DID is nearly universally associated with an antecedent history of significant relational traumatization—most often first occurring in childhood. However, clinicians should use careful clinical judgment about how aggressively to pursue details of traumatic experiences during initial interviews, especially when those experiences seem to be poorly or incompletely remembered, or if remembering or recounting the trauma appears to overwhelm the individual's emotional capacities. Note that documentation of sexual abuse history is usually a goal of an ACC supported assessment but hopefully details have emerged slowly over time in support sessions with a counsellor. Poorly recalled or inconsistent recall of trauma history may be an indication of a dissociative disorder.

Differential Diagnosis and Misdiagnosis of DID

It is important that clinicians appreciate the similarities and differences between the symptoms of dissociative disorders and other frequently encountered disorders.

False negative diagnosis: Bipolar, affective, psychotic, seizure, and borderline personality disorders are among the common false negative diagnoses of patients with DID and Other Specified Dissociative Disorder (see Appendix 1). False negative diagnoses of DID readily occur when the assessment interview does not include questions about dissociation and trauma, or focuses on more evident comorbid conditions, and when evaluators have failed to attend to critical process issues such as developing a working alliance.

False positive: Conversely, clinicians who specialize in dissociative disorders must be able to recognize and diagnose non-dissociative disorders so that they do not incorrectly diagnose DID or fail to identify the presence of true comorbid conditions.

Dissociative symptoms are central in other dissociative disorders and Post Traumatic Stress Disorder (PTSD), and can be part of the clinical presentation of patients with somatization disorder, panic disorder, borderline personality disorder and even psychosis. It should not be assumed that symptoms such as amnesia or even identity “fragmentation” automatically connote a diagnosis of DID.

Mood changes in bipolar patients, especially those with comorbid PTSD, have been confused with DID: Cycling between mood states in bipolar mood disorder can be misconstrued as DID identity alterations, particularly if assessment appointments are conducted over an extended period of time. Some psychotic patients with delusions of being inhabited by other people may be misdiagnosed as DID. In addition, some patients may have dissociative symptoms but a non-dissociative primary diagnosis. For example, a subgroup of patients with a schizophrenic disorder and a history of childhood trauma have concurrent dissociative symptoms, or in less frequent cases a comorbid dissociative disorder can be seen alongside schizophrenia.

Personality-disordered patients who have dissociative symptoms and identity disturbances may be misdiagnosed as DID: Many patients with borderline traits, as well as patients with other personality disorders, have histories of childhood maltreatment. When these patients are subjected to premature, intense exploration of trauma memories, they may have an increased sense of identity fragmentation that can be misdiagnosed as DID. Note that up to 70% of patients with DID have an initial diagnosis of BPD, with the minority meeting BPD diagnosis after DID therapy.

Inexperienced clinicians may also confuse a patient’s investment in a metaphorical “inner child” or similar phenomena with clinical DID: The formulation of an “inner child” can be mistaken for dissociative identities. Clinicians who are poorly trained in hypnosis may confuse hypnotic phenomena, such as the production of “ego states,” with clinical DID. In some instances, these problems can be compounded by patient’s desire to have a more “interesting” or elaborate disorder, resulting in the patient coming to believe that he or she has DID. This is contrary to typical DID patients’ pervasive pattern

of disavowal of dissociated aspects of themselves, of overwhelming trauma, and of the diagnosis of DID—at least during initial phases of treatment.

As with any psychiatric condition, a presentation of DID may be factitious or simulated: Clinicians should be alert to this concern, especially in situations where there is strong motivation to simulate an illness (e.g., pending legal charges, civil litigation, and/or disability or compensation determinations). The SCID-D, the MID, the Test of Memory Malingering, and other diagnostic inventories can be useful in differentiating feigned DID from bona fide patients with DID (see Appendix 2).

DID and Somatoform Comorbidity: High rates of somatization and somatoform disorders are found in patients with DID. Common varied symptoms include abdominal pain, pelvic pain, joint pain, face and head pain, lump in the throat, back pain, non-epileptic seizures, and pseudo-asthma, among others. Somatoform dissociation may explain the high rates of childhood maltreatment, particularly sexual abuse, found in patients with somatic symptom disorder, illness anxiety disorder, and functional neurological symptom disorder (conversion disorder), particularly non-epileptic seizures. Some patients with DID may be preoccupied with somatoform pain syndromes and take high doses of narcotic analgesics with limited response. Other patients with DID dissociate pain for long periods of time, thus delaying medical care until severe complications have occurred (e.g., even metastatic cancer). Many patients with DID may have difficulties with medical procedures or treatments.

Appendix 1: Dissociative Identity Disorder (DID) definition

The DSM–5 (American Psychiatric Association, 2013) lists the following diagnostic criteria for DID (300.14; p. 292):

1. 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, 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. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.
3. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
4. 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 attributable to the physiological effects of a substance (e.g., blackouts or chaotic behaviour during alcohol intoxication or other medical condition, e.g., complex partial seizures).

Other Specified Dissociative Disorder - OSDD

A substantial proportion of the dissociative cases encountered in clinical settings receive a diagnosis of OSDD. Many of these OSDD cases are well described by the DSM–5 Example 1 of OSDD (APA, 2013, 300.15, p. 306), where there are two different groupings:

- (a) Cases with the same alterations in identity as full-blown DID, but where there appears to be no dissociative amnesia
- (b) Cases where there is identity disturbance with less marked discontinuities in sense of agency or self. These can look “almost DID”

OSDD-1 patients are typically subject to DID-like disruptions in their functioning caused by switches in self-states and intrusions of feelings and memories into consciousness. These latter phenomena are often more subtle than cases with florid DID, so it requires more skill and expertise on the part of clinicians to discern their presence.

Appendix 2: Clinical instruments to assess dissociative symptoms or diagnoses

Comprehensive clinician administered structured interviews

Structured Clinical Interview for DSM–IV Dissociative Disorders–Revised (SCID-D-R)

The interviewer, whether a clinician or a trained technician, must have considerable familiarity with dissociative symptoms. Training required for all assessors or a sub-group trained for secondary assessment

- 277-item interview that assesses five symptoms of dissociation: amnesia, depersonalization, derealization, identity confusion, and identity alteration. Most items have follow-up questions that ask for a description of the experience, specific examples, and the frequency of the experience and its impact on social functioning and work performance.
 - Diagnoses the five DSM–IV dissociative disorders; it also yields a score for each of the five dissociative symptoms and a total score based on the frequency and intensity of symptoms.
 - Takes 45 to 180 min or more to administer therefore unlikely to be feasible to use in a one-off supported assessment- need second session.
 - Considered to be the gold standard for diagnosis of dissociative disorders.
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The Dissociative Disorders Interview Schedule (DDIS): <http://www.rossinst.com/ddis>

- 132-item structured interview that assesses the symptoms of DSM–5 dissociative disorders, somatization disorder, borderline personality disorder, and major depressive disorder.
 - It also assesses substance abuse, Schneiderian first-rank symptoms, trance, childhood abuse, secondary features of DID, and supernatural/paranormal experiences.
 - Usually takes 30 to 45 min to administer.
 - Provides diagnoses and the number of items that were endorsed in each section of the interview but does not assess the frequency or severity of symptoms.
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Office Mental Status Examination for Complex Chronic Dissociative Symptoms and Multiple Personality Disorder (Loewenstein, 1991).

- Semi-structured clinical interview for chronic complex dissociative symptoms developed primarily through attempts to diagnose MPD naturalistically without intrusive or hypnotic methods.
 - Includes typical answers given by MPD patients from author's clinical notes in the assessment of several hundred severely dissociative patients.
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Continued ...

Comprehensive clinician administered structured interviews

Multidimensional Inventory of Dissociation (MID): http://www.mid-assessment.com	<ul style="list-style-type: none">• 218-item instrument with 168 dissociation items and 50 validity items.• Takes 30 to 90 min to complete.
Multiscale diagnostic instrument designed to comprehensively assess dissociative phenomena.	<ul style="list-style-type: none">• The MID and its Excel®-based scoring program (freely available to mental health professionals) generates both scale scores and diagnoses (i.e., DID, OSDD, PTSD, and severe borderline personality disorder).• Measures 23 dissociative symptoms and six response sets that serve as validity scales. The 168 dissociation items have 12 first-order factors (self-confusion, angry intrusions, dissociative disorientation, amnesia, distress about memory problems, experience of alternate identities, derealisation/depersonalisation, persecutory intrusions, trance, flashbacks, body symptoms, gaps in autobiographical memory) and one second-order factor (pathological dissociation).

Brief self-report instruments

Designed only for screening and should not be used by themselves to rule in or rule out a DID diagnosis

Dissociative Experiences Scale (DES): http://traumadissociation.com/des	<ul style="list-style-type: none">• 28-item self-report instrument whose items tap primarily absorption, imaginative involvement, depersonalization, derealisation, and amnesia.• Most widely used dissociation measure in research and clinical practice; translated into many languages. Use this screening for all ACC sensitive claims supported assessments with high scores ≥ 30 requiring in depth clinical assessment or referral for SCID-DR
DES-Taxon	Uses eight questions from the DES (items: 3,5,7,8,12,13,22,27) that are most closely identified with a taxon (class) of individuals who demonstrate “pathological dissociation”
Dissociation Questionnaire (DIS-Q) Developed in Belgium and The Netherlands, the DIS-Q is more commonly used by European than North American clinicians and researchers.	<ul style="list-style-type: none">• 63-item self-report instrument. The initial item pool from which the DIS-Q was developed included the DES, the Perceptual Alteration Scale and the Questionnaire of Experiences of Dissociation, with additional items derived from interviews with dissociative patients.• Measures identity confusion and fragmentation, loss of control, amnesia, and absorption.
Somatoform Dissociation Questionnaire-20 (SDQ-20): http://www.enijenhuis.nl/sdq/	<ul style="list-style-type: none">• 20-item self-report instrument that uses a 5-point Likert scale to assess dissociation occurring at sensory, motor and somatic levels.• The SDQ-20 items address tunnel vision, auditory distancing, muscle contractions, psychogenic blindness, difficulty urinating, insensitivity to pain, psychogenic paralysis, non-epileptic seizures, and so on. It is explicitly conceptualized as a measure of somatoform dissociation.

Continued ...

Brief self-report instruments

Designed only for screening and should not be used by themselves to rule in or rule out a DID diagnosis

SDQ-5: <http://www.enijenhuis.nl/sdq/>

A shorter version of the SDQ-20, composed of five items from the SDQ-20. Developed as a screening instrument for dissociative disorders and correlates well with the SDQ-20.

Other Psychological Tests

Some measures commonly used in psychological testing (e.g., the Rorschach Inkblot Test, Minnesota Multiphasic Personality Inventory–2, Wechsler Adult Intelligence Scale–Revised, Millon Clinical Multiaxial Inventory–III)

Can provide understanding of the patient’s personality structure and may yield information useful in making the differential diagnosis between disorders often confused with DID, such as borderline personality disorder and psychotic disorders.

However, **commonly used psychological tests were not designed to detect dissociative disorders** and may lead to misdiagnosis when the evaluator (a) is not familiar with the typical responses of dissociative patients on these tests, (b) relies primarily on scoring scales not normed for a dissociative population, (c) does not administer additional dissociation-specific tests (such as structured clinical interviews), and (d) does not inquire specifically about dissociative symptoms during the clinical or testing interview.

Adapted from International Society for the Study of Trauma and Dissociation (2011): Guidelines for Treating Dissociative Identity Disorder in Adults, Third Revision, *Journal of Trauma & Dissociation*, 12(2), 115-187.

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The Board of Directors of the International Society for the Study of Trauma and Dissociation endorses these summarised guidelines for the diagnosis of Dissociative Identity Disorder.

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Disclaimer

All information in this publication was correct at the time of printing. This information is intended to serve only as a general guide to arrangements under the Accident Compensation Act 2001 and regulations. For any legal or financial purposes this Act takes precedence over the contents of this guide.