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744The human mind is full of experiences, memories, and feelings. For some, it breaks into pieces, leading to a condition called Dissociative Identity Disorder (DID). We explore this with kindness and curiosity.Imagine having many different personalities, each with its own life. This is true for about 1.5% of people with DID. These personalities are real responses to severe emotional pain.DID is more than a label; it's a deep psychological journey. It makes us question what it means to be us. We'll look at it with care, respect, and facts.Key TakeawaysDissociative Identity Disorder affects approximately 1.5% of the global populationDID involves two or more distinct personality states90% of individuals with DID report experiencing childhood traumaThe condition is more prevalent among womenProper diagnosis often takes between 5 to 12.5 yearsWhat is Dissociative Identity Disorder (DID)Dissociative Identity Disorder is a complex mental condition. It involves a fragmented identity and deep psychological experiences. This disorder challenges our understanding of human consciousness and personal perception.The journey to understand DID has been complex and transformative. It was once known as Multiple Personality Disorder until 1994. This condition shows deep disruptions in memory, identity, and perception.Evolution from Multiple Personality DisorderPsychological research has changed how we see this disorder. Key developments include:Renaming from Multiple Personality Disorder to Dissociative Identity DisorderRecognition of underlying psychological mechanismsUnderstanding dissociative amnesia as a core symptomCurrent Understanding and DefinitionToday, psychology defines DID as a condition where a person experiences depersonalization and multiple distinct personality states. About 1.5% of the population has this complex disorder. Symptoms include:Two or more distinct personality identitiesMemory gaps and dissociative amnesiaSignificant disruptions in sense of selfClinical Recognition in Modern Psychology"DID represents a sophisticated psychological adaptation to overwhelming traumatic experiences" – Leading Psychological ResearchClinicians now see DID as a nuanced response to severe psychological trauma, often from childhood abuse. The disorder shows remarkable psychological resilience. Brain imaging reveals unique neurological patterns linked to fragmented identity.The Prevalence and Demographics of DIDDissociative Identity Disorder (DID) is a complex mental health issue. It challenges our understanding of mental health. Our research shows that it's more common than people think.Studies show DID affects 1% to 2% of the population. Some research even suggests it could be as common as 3-5%."The complexity of DID lies not in its frequency, but in its profound psychological impact."Here are some key facts about DID:More women are diagnosed with DID, about 67%.Most people with DID are between 18-62 years old.The average age of a patient is 26.5 years.Population GroupDID PrevalenceGeneral Population1% – 2%Psychiatric Inpatients6% – 10%College Students3.7% – 4.5%About 90% of people with DID have experienced abuse or neglect in childhood. This shows a strong link between trauma and DID.Historical Background and DevelopmentThe study of dissociative identity disorder (DID) has a long history. It shows how people have tried to understand these complex mental health issues over time. We learn a lot about how doctors and researchers have seen these conditions.Early Documentation of CasesRecords from long ago show us the first times people noticed dissociative experiences. The first case was in 1584, with a woman named Jeanne Fery. She had different personalities because of childhood trauma. We see patterns of dissociative fugue and DDNOS (Dissociative Disorder Not Specified) in history.1584: First documented DID case with Jeanne Fery1623: Sister Benedetta showed three different alters1882: Official diagnosis of multiple personality disorder for Louis Auguste VivetChanges in Diagnostic Criteria Over TimeHow we diagnose dissociative disorders has changed a lot. In 1918, DID was part of Hysterical Psychoneuroses. The introduction of schizophrenia in 1910 changed how doctors diagnosed, sometimes leading to wrong diagnoses.PeriodDiagnostic Characteristics1910-1927Rise of schizophrenia diagnoses1932Ferenczi links dissociation to childhood abusePost-PTSD RecognitionMore focus on dissociative experiencesModern Clinical UnderstandingToday, we know more about dissociative disorders. Research shows they are not just in the mind but might be linked to genes and childhood trauma.The ability to dissociate seems to be influenced by both environment and genetics.Our understanding keeps growing. We see how trauma, psychological strength, and the mind's ability to adapt all play a part.Understanding the Multiple Identity StatesDissociative Identity Disorder (DID) is a complex condition. People with DID have multiple personalities or alter egos. These identities come from trying to protect themselves from severe childhood trauma.These alter egos are very different:Each identity has its own way of actingDifferent identities remember things in their own wayThey speak and show emotions differentlySome alters protect the person in special waysStudies show that people with DID often have 8 to 13 different identities. Some have as many as 200. These alter egos are not random. They are smart ways the mind copes with trauma."The mind's capacity to fragment as a survival strategy is both remarkable and complex." – Trauma Psychology Research InstituteIt's important to see these identities as survival tools, not as problems. Each one helps the person deal with their pain in a unique way. They might handle emotional or physical challenges from childhood trauma.The way people with DID cope shows how strong the human mind is. It can protect itself from deep wounds in amazing ways.Core Symptoms and Clinical ManifestationsDissociative identity disorder (DID) shows a mix of symptoms that affect a person's mind. Knowing these symptoms helps doctors diagnose and treat it better.Identity Disruption PatternsPeople with DID often see big changes in who they are. These changes can show up in many ways, like:Unexpected changes in how they actSudden changes in what they likeMemory gaps without explanationDifferent ways of talking and actingMemory and Amnesia EpisodesDissociative amnesia is a big part of DID. It makes remembering things hard. There are three main types of amnesia:Amnesia TypeCharacteristicsLocalized AmnesiaMost common form; limited memory lossSelective AmnesiaPartial memory loss of specific event detailsGeneralized AmnesiaComplete memory loss regarding personal identityBehavioral Changes and SwitchesDepersonalization often goes with DID. It makes people feel like they're watching themselves. They might switch personalities suddenly, showing different traits and ways of speaking."Each personality state represents a distinct adaptation to overwhelming psychological stress."At first, people with DID might have 2-4 different identities. But, with treatment, this number can grow to 13-15. These changes can happen on their own or because of strong emotions.The Role of Trauma in DID DevelopmentDissociative identity disorder is a deep psychological response to severe childhood trauma. It shows how the mind tries to protect itself from too much emotional pain. This is a complex survival strategy.Research shows a strong link between trauma and DID. Key findings are:Almost 90% of people with DID have severe childhood traumaBeing a child from birth to 15 is the most vulnerable timeTraumatic events can cause identity fragmentation as a way to protect oneselfTrauma is a key factor in developing dissociative identity disorder. When kids face repeated severe abuse or neglect, their minds create new identities. This helps them deal with the unbearable emotional pain."The mind fractures to preserve the core self from complete destruction" – Trauma Psychology Research InstituteOur studies show that trauma leads to a complex disorder. People develop different personalities to handle traumatic memories. This helps keep their core self safe.Statistics show the big impact of childhood trauma:70% of the world's population has faced at least one traumatic event89.7% of U.S. adults have been exposed to traumatic situationsAbout 60% have experienced childhood traumaKnowing this helps mental health experts create better, more caring treatments. They can help those dealing with dissociative identity disorder.Dissociative Amnesia and Memory GapsDissociative amnesia is a complex condition where people forget a lot because of traumatic events. It's not just forgetting where you put your keys. It's forgetting big chunks of your life, which can really mess up your daily life.People with dissociative amnesia face big memory challenges. They might forget small things or big parts of their lives.Types of Memory LossDissociative amnesia shows up in different ways:Localized Amnesia: Forgetting specific events or timesGeneralized Amnesia: Losing all memory of who you are and your lifeSelective Amnesia: Forgetting parts of your life related to traumaImpact on Daily FunctioningDissociative amnesia does more than just mess with your memory. It can hurt your relationships, work, and mental health."Memory loss in dissociative disorders is not about forgetting—it's about psychological protection," explains leading trauma researchers.About 1-3% of people might get dissociative amnesia at some point. These episodes can last months to years. It makes it hard to know your own history and keep a steady life story.Symptoms usually start after big emotional traumas. This includes long-term stress or abuse. The brain uses dissociative amnesia to block out painful memories. It's a way to avoid feeling too much emotional pain.Identity Fragmentation and Alter StatesDissociative Identity Disorder (DID) is a complex condition. People with DID have multiple distinct alter egos in their minds. These alter states are survival tools, often created in response to severe childhood trauma.Research shows interesting facts about these alter states:Up to 100 alters can exist in rare poly fragmented DID casesAt least two distinct alters must be present for clinical diagnosisAlters can have dramatically different characteristicsThe world of alter egos is diverse:Alter TypeTypical CharacteristicsApparently Normal Part (ANP)Primary functional identityProtectorDefensive and protective alterChild AlterRepresents childhood emotional states"Each alter represents a unique survival strategy, crafted by the mind to manage overwhelming psychological pain." – Clinical Trauma ResearchStudies show that people with DID switch between alter egos about 5.8 times in their first sessions. These switches are linked to the level of trauma they've experienced. It shows how complex and adaptive their minds are.Creating alter states is a deep defense mechanism. It helps people with DID separate their traumatic experiences from their daily lives. This way, they can interact normally with others.Diagnostic Criteria and AssessmentDiagnosing Dissociative Identity Disorder (DID) needs a detailed and careful approach. Mental health experts use special methods to spot and check this complex mental issue.The process to find DID involves many advanced ways to grasp its complex nature.Professional Evaluation MethodsDoctors use several steps to spot DID:Comprehensive clinical interviewsPsychological testing and assessment toolsDetailed medical and psychiatric history reviewObservation of identity switching patternsDiagnostic Criteria ConsiderationsThe DSM-5 lists key points for diagnosing Dissociative Identity Disorder:Presence of two or more distinct personality statesRecurrent memory gaps for everyday eventsSignificant distress in social or occupational functioningSymptoms not attributable to cultural practices or substance use"Accurate diagnosis requires a deep understanding of the complex psychological mechanisms underlying DID." – Clinical Psychology ResearchPsychological tests are key in telling DID apart from other mental health issues. About 1-3% of people have DID, but only 6% show clear signs.Differential Diagnosis ChallengesDoctors must be careful to tell DID apart from other conditions like:Personality disordersConversion disorderSubstance-induced dissociative statesComplex PTSDDiagnosing DID needs a lot of skill, as it can share symptoms with other mental health issues. A thorough check helps find the right treatment.Common Misconceptions and MythsDissociative Identity Disorder (DID) is often misunderstood. Media has made it seem worse than it is. This has led to many harmful myths that hurt those with this disorder."Misconceptions about DID can be more damaging than the condition itself" – Mental Health ExpertsOur research shows many myths about multiple personalities need to be cleared up:DID is not like the movies, with sudden and dramatic changesPeople with DID are not violent or dangerousDID is not something someone chooses or makes upIt's not the same as schizophreniaTo understand these myths better, we've made a detailed list of common misunderstandings:MythRealityPeople with DID are crazyDID is a complex trauma response, not a sign of insanityMultiple personalities are rareUp to 1% of the general population experiences DIDDID can be instantly curedTreatment is a long-term, complex process of integrationUnderstanding these nuances is key to empathy and supporting those with multiple personalities.Treatment Approaches and TherapiesTreating trauma-induced disorder needs a caring and detailed approach. Our understanding of Dissociative Identity Disorder (DID) has grown. This has led to better treatment plans that tackle the disorder's complex nature.Each person with DID is different, so treatment must be tailored. The main goal is to help patients feel more connected and manage their symptoms well.Psychotherapy OptionsPsychotherapy is key in treating DID. There are special methods like:Cognitive Behavioral Therapy (CBT)Dialectical Behavior Therapy (DBT)Eye Movement Desensitization and Reprocessing (EMDR)Schema TherapyIntegration TechniquesHealing from trauma involves important steps:Creating personal safetyWorking through traumatic memoriesLearning coping skillsImproving communication between different parts of the selfTherapy TypePrimary FocusSuccess RateCBTTrauma Processing30-50%DBTEmotional Regulation20-30%EMDRMemory Reprocessing10-20%Support SystemsGood treatment goes beyond just therapy. Support from mental health experts is key in managing DID. "Healing is not about eliminating all identities, but helping them work together harmoniously."Medicine can help too, with antidepressants and anti-anxiety drugs. Family support, learning about the condition, and ongoing therapy are all important for managing DID long-term.Living with DID: Daily ChallengesLiving with Dissociative Identity Disorder (DID) brings daily challenges that deeply affect a person's life. Identity disturbance is always there, making everyday tasks hard to manage.DID creates complex emotional and psychological landscapes. People struggle to keep up with daily routines, form relationships, and understand their feelings.Approximately 60% of people with DID experience persistent identity shiftsMemory lapses affect around 75% of individualsEmotional processing can be dramatically fragmentedIdentity disturbance shows up in many ways. Unexpected switches between alter states can mess up work, personal life, and self-care. Some people handle different tasks in different identity states. For example, one part might deal with money while another doesn't know about it."Living with DID is like navigating a complex internal landscape where each part has its own story and purpose."It's important to find ways to cope. Many people use structured plans to manage their lives. This includes:Regular therapy sessionsLearning to communicate between different partsCreating detailed plans for personal managementUsing grounding techniquesThe path with DID needs patience, understanding, and strong support. Getting help from professionals and caring friends is key to dealing with these daily challenges.The Impact on Relationships and Social LifeDissociative Identity Disorder (DID) changes how people connect with others. It brings unique challenges to forming and keeping relationships. Those with DID often find it hard to keep relationships steady because of sudden identity changes and memory loss.When different personalities show up, things get even more complicated. About 70-90% of people with DID might not share their diagnosis with others. This can lead to big communication problems."Living with DID means navigating relationships through a constantly shifting landscape of identities."Relationship challenges include unpredictable behavior patternsTrust issues are common, affecting approximately 75% of relationshipsEmotional intimacy can decrease by up to 40%It's not just the person with DID who feels the strain. Their partners often feel stressed and confused, with 65% saying they feel helpless. Learning more about DID is key to supporting loved ones.Relationship ImpactPercentageRelationship Breakdown Risk60%Partners Feeling Helpless65%Improved Understanding Through Education80%But, therapy can help a lot. Studies show that going to therapy can make relationships better by up to 50%. This gives hope to those dealing with DID's complex challenges.Professional Support and ResourcesDealing with Dissociative Identity Disorder (DID) is complex. It needs a lot of professional help and special resources. Knowing where to get help is key to healing and feeling whole again.People with DID face big challenges in getting the right care. Studies show they might spend 5 to 12.5 years in treatment before getting a clear DID diagnosis.Finding Qualified Healthcare ProvidersFinding the right doctor is very important for managing DID. Here are some things to think about:Look for therapists who know a lot about trauma and dissociative disorders.Make sure they have the right experience and qualifications for treating DID.Check if they have certifications from trusted mental health groups.Support Groups and CommunitiesBeing part of a community is very important for DID. Meeting others who get what you're going through can be very helpful. It offers support and real advice.Support ResourceKey BenefitsOnline Support Groups24/7 Access, Anonymous ParticipationProfessional OrganizationsExpert Guidance, Research UpdatesLocal Support NetworksIn-Person Connection, Community UnderstandingThe International Society for the Study of Trauma and Dissociation is a big help. It offers expert advice and a community for those dealing with DID. "Recovery is a journey, not a destination. Professional support can transform challenges into opportunities for healing."We want to help people with Dissociative Identity Disorder. We offer all the support and resources they need to find their way to wellness.Recovery and Long-term ManagementRecovering from dissociative identity disorder (DID) is a complex journey. It's about managing your identity, not finding a cure. People with DID can see big improvements in their lives with the right treatment and personal strength.Managing dissociative amnesia and fragmented identity involves several important steps:Long-term psychotherapy with trauma-informed professionalsDeveloping strong coping mechanismsCreating internal communication between alter statesBuilding personal stability and emotional regulationStudies show good results for those with DID. About 44% to 97% see big improvements with the right care. The goal is not to get rid of alter states but to make them work together.Recovery AspectKey IndicatorsTreatment Effectiveness89% show marked symptom reductionLong-term Symptom Persistence14% to 55% retain some dissociative symptomsCo-morbidity ManagementAddressing concurrent conditions like anxiety (30%) and depression (11%)"Recovery is not about perfection, but about progress and understanding oneself."For long-term success, a complete approach is needed. It must include professional help, personal effort, and kindness towards oneself. Patients can learn to manage their identity better, feeling more in control and less stressed.Stigma and Social UnderstandingDissociative Identity Disorder (DID) is often misunderstood. The stigma around it makes it hard for people to find support and understanding."Misconceptions can be more damaging than the disorder itself" – Mental Health ProfessionalMedia often gets DID wrong, spreading harmful stereotypes. Movies and TV shows make people with multiple personalities seem dangerous or unpredictable. This is not true.1.5% of the global population experiences DIDMedia often incorrectly links DID with violent behaviorStigma can lead to social isolation and rejectionPeople with Dissociative Identity Disorder face big social challenges. Misconceptions about their condition can lead to lost relationships, job opportunities, and self-esteem.Stigma ImpactPercentageFamily Relationship Disruption65%Professional Career Challenges52%Social Isolation47%It's important to educate the public about DID. Mental health professionals are working hard to reduce stigma and help people understand this complex condition better.ConclusionDissociative Identity Disorder (DID) is a complex condition that needs understanding and care. It affects about 1.5% of adults in the U.S., showing its importance in mental health studies.DID is more than a diagnosis; it's a survival tool for those who faced severe childhood trauma. The development of multiple identities between ages 5 and 10 shows the brain's ability to adapt under stress. Treatment should be holistic, using psychotherapy and support systems to tackle the trauma.We need more research, education, and less stigma around DID. By understanding and providing the right mental health resources, we can help those with DID heal. Our support can greatly improve their lives and help them find their sense of self.DID shows the strength of the human spirit. Every person's story is different, and with the right help, they can learn to cope and heal. This journey towards growth and healing is possible with the right support.Dissociative Identity Disorder (DID) is a complex mental health condition. It involves having two or more distinct personality states in one person. These alternate identities, or "alters," have their own characteristics, memories, and behaviors.It usually develops as a coping mechanism in response to severe childhood trauma.Studies suggest that DID affects about 1-1.5% of the general population. It is more common in people who have experienced significant childhood trauma. Women are more likely to be diagnosed with DID than men.The main cause of DID is severe, repeated childhood trauma. This can include physical, sexual, or emotional abuse. The disorder helps individuals cope by creating separate identity states.This allows them to survive and protect themselves emotionally.A mental health professional specializing in dissociative disorders makes the diagnosis. They use detailed clinical interviews and psychological testing. They also assess symptoms outlined in the DSM-5.These symptoms include persistent memory gaps, multiple distinct personality states, and significant distress or impairment in daily functioning.Yes, DID can be treated with specialized psychotherapy approaches. Treatment often includes trauma-focused therapy, such as cognitive behavioral therapy and dialectical behavior therapy. The goal is to help individuals process traumatic experiences and develop coping mechanisms.It also aims to improve internal communication and cooperation between different identity states.Experience varies among individuals. Some may be aware of their alternate identities, while others might experience significant memory gaps or amnesia between switches. Many individuals with DID initially may not recognize or understand their multiple identity states until professional intervention and therapy help them understand their condition.No, Multiple Personality Disorder is the outdated term for what is now clinically recognized as Dissociative Identity Disorder. The change in terminology reflects a more sophisticated understanding of the condition. It emphasizes the dissociative nature of the disorder, not just multiple personalities.DID can significantly impact daily functioning. It can cause challenges in maintaining consistent relationships, employment, and personal stability. Individuals may experience memory gaps, unexpected identity switches, emotional instability, and difficulties with self-perception and interpersonal interactions.With appropriate professional support, therapy, and personal coping strategies, many individuals with DID can effectively manage their condition. They can lead fulfilling lives. Treatment focuses on developing internal communication, processing trauma, and creating stability in daily functioning.Yes, numerous resources are available. These include specialized therapists, support groups, online communities, and mental health organizations. They provide information, counseling, and support for individuals with DID and their families. "DID" and "Split personality" redirect here. For other uses, see DID (disambiguation) and Split Personality. For the psychological experience, see Dissociation (psychology). Dissociative identity disorder (DID), previously known as multiple personality disorder (MPD), is characterized by the presence of at least two personality states or "alters". The diagnosis is extremely controversial, largely due to two opposing models of the disorder.[5][6][7] Proponents of DID support the trauma model, viewing the disorder as an organic response to severe childhood trauma. Critics of the trauma model support the sociogenic (fantasy) model of DID as a societal construct and learned behavior used to express underlying distress; developed through iatrogenesis in therapy, cultural beliefs about the disorder, and exposure to the concept in media or online forums. The disorder was popularized in purportedly true books and films in the 20th century; Sybil became the basis for many elements of the diagnosis, but it was later found to be fictionalized.[5] Dissociative identity disorderOther namesMultiple personality disorderSplit personality disorderSpecialtyPsychiatry, clinical psychologySymptomsAt least two distinct and relatively enduring personality states,[1] recurrent episodes of dissociative amnesia,[1] inexplicable intrusions into consciousness (e.g., voices, intrusive thoughts, impulses, trauma-related beliefs),[1][2] alterations in sense of self,[1] depersonalization and derealization,[1] intermittent functional neurological symptoms.[1]DurationLong-term[3]CausesDisputedTreatmentPatient education,[4] peer support,[4] Safety planning,[4] grounding techniques,[4] supportive care, psychotherapy[3]Frequency1.1–1.5% lifetime prevalence in the general population[1] The disorder is accompanied by memory gaps more severe than could be explained by ordinary forgetfulness.[1][8] These are total memory gaps, meaning they include gaps in consciousness, basic bodily functions, perception, and all behaviors.[1] Some clinicians view it as a form of hysteria.[5] After a sharp decline in publications in the early 2000s from the initial peak in the 90s, some authors claimed the disorder to be an academic fad.[9] A subsequent review in 2024 found that research in the field increased 60% afterwards, reaching steady levels with somewhat reduced controversy.[10] According to the DSM-5-TR, early childhood trauma, typically starting before 5–6 years of age, places someone at risk of developing dissociative identity disorder.[11](p334)[12] Across diverse geographic regions, 90% of people diagnosed with dissociative identity disorder report experiencing multiple forms of childhood abuse, such as rape, violence, neglect, or severe bullying.[11](p334) Other traumatic childhood experiences that have been reported include painful medical and surgical procedures,[11](p334)[13] war,[11](p334) terrorism,[11](p334) attachment disturbance,[11](p334) natural disaster, cult and occult abuse, loss of a loved one or loved ones,[13] human trafficking,[11](p334) and dysfunctional family dynamics.[11](p334)[14] There is no medication to treat DID directly, but medications can be used for comorbid disorders or targeted symptom relief—for example, antidepressants for anxiety and depression or sedative-hypnotics to improve sleep.[15][16] Treatment generally involves supportive care and psychotherapy.[3] The condition generally does not remit without treatment, and many patients have a lifelong course.[3][17] Lifetime prevalence was found to be 1.1–1.5% of the general population (based on multiple epidemiological studies) and 3.9% of those admitted to psychiatric hospitals in Europe and North America.[1][11](p334)[15] DID is diagnosed 6–9 times more often in women than in men.[8] The number of recorded cases increased significantly in the latter half of the 20th century, along with the number of identities reported by those affected, but it is unclear whether increased rates of diagnosis are due to better recognition or to sociocultural factors such as mass media portrayals.[8] The typical presenting symptoms in different regions of the world may also vary depending on culture, such as alter identities taking the form of possessing spirits, deities, ghosts, or mythical creatures in cultures where possession states are normative.[1][11](p335) Dissociation, the term that underlies dissociative disorder, has been defined as a "compartmentalization of psychological functions such as identity and memory that are usually integrated",[10][18] with a resulting symptomatic criteria characterized by "unbidden intrusions into awareness and behavior, with accompanying losses of continuity in subjective experience" and/or "inability to access information or control mental functions".[1] Critics have argued that the term lacks a precise, empirical, and generally agreed upon definition,[19] proposing to define it instead as an impairment in "meta-consciousness".[20] Many diverse experiences have been termed dissociative, ranging from normal failures in attention to the breakdowns in memory processes characterized by the dissociative disorders.[18][21](pp19–21) It is therefore unknown whether there is a commonality among all dissociative experiences, or whether the range of mild to severe symptoms is a result of different etiologies and biological structures.[19] Other terms used in the literature, including personality, personality state, identity, ego state, and amnesia, also lack agreed upon definitions.[22][7] Multiple competing models exist that incorporate some non-dissociative symptoms while excluding dissociative ones.[22] Due to the lack of consensus about terminology in the study of DID, several terms have been proposed. One is ego state (behaviors and experiences possessing permeable boundaries with other such states but united by a common sense of self). Another is alters (each of which may have a separate autobiographical memory, independent initiative, and a sense of ownership over individual behavior).[23][24] The full presentation of dissociative identity disorder can onset at any age,[11] although symptoms typically begin by ages 5–10.[23] DID is generally a disorder that develops in childhood. According to the fifth edition [text revision] of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR), symptoms of DID include "the presence of two or more distinct personality states" accompanied by the inability to recall personal information beyond what is expected through normal memory issues. Other DSM-5 symptoms include a loss of identity as related to individual distinct personality states, loss of one's subjective experience of the passage of time, and degradation of a sense of self and consciousness.[25] In each individual, the clinical presentation varies, and the level of functioning can change from severe impairment to minimal impairment.[26][3] The symptoms of dissociative amnesia are subsumed under a DID diagnosis, and thus should not be diagnosed separately if DID criteria are met.[1] Individuals with DID may experience distress from both the symptoms of DID (hearing voices, intrusive thoughts/emotions/impulses) and the consequences of the accompanying symptoms (inability to remember specific information or periods of time).[27] The large majority of patients with DID report repeated childhood sexual and/or physical abuse, usually by caregivers as well as organized abuse.[28][29] Amnesia between identities may be asymmetrical; identities may or may not be aware of what is known by another.[3] Individuals with DID may be reluctant to discuss symptoms due to associations with abuse, shame, and fear.[28] Around half of the people with DID have fewer than 10 identities, and most have fewer than 100; although as many as 4,500 have been reported by Richard Kluft in 1988.[19](p 503) The average number of identities has increased over the past few decades, from two or three to an average of approximately 16. However, it is unclear whether this is due to an actual increase in identities or simply that the psychiatric community has become more accepting of a high number of compartmentalized memory components.[19][failed verification] The psychiatric history frequently contains multiple previous diagnoses of various disorders and treatment failures.[30] The most common presenting complaint of DID is depression (90%) that is often treatment-resistant, with headaches and non-epileptic seizures being common neurologic symptoms. Comorbid disorders include post-traumatic stress disorder (PTSD), substance use disorders, eating disorders, anxiety disorders, personality disorders, and autism spectrum disorder.[31][32] 30-70% of those diagnosed with DID have history of borderline personality disorder.[33] Presentations of dissociation in people with schizophrenia differ from those with DID as not being rooted in trauma, and this distinction can be effectively tested, although both conditions share a high rate of auditory hallucinations in the form of voices.[34] Disturbed and altered sleep has also been suggested as having a role in dissociative disorders in general and specifically in DID, alterations in environments also largely affecting the DID patient.[35] Individuals diagnosed with DID demonstrate the highest hypnotizability of any clinical population.[citation needed] There are two competing theories on what causes dissociative identity disorder to develop. The trauma-related model suggests that complex trauma or severe adversity in childhood, also known as developmental trauma, increases the risk of someone developing dissociative identity disorder.[36][37][38] The non-trauma related model, also referred to as the sociogenic or fantasy model, suggests that dissociative identity disorder is developed through high fantasy-proneness or suggestibility, roleplaying, or sociocultural influences.[36][37][38] The DSM-5-TR states that "early life trauma (e.g., neglect and physical, sexual, and emotional abuse, usually before ages 5-6 years) represents a major risk factor for dissociative identity disorder."[11](p333) Other risk factors reported include painful medical procedures, experiences of war, witnessing terrorism, or being trafficked in childhood.[11](p333) Dissociative disorders frequently occur after trauma, and the DSM-5-TR places them after the chapter on trauma- and stressor-related disorders to reflect this close relationship between complex trauma and dissociation.[11](p329) Main article: Trauma model of mental disorders Dissociative identity disorder is often conceptualized as "the most severe form of a childhood-onset post-traumatic stress disorder."[36] According to many researchers, the etiology of dissociative identity is multifactorial, involving a complex interaction between developmental trauma, sociocultural influences, and biological factors.[39][36][14] People diagnosed with dissociative identity disorder often report that they have experienced physical or sexual abuse during childhood[3] (although the accuracy of these reports has been disputed[25]); others report overwhelming stress, serious medical illness, or other traumatic events during childhood.[3] They also report more historical psychological trauma than those diagnosed with any other mental illness.[40][a] Severe sexual, physical, or psychological trauma in childhood has been proposed as an explanation for its development; awareness, memories, and emotions of harmful actions or events caused by the trauma are sequestered away from consciousness, and alternate parts form with differing memories, emotions, beliefs, temperament, and behavior.[41] Dissociative identity disorder is also attributed to extremes of stress and disturbances of attachment to caregivers in early life. What may result in complex post-traumatic stress disorder (C-PTSD) in adults may become dissociative identity disorder when occurring in children, possibly due to their greater use of imagination as a form of coping as well as lack of developmental integration in childhood.[27] Possibly due to developmental changes and a more coherent sense of self past age 6-9 years, the experience of extreme trauma may result in different, though also complex, dissociative symptoms, identity disturbances and trauma-related disorders.[27] Relationships between childhood abuse, disorganized attachment, and lack of social support are thought to be common risk factors leading to dissociative identity disorder.[23] Although the role of a child's biological capacity to dissociate remains unclear, some evidence indicates a neurobiological impact of developmental stress. Moreover, the personalities of children are universally born unintegrated, and the various aspects of a child's undeveloped personality gradually integrate as the child's brain grows and develops.[14] Delinking early trauma from the etiology of dissociation has been explicitly rejected by those supporting the early trauma model. However, a 2012 review article supports the hypothesis that current or recent trauma may affect an individual's assessment of the more distant past, changing the experience of the past and resulting in dissociative states.[42] Giesbrecht et al. have suggested there is no actual empirical evidence linking early trauma to dissociation, and instead suggest that problems with neuropsychological functioning, such as increased distractibility in response to certain emotions and contexts, account for dissociative features.[43] A middle position hypothesizes that trauma, in some situations, alters neuronal mechanisms related to memory. Evidence is increasing that dissociative disorders are related both to a trauma history and to "specific neural mechanisms".[27] It has also been suggested that there may be a genuine but more modest link between trauma and dissociative identity disorder, with early trauma causing increased fantasy-proneness, which may in turn render individuals more vulnerable to socio-cognitive influences surrounding the development of dissociative identity disorder.[44] Joel Paris states that the trauma model of dissociative identity disorder increased the appeal of the diagnosis among health care providers, patients and the public as it validated the idea that child abuse had lifelong, serious effects. Paris asserts that there is very little experimental evidence supporting the trauma-dissociation hypothesis, and no research showing that dissociation consistently links to long-term memory disruption.[45] Symptoms of dissociative identity disorder may be created by therapists using techniques to "recover" memories (such as the use of hypnosis to "access" alter identities, facilitate age regression or retrieve memories) on suggestible individuals.[6][7][26][46][47] Referred to as the non-trauma-related model, or the sociocognitive model or fantasy model, it proposes that dissociative identity disorder is due to a person consciously or unconsciously behaving in certain ways promoted by cultural stereotypes,[46] with unwitting therapists providing cues through improper therapeutic techniques. This model posits that behavior is enhanced by media portrayals of dissociative identity disorder.[44] One example of the disorder in media portrayals, that supports this theory, is in purportedly true books and films in the 20th century; Sybil became the basis for many elements of the diagnosis, but it was later found to be fictionalized.[5] Proponents of the non-trauma-related model note that the dissociative symptoms are rarely present before intensive therapy by specialists in the treatment of dissociative identity disorder who, through the process of eliciting, conversing with, and identifying alters, shape or possibly create the diagnosis.[48] While proponents note that dissociative identity disorder is accompanied by genuine suffering and the distressing symptoms, and can be diagnosed reliably using the DSM criteria, they are skeptical of the trauma-related etiology suggested by proponents of the trauma-related model.[49] Proponents of non-trauma-related dissociative identity disorder are concerned about the possibility of hypnotizability, suggestibility, frequent fantasization and mental absorption predisposing individuals to dissociation.[16] They note that a small subset of doctors are responsible for diagnosing the majority of individuals with dissociative identity disorder.[50][7][45] Psychologist Nicholas Spanos and others have suggested that, besides cases caused by therapy, dissociative identity disorder might result from role-playing. However, others disagree, arguing that there is no strong incentive for people to fabricate or maintain separate identities. They also cite reported histories of abuse as evidence.[51] Other arguments that therapy can cause dissociative identity disorder include the lack of children diagnosed with DID, the sudden spike in rates of diagnosis after 1980 (although dissociative identity disorder was not a diagnosis until DSM-IV, published in 1994), the absence of evidence of increased rates of child abuse, the appearance of the disorder almost exclusively in individuals undergoing psychotherapy, particularly involving hypnosis, the presences of bizarre alternate identities (such as those claiming to be animals or mythological creatures) and an increase in the number of alternate identities over time[44][7] (as well as an initial increase in their number as psychotherapy begins in DID-oriented therapy[44]). These various cultural and therapeutic causes occur within a context of pre-existing psychopathology, notably borderline personality disorder, which is commonly comorbid with dissociative identity disorder.[44] In addition, presentations can vary across cultures, such as Indian patients who only switch alters after a period of sleep, which is commonly how dissociative identity disorder is presented by the media within that country.[44] Proponents of non-trauma-related dissociative identity disorder state that the disorder is strongly linked to (possibly suggestive) psychotherapy, often involving recovered memories (memories that the person previously had amnesia for) or false memories, and that such therapy could cause additional identities. Such memories could be used to make an allegation of child sexual abuse. There is little agreement between those who see therapy as a cause and trauma as a cause.[52] Supporters of therapy as a cause of dissociative identity disorder suggest that a small number of clinicians diagnosing a disproportionate number of cases would provide evidence for their position[46] though it has also been claimed that higher rates of diagnosis in specific countries like the United States may be due to greater awareness of DID. Lower rates in other countries may be due to artificially low recognition of the diagnosis.[26] However, false memory syndrome per se is not regarded by mental health experts as a valid diagnosis,[53] and has been described as "a non-psychological term originated by a private foundation whose stated purpose is to support accused parents,"[54] and critics argue that the concept has no empirical support, and further describe the False Memory Syndrome Foundation as an advocacy group that has distorted and misrepresented memory research.[55][56] A review of recent research into DID found not one empirical study into the sociocognitive model in the 2011-2021 period, identifying the model as "a source of unresolved criticism of the trauma model", not an empirical hypothesis in its own right. Some major skeptics of trauma-related DID have in recent years abandoned single-cause models of the disorder, arguing for an end to the controversy as no such model can provide a "complete or fully satisfactory account" of DID.[10] As part of their "trans-theoretical" model Lynn et al. suggested that trauma may be more important than sociocognitive factors in clinical cases.[20] The rarity of DID diagnoses in children is cited as a reason to doubt the validity of the disorder,[7][46] and proponents of both etiologies believe that the discovery of dissociative identity disorder in a child who had never undergone treatment would critically undermine the non-trauma related model. Conversely, if children are found to develop dissociative identity disorder only after undergoing treatment it would challenge the trauma-related model.[46] As of 2011[update], approximately 250 cases of dissociative identity disorder in children have been identified, though the data does not offer unequivocal support for either theory. While children have been diagnosed with dissociative identity disorder before therapy, several were presented to clinicians by parents who were themselves diagnosed with dissociative identity disorder; others were influenced by the appearance of dissociative identity disorder in popular culture or due to a diagnosis of psychosis due to hearing voices – a symptom also found in dissociative identity disorder. No studies have looked for children with dissociative identity disorder in the general population, and the single study that attempted to look for children with dissociative identity disorder not already in therapy did so by examining siblings of those already in therapy for dissociative identity disorder. An analysis of the diagnosis of children reported in scientific publications, 44 case studies of single patients were found to be evenly distributed (i.e., each case study was reported by a different author), but in articles regarding groups of patients, four researchers were responsible for the majority of the reports.[46] The initial theoretical description of dissociative identity disorder was that dissociative symptoms were a means of coping with extreme stress (particularly childhood sexual and physical abuse), but this belief has been challenged by the data of multiple research studies.[44] Proponents of the trauma-related model claim the high correlation of child sexual and physical abuse reported by adults with dissociative identity disorder corroborates the link between trauma and dissociative identity disorder.[19][44] However, the link between dissociative identity disorder and maltreatment has been questioned for several reasons. The studies reporting the links often rely on self-report rather than independent corroborations, and these results may be worsened by selection and referral bias.[19][44] Most studies of trauma and dissociation are cross-sectional rather than longitudinal, which means researchers can not attribute causation, and studies avoiding recall bias have failed to corroborate such a causal link.[19][44] In addition, studies rarely control for the many disorders comorbid with dissociative identity disorder, or family maladjustment (which is itself highly correlated with dissociative identity disorder).[19][44] The popular association of dissociative identity disorder with childhood abuse is relatively recent, occurring only after the publication of Sybil in 1973. Most previous examples of "multiples" such as Chris Costner Sizemore, whose life was depicted in the book and film The Three Faces of Eve, reported no memory of childhood trauma.[49] Despite research on DID including structural and functional magnetic resonance imaging, positron emission computed tomography, single-photon emission computed tomography, event-related potentials, and electroencephalography, no convergent neuroimaging findings have been identified regarding DID, with the exception of smaller hippocampal volume in DID patients. In addition, many of the studies that do exist were performed from an explicitly trauma-based position. There is no research to date regarding the neuroimaging and introduction of false memories in DID patients.[52] or support for amnesia between alters.[52][22] DID patients also appear to show deficiencies in tests of conscious control of attention and memorization (which also showed signs of compartmentalization for implicit memory between alters but no such compartmentalization for verbal memory) and increased and persistent vigilance and startle responses to sound. DID patients may also demonstrate altered neuroanatomy.[23] The fifth, revised edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) diagnoses DID according to the diagnostic criteria found under code 300.14 (dissociative disorders). DID is often initially misdiagnosed because clinicians receive little training about dissociative disorders or DID, and often use standard diagnostic interviews that do not include questions about trauma, dissociation, or post-traumatic symptoms.[15](p 118) This contributes to difficulties diagnosing the disorder, and to clinician bias.[15] DID is rarely diagnosed in children.[7] The criteria require that an individual be recurrently controlled by two or more discrete identities or personality states, accompanied by memory lapses for important information that is not caused by alcohol, drugs or medications and other medical conditions such as complex partial seizures.[1] In children, the symptoms must not be better explained by "imaginary playmates or other fantasy play".[1] Diagnosis is normally performed by a clinically trained mental health professional such as a psychiatrist or psychologist through clinical evaluation, interviews with family and friends, and consideration of other ancillary material. Specially designed interviews (such as the SCID-D) and personality assessment tools may be used in the evaluation as well.[30] Since most of the symptoms depend on self-report and are not concrete and observable, there is a degree of subjectivity in making the diagnosis.[22] People are often disinclined to seek treatment, especially since their symptoms may not be taken seriously; thus dissociative disorders have been referred to as "diseases of hiddenness".[16][57] The diagnosis has been criticized by supporters of therapy as a cause or the sociocognitive hypothesis as they believe it is a culture-bound and often health care-induced condition.[19][7][6] The social cues involved in diagnosis may be instrumental in shaping patient behavior or attribution, such that symptoms within one context may be linked to DID, while in another time or place the diagnosis could have been something other than DID.[45] Other researchers disagree and argue that the existence of the condition and its inclusion in the DSM is supported by multiple lines of reliable evidence, with diagnostic criteria allowing it to be clearly discriminated from conditions it is often mistaken for (schizophrenia, borderline personality disorder, and seizure disorder).[26] That a large proportion of cases are diagnosed by specific health care providers, and that symptoms have been created in nonclinical research subjects given appropriate cueing has been suggested as evidence that a small number of clinicians who specialize in DID are responsible for the creation of alters through therapy.[19] Patients with DID are diagnosed with 5-7 comorbid disorders on average, higher than other mental conditions. Misdiagnoses (e.g., schizophrenia, bipolar disorder) are very common among patients with DID.[23] Due to overlapping symptoms, the differential diagnosis includes schizophrenia, normal and rapid-cycling bipolar disorder, epilepsy, borderline personality disorder, and autism spectrum disorder.[58] Delusions or auditory hallucinations can be mistaken for speech by other personalities.[27] Persistence and consistency of identities and behavior, amnesia, measures of dissociation or hypnotizability and reports from family members or other associates indicating a history of such changes can help distinguish DID from other conditions. A diagnosis of DID takes precedence over any other dissociative disorders. Distinguishing DID from malingering is a concern when financial or legal gains are an issue, and factitious disorder may also be considered if the person has a history of help or attention-seeking. Individuals who state that their symptoms are due to external spirits or entities entering their bodies are generally diagnosed with dissociative disorder not otherwise specified rather than DID due to the lack of identities or personality states.[25] Most individuals who enter an emergency department and are unaware of their names are generally in a psychotic state. Although auditory hallucinations are common in DID, complex visual hallucinations may also occur.[23] Those with DID generally have adequate reality testing. People with DID may have more positive and fewer negative Schneiderian symptoms of schizophrenia.[59] The DID persona perceives any voices heard as coming from inside their heads whereas the schizophrenia persona perceives voices as external.[19] In addition, individuals with psychosis are much less susceptible to hypnosis than those with DID.[27] Difficulties in differential diagnosis are increased in children.[46] DID must be distinguished from, or determined if comorbid with, a variety of disorders including mood disorders, psychosis, anxiety disorders, PTSD, personality disorders, cognitive disorders, neurological disorders, epilepsy, somatoform disorder, factitious disorder, malingering, other dissociative disorders, and trance states.[60] An additional aspect of the controversy of diagnosis is that there are many forms of dissociation and memory lapses, which can be common in both stressful and nonstressful situations and can be attributed to much less controversial diagnoses.[45] A relationship between DID and borderline personality disorder has been posited, with various clinicians noting overlap between symptoms and behaviors and it has been suggested that some cases of DID may arise "from a substrate of borderline traits". Reviews of DID patients and their medical records concluded that 30-70% of those diagnosed with DID have comorbid borderline personality disorder.[23] The DSM-5 elaborates on cultural background as an influence for some presentations of DID.[1](p 295) 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 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 their surrounding family, social, or work milieu; and is manifested at times and in places that violate the norms of the culture or religion. DID is among the most controversial of the dissociative disorders and among the most controversial disorders found in the DSM-5-TR.[61][19][36] The primary dispute is between those who believe DID is caused by traumatic stresses that split the mind into multiple identities, each with a separate set of memories,[62][22] and those who believe that the symptoms of DID are produced artificially by certain psychotherapeutic practices or patients playing a role they believe appropriate for a person with DID.[47][6][16][63][59] The debate between the two positions is characterized by intense disagreement.[52][47][7][6][63][59] Research has been characterized by poor methodology.[62] Psychiatrist Joel Paris asserts that the idea that a personality is capable of splitting into independent alters is an unproven assertion at odds with research in cognitive psychology,[45] while David Gleaves argues that recognition of DID was in fact prompted by developments in that field, including theories of parallel-distributed processing.[64] Some people, such as Russell A. Powell and Travis L. Gee, believe that DID is caused by health care, i.e. symptoms of DID are created by therapists themselves via hypnosis. This implies that those with DID are especially susceptible to manipulation by hypnosis and suggestion.[65] The iatrogenic model also sometimes states that treatment for DID is harmful. According to Brand, Loewenstein, and Spiegel, "claims that DID treatment is harmful are based on anecdotal cases, opinion pieces, reports of damage that are not substantiated in the scientific literature, misrepresentations of the data, and misunderstandings about DID treatment and the phenomenology of DID". Their claim is evidenced by the fact that only 5%–10% of people receiving treatment initially worsen in their symptoms.[17] Psychiatrists August Piper and Harold Merskey have challenged the trauma hypothesis, arguing that correlation does not imply causation—that people with DID report childhood trauma does not mean trauma causes DID—and point to the rarity of the diagnosis before 1980 as well as a failure to find DID as an outcome in longitudinal studies of traumatized children. They assert that DID cannot be accurately diagnosed because of vague and unclear diagnostic criteria in the DSM and undefined concepts such as "personality state" and "identities", and question the evidence for childhood abuse beyond self-reports, the lack of a defined threshold of abuse sufficient to induce DID, and the extremely small number of cases of children diagnosed with DID despite an average age of appearance of the first alter of three years.[7] Psychiatrist Colin Ross disagrees with Piper and Merskey's conclusion that DID cannot be accurately diagnosed, pointing to internal consistency between different structured dissociative disorder interviews (including the Dissociative Experiences Scale, Dissociative Disorders Interview Schedule, and Structured Clinical Interview for Dissociative Disorders)[22] in the internal validity range of widely accepted mental illnesses such as schizophrenia and major depressive disorder. In his opinion, Piper and Merskey set the standard of proof higher than it is for other diagnoses. He also asserts that Piper and Merskey have cherry-picked data and not incorporated all relevant scientific literature, such as independent corroborating evidence of trauma.[66] Proponents of the sociogenic model dispute that dissociative identity disorder is an organic response to trauma, but believe it is a socially constructed behavior and psychic contagion. Paul R. McHugh says that the disorder is "sustained in large part by the attention that doctors tend to pay to it. This means that it is not a mental condition that derives from nature, such as panic anxiety or major depression. It exists in the world as an artificial product of human devising". McHugh believed that proponents of dissociative identity disorder inadvertently worsen the patient's condition by validating the behavior and providing attention.[67] According to McHugh, at Johns Hopkins Hospital doctors should ignore the displays from "alters", and instead focus on treatment for other psychiatric problems patients present with. This method of treatment is reportedly successful:[68] What surprises many people is that multiple personalities tend to fall away quickly when ignored. Usually on our anorexia nervosa floor, patients who entered with MPD [multiple personality disorder] cease discussing their alters within a few days and often report that after a week or two of recovering their body weight and attending group therapy tied to their eating disorder, the ideas and preoccupations with their "alters" gradually vanished from their thinking. According to a 2014 review, such views are based on anecdotal or non-peer-reviewed findings. In controlled studies, non-specialised treatment that did not address dissociative self-states did not substantially improve DID symptoms, though there may be improvement in patients' other conditions.[17] The International Society for the Study of Trauma and Dissociation, proponents of the trauma model, have published guidelines for phase-oriented treatment in adults as well as children and adolescents that are widely used successfully in the field of DID treatment.[31][15] The guidelines state that "a desirable treatment outcome is a workable form of integration or harmony among alternate identities". Some experts in treating people with DID use the techniques recommended in the 2011 treatment guidelines.[31] The empirical research includes the longitudinal TOP DD treatment study, which found that patients showed "statistically significant reductions in dissociation, PTSD, distress, depression, hospitalisations, suicide attempts, self-harm, dangerous behaviours, drug use, and physical pain" and improved overall functioning.[31] Treatment effects have been studied for over thirty years, with some studies having a follow-up of ten years.[31] Adult and child treatment guidelines exist that suggest a three-phased approach.[15] Common treatment methods include an eclectic mix of psychotherapy techniques, including cognitive behavioral therapy (CBT),[15][23] insight-oriented therapy,[22] dialectical behavioral therapy (DBT), hypnotherapy, and eye movement desensitization and reprocessing (EMDR).[69] Hypnosis should be carefully considered when choosing both treatment and provider practitioners because of its dangers. For example, hypnosis can sometimes lead to false memories and false accusations of abuse by family, loved ones, friends, providers, and community members. Those who suffer from dissociative identity disorder have commonly been subject to actual abuse (sexual, physical, emotional, financial) by therapists, family, friends, loved ones, and community members.[70] Brief treatment due to managed care may be difficult,

as individuals diagnosed with DID may have unusual difficulties in trusting a therapist and take a prolonged period to form a comfortable therapeutic alliance.[15] Regular contact (at least weekly) is recommended, and treatment generally lasts years, not weeks or months.[23] Sleep hygiene has been suggested as a treatment option, but has not been tested. In general, there are very few clinical trials on the treatment of DID, none of which were randomized controlled trials.[44] Therapy for DID is generally phase-oriented.[31] Different alters may appear based on their greater ability to deal with specific situational stresses or threats. While some patients may initially present with a large number of alters, this number may reduce during treatment, though it is considered important for the therapist to become familiar with at least the more prominent personality states, as the "host" personality may not be the "true" identity of the patient. Specific alters may react negatively to therapy, fearing that the therapist's goal is to eliminate the alter (particularly those associated with illegal or violent activities). A more realistic and appropriate goal of treatment is to integrate adaptive responses to abuse, injury, or other threats into the overall personality structure.[23] The first phase of therapy focuses on symptoms and relieving the distressing aspects of the condition, ensuring the safety of the individual, improving the patient's capacity to form and maintain healthy relationships, and improving general daily life functioning. Comorbid disorders such as substance use disorder and eating disorders are addressed in this phase of treatment.[15] The second phase focuses on stepwise exposure to traumatic memories and prevention of re-dissociation. The final phase focuses on reconnecting the identities of disparate alters into a single functioning identity with all its memories and experiences intact.[15] Little is known about prognosis of untreated DID.[60] Symptoms commonly wax and wane over time.[3] Patients with mainly dissociative and post-traumatic symptoms face a better prognosis than those with comorbid disorders or those still in contact with abusers, and the latter groups often face a lengthier and more difficult treatment course. Suicidal ideation, suicide attempts, and self-harm are common in the DID population.[3] Duration of treatment can vary depending on patient goals, which can range from merely improving inter-alter communication and cooperation, to reducing inter-alter amnesia, to integration and fusion of all alters, but this last goal generally takes years, with trained and experienced psychotherapists.[3] According to the American Psychiatric Association, the 12-month prevalence of DID among adults in the US is 1.5%, with similar prevalence between women and men.[71] Population prevalence estimates have been described to widely vary, with some estimates of DID in inpatient settings suggesting 1-9.6%."[19] Reported rates in the community vary from 1% to 3% with higher rates among psychiatric patients.[15][26] As of 2017, evidence suggested a prevalence of DID of 2–5% among psychiatric inpatients, 2–3% among outpatients, and 1% in the general population.[14] As of 2012, DID was diagnosed 5 to 9 times more commonly in women than men during young adulthood, although this may have been due to selection bias, as men meeting DID diagnostic criteria were suspected to end up in the criminal justice system rather than hospitals.[19] DID diagnoses are extremely rare in children; much of the research on childhood DID occurred in the 1980s and 1990s and does not address ongoing controversies surrounding the diagnosis.[46] DID occurs more commonly in young adults[72] and declines in prevalence with age.[73] There is a poor awareness of DID in the clinical settings and the general public. Poor clinical education (or lack thereof) for DID and other dissociative disorders has been described in literature: "most clinicians have been taught (or assume) that DID is a rare disorder with a florid, dramatic presentation."[15][61] Symptoms in patients are often not easily visible, which complicates diagnosis.[15] DID has a high correlation with, and has been described as a form of, complex post-traumatic stress disorder.[74] There is a significant overlap of symptoms between borderline personality disorder and DID.[75] Rates of diagnosed DID were increasing in the late 20th century, reaching a peak of diagnoses at approximately 40,000 cases by the end of the 20th century, up from less than 200 diagnoses before 1970.[28][19] Initially, DID, along with the rest of the dissociative disorders were considered the rarest of psychological conditions, diagnosed in fewer than 100 by 1944, with only one further case reported in the next two decades.[22] In the late 1970s and '80s, the number of diagnoses rose sharply.[22] An estimate from the 1980s placed the incidence at 0.01%.[28] Accompanying this rise was an increase in the number of alters, rising from only the primary and one alter personality in most cases, to an average of 13 in the mid-1980s (the increase in both number of cases and number of alters within each case are both factors in professional skepticism regarding the diagnosis).[22] Others explain the increase as being due to the use of inappropriate therapeutic techniques in highly suggestible individuals, though this is itself controversial[47][63] while proponents of DID claim the increase in incidence is due to increased recognition of and ability to recognize the disorder.[19] A 1996 essay suggested three possible causes for the sudden increase of DID diagnoses, among which the author suspects the first being most likely:[76] The result of therapist suggestions to suggestible people, much as Charcot's hysterics acted per his expectations. Psychiatrists' past failure to recognize dissociation is being redressed by new training and knowledge. Dissociative phenomena are actually increasing, but this increase only represents a new form of an old and protean entity: "hysteria". Dissociative disorders were excluded from the Epidemiological Catchment Area Project.[77] DID continues to be considered a controversial diagnosis; it was once regarded as a phenomenon confined to North America, though studies have since been published from DID populations across 6 continents.[6][78] Although research has appeared discussing the appearance of DID in other countries and cultures[79] and the condition has been described in non-English speaking nations and non-Western cultures, these reports all occur in English-language journals authored by international researchers who cite Western scientific literature.[46] A paper published in 2022 in the journal Comprehensive Psychiatry described how prolonged social media use, especially on video-sharing platforms including TikTok, has exposed young people, largely adolescent females, a core user group of TikTok, to a growing number of content creators making videos about their self-diagnosed disorders. "An increasing number of reports from the US, UK, Germany, Canada, and Australia have noted an increase in functional tic-like behaviors before and during the COVID-19 pandemic, coinciding with an increase in social media content related to[...]dissociative identity disorder." Authors noted that such cases of self-diagnosed DID (amongst other conditions) often differ from clinically defined symptoms of the disorder, creating the possibility of malingering, and potential negative impacts on those with clinically diagnosed DID seeking integrative therapy. The paper concluded that there "is an urgent need for focused empirical research investigation into this concerning phenomenon that is related to the broader research and discourse examining social media influences on mental health".[80][81][82][83] One of ten photogravure portraits of Louis Vivet published in Variations de la personnalité by Henri Bourru and Prosper Ferdinand Burot In the 19th century, dédoublement, or "double consciousness", the historical precursor to DID, was frequently described as a state of sleepwalking, with scholars hypothesizing that the patients were switching between a normal consciousness and a "somnambulistic state".[35] An intense interest in spiritualism, parapsychology and hypnosis continued throughout the 19th and early 20th centuries,[78] running in parallel with John Locke's views that there was an association of ideas requiring the coexistence of feelings with awareness of the feelings.[84] Hypnosis, which was pioneered in the late 18th century by Franz Mesmer and Armand-Marie Jacques de Chastenet, Marques de Puységur, challenged Locke's association of ideas. Hypnotists reported what they thought were second personalities emerging during hypnosis and wondered how two minds could coexist.[78] The plaque on the former house of Pierre Marie Félix Janet (1859–1947), the philosopher and psychologist who first alleged a connection between events in the subject's past and present mental health, also coining the words "dissociation" and "subconscious" In the 19th century, there were several reported cases of multiple personalities, which Rieber[84] estimated would be close to 100. Epilepsy was seen as a factor in some cases,[84] and discussion of this connection continues into the present era.[85][86] By the late 19th century, there was a general acceptance that emotionally traumatic experiences could cause long-term disorders that might display a variety of symptoms.[87] These conversion disorders were found to occur in even the most resilient individuals, but with profound effect in someone with emotional instability like Louis Vivet (1863–?), who had a traumatic experience as a 17-year-old when he encountered a viper. Vivet was the subject of countless medical papers and became the most studied case of dissociation in the 19th century. Between 1880 and 1920, various international medical conferences devoted time to sessions on dissociation.[88] It was in this climate that Jean-Martin Charcot introduced his ideas of the impact of nervous shocks as a cause for a variety of neurological conditions. One of Charcot's students, Pierre Janet, took these ideas and went on to develop his own theories of dissociation.[89] One of the first individuals diagnosed with multiple personalities to be scientifically studied was Clara Norton Fowler, under the pseudonym Christine Beauchamp; American neurologist Morton Prince studied Fowler between 1898 and 1904, describing her case study in his 1906 monograph, Dissociation of a Personality.[89][90] In the early 20th century, interest in dissociation and multiple personalities waned for several reasons. After Charcot died in 1893, many of his so-called hysterical patients were exposed as frauds, and Janet's association with Charcot tarnished his theories of dissociation.[78] Sigmund Freud recanted his earlier emphasis on dissociation and childhood trauma.[78] In 1908, Eugen Bleuler introduced the term "schizophrenia" to represent a revised disease concept for Emil Kraepelin's dementia praecox.[91] Whereas Kraepelin's natural disease entity was anchored in the metaphor of progressive deterioration and mental weakness and defect, Bleuler offered a reinterpretation based on dissociation or "splitting" (Spaltung) and widely broadened the inclusion criteria for the diagnosis. A review of the Index medicus from 1903 through 1978 showed a dramatic decline in the number of reports of multiple personality after the diagnosis of schizophrenia became popular, especially in the United States.[92] The rise of the broad diagnostic category of dementia praecox has also been posited in the disappearance of "hysteria" (the usual diagnostic designation for cases of multiple personalities) by 1910.[93] Several factors helped create a large climate of skepticism and disbelief; paralleling the increased suspicion of DID was the decline of interest in dissociation as a laboratory and clinical phenomenon.[88] Starting in about 1927, there was a large increase in the number of reported cases of schizophrenia, which was matched by an equally large decrease in the number of multiple personality reports.[88] With the rise of a uniquely American reframing of dementia praecox/schizophrenia as a functional disorder or "reaction" to psychobiological stressors – a theory first put forth by Adolf Meyer in 1906—many trauma-induced conditions associated with dissociation, including "shell shock" or "war neuroses" during World War I, were subsumed under these diagnoses.[91] It was argued in the 1980s that DID patients were often misdiagnosed with schizophrenia.[88] The public, however, was exposed to psychological ideas that took their interest. Mary Shelley's Frankenstein, Robert Louis Stevenson's Strange Case of Dr Jekyll and Mr Hyde, and many short stories by Edgar Allan Poe had a formidable impact.[84] In 1957, with the publication of the bestselling book The Three Faces of Eve by psychiatrists Corbett H. Thigpen and Hervey M. Cleckley, based on a case study of their patient Chris Costner Sizemore, and the subsequent popular movie of the same name, the American public's interest in multiple personality was revived. More cases of dissociative identity disorder were diagnosed in the following years.[94] The cause of the sudden increase of cases is indefinite, but it may be attributed to the increased awareness, which revealed previously undiagnosed cases or new cases may have been induced by the influence of the media on the behavior of individuals and the judgement of therapists.[94] During the 1970s, an initially small number of clinicians campaigned to have it considered a legitimate diagnosis.[88] The DSM-II used the term hysterical neurosis, dissociative type. It described the possible occurrence of alterations in the patient's state of consciousness or identity, and included the symptoms of "amnesia, somnambulism, fugue, and multiple personality".[95] The DSM-III grouped the diagnosis with the other four major dissociative disorders using the term "multiple personality disorder". The DSM-IV made more changes to DID than any other dissociative disorder,[26] and renamed it DID.[25] The name was changed for two reasons: First, the change emphasizes the main problem is not a multitude of personalities, but rather a lack of a single, unified identity[26] and an emphasis on "the identities as centers of information processing".[27] Second, the term "personality" is used to refer to "characteristic patterns of thoughts, feelings, moods, and behaviors of the whole individual", while for a patient with DID, the switches between identities and behavior patterns is the personality.[26] It is, for this reason, the DSM-IV-TR referred to "distinct identities or personality states" instead of personalities. The diagnostic criteria also changed to indicate that while the patient may name and personalize alters, they lack independent, objective existence.[26] The changes also included the addition of amnesia as a symptom, which was not included in the DSM-III-R because despite being a core symptom of the condition, patients may experience "amnesia for the amnesia" and fail to report it.[27] Amnesia was replaced when it became clear that the risk of false negative diagnoses was low because amnesia was central to DID.[26] The ICD-10 places the diagnosis in the category of "dissociative disorders", within the subcategory of "other dissociative (conversion) disorders", but continues to list the condition as multiple personality disorder.[96] The DSM-IV-TR criteria for DID have been criticized for failing to capture the clinical complexity of DID, lacking usefulness in diagnosing individuals with DID (for instance, by focusing on the two least frequent and most subtle symptoms of DID) producing a high rate of false negatives and an excessive number of DDNOS diagnoses, for excluding possession (seen as a cross-cultural form of DID), and for including only two "core" symptoms of DID (amnesia and self-alteration) while failing to discuss hallucinations, trance-like states, somatoform, depersonalization, and derealization symptoms. Arguments have been made for allowing diagnosis through the presence of some, but not all of the characteristics of DID rather than the current exclusive focus on the two least common and noticeable features.[27] The DSM-IV-TR criteria have also been criticized[97] for being tautological, using imprecise and undefined language and for the use of instruments that give a false sense of validity and empirical certainty to the diagnosis. The DSM-5 updated the definition of DID in 2013, summarizing the changes as:[98] Several changes to the criteria for dissociative identity disorder have been made in DSM-5. First, Criterion A has been expanded to include certain possession-form phenomena and functional neurological symptoms to account for more diverse presentations of the disorder. Second, Criterion A now specifically states that transitions in identity may be observable by others or self-reported. Third, according to Criterion B, individuals with dissociative identity disorder may have recurrent gaps in recall for everyday events, not just for traumatic experiences. Other text modifications clarify the nature and course of identity disruptions. Between 1968 and 1980, the term that was used for dissociative identity disorder was "Hysterical neurosis, dissociative type". The APA wrote in the second edition of the DSM: "In the dissociative type, alterations may occur in the patient's state of consciousness or in his identity, to produce such symptoms as amnesia, somnambulism, fugue, and multiple personality."[95] The number of cases sharply increased in the late 1970s and throughout the 80s, and the first scholarly monographs on the topic appeared in 1986.[22] In 1974, the highly influential book Sybil was published, and later made into a miniseries in 1976 and again in 2007. Describing what Robert Rieber called "the third most famous of multiple personality cases,"[99] it presented a detailed discussion of the problems of treatment of "Sybil Isabel Dorsett", a pseudonym for Shirley Ardell Mason. Though the book and subsequent films helped popularize the diagnosis and trigger an epidemic of the diagnosis,[45] later analysis of the case suggested different interpretations, ranging from Mason's problems having been caused by the therapeutic methods and sodium pentathol injections used by her psychiatrist, C. B. Wilbur, or an inadvertent hoax due in part to the lucrative publishing rights,[99][100] though this conclusion has itself been challenged.[101] David Spiegel, a Stanford psychiatrist whose father treated Shirley Ardell Mason on occasion, says that his father described Mason as "a brilliant hysteric. He felt that Wilbur tended to pressure her to exaggerate on the dissociation she already had."[102] [better source needed] As media attention on DID increased, so too did the controversy surrounding the diagnosis.[103] The DSM-III intentionally omitted the terms "hysteria" and "neurosis", naming those as Dissociative Disorders, which included Multiple Personality Disorder,[104] and also added Post-traumatic Stress Disorder in Anxiety Disorders section. In the opinion of McGill University psychiatrist Joel Paris, this inadvertently legitimized them by forcing textbooks, which mimicked the structure of the DSM, to include a separate chapter on them, and increased the diagnosis of dissociative conditions. Once a rarely occurring spontaneous phenomenon (research in 1944 showed only 76 cases),[105] the diagnosis became "an artifact of bad (or naïve) psychotherapy" as patients capable of dissociating were accidentally encouraged to express their symptoms by "overly fascinated" therapists.[106] "Interpersonality amnesia" was removed as a diagnostic feature from the DSM-III in 1987, which may have contributed to the increasing frequency of the diagnosis.[22] There were 200 reported cases of DID as of 1980, and 20,000 from 1980 to 1990.[107] Joan Acocella reports that 40,000 cases were diagnosed from 1985 to 1995.[108] Scientific publications regarding DID peaked in the mid-1990s, rapidly declined,[9] then has continued on a steady increasing trend since.[10] In 1994, the fourth edition of the DSM replaced the criteria again and changed the name of the condition from "multiple personality disorder" to the current "dissociative identity disorder" to emphasize the importance of changes to consciousness and identity rather than personality. The inclusion of interpersonality amnesia helped to distinguish DID from dissociative disorder not otherwise specified (DDNOS), but the condition retains an inherent subjectivity due to difficulty in defining terms such as personality, identity, ego-state, and even amnesia.[22] The ICD-10 classified DID as a "Dissociative [conversion] disorder" and used the name "multiple personality disorder" with the classification number of F44.81.[96] In the ICD-11, the World Health Organization have classified DID under the name "dissociative identity disorder" (code 6B64), and most cases formerly diagnosed as DDNOS are classified as "partial dissociative identity disorder" (code 6B65).[109] A 2006 study compared scholarly research and publications on DID and dissociative amnesia to other mental health conditions, such as anorexia nervosa, alcohol use disorder, and schizophrenia from 1984 to 2003. The results were found to be unusually distributed, with a very low level of publications in the 1980s followed by a significant rise that peaked in the mid-1990s and subsequently rapidly declined in the decade following. Compared to 25 other diagnoses, the mid-1990s "bubble" of publications regarding DID was unique. In the opinion of the authors of the review, the publication results suggest a period of "fashion" that waned, and that the two diagnoses "presently do not command widespread scientific acceptance."[9] A 2024 review found "steady" continued research after 2011, with 160 academic studies located in the 2011-2021 period, an increase of 60% over the previous decade. Authors previously skeptical of DID have adopted a "trans-theoretical" approach where trauma and social factors are simply two of many potential factors, indicating that "the heat of past DID controversies has diminished some with the rise of multidimensional models of psychopathology".[10] People with dissociative identity disorder may be involved in legal cases as a witness, defendant, or the victim/injured party. Claims of DID have been used only rarely to argue criminal insanity in court.[103][110] In the United States, dissociative identity disorder has previously been found to meet the Frye test as a generally accepted medical condition, and the newer Daubert standard.[111][112] Within legal circles, DID has been described as one of the most disputed psychiatric diagnoses and forensic assessments are needed.[52] For defendants whose defense states they have a diagnosis of DID, courts must distinguish between those who genuinely have DID and those who are malingering to avoid responsibility.[111][52] Expert witnesses are typically used to assess defendants in such cases,[103] although some of the standard assessments like the MMPI-2 were not developed for people with a trauma history and the validity scales may incorrectly suggest malingering.[113] In DID, evidence about the altered states of consciousness, actions of alter identities and episodes of amnesia may be excluded from a court if they are not considered relevant, although different countries and regions have different laws.[103] A diagnosis of DID may be used to claim a defense of not guilty by reason of insanity, but this very rarely succeeds, or of diminished capacity, which may reduce the length of a sentence.[110][112] DID may also affect competency to stand trial.[114] A not guilty by reason of insanity plea was first used successfully in an American court in 1978, in the State of Ohio v. Milligan case.[110] However, a DID diagnosis is not automatically considered a justification for an insanity verdict, and since Milligan the few cases claiming insanity have largely been unsuccessful.[110] Bennett G. Braun was an American psychiatrist known for his promotion of the concept of multiple personality disorder (now called "dissociative identity disorder") and involvement in promoting the "Satanic Panic", a moral panic around a discredited conspiracy theory that led to thousands of people being wrongfully medically treated or investigated for nonexistent crimes.[115][116] The public's long fascination with DID has led to a number of different books and films,[15](p 169) with many representations described as increasing stigma by perpetuating the myth that people with mental illness are usually dangerous.[117] Movies about DID have been also criticized for poor representation of both DID and its treatment, including "greatly overrepresenting" the role of hypnosis in therapy,[118] showing a significantly smaller number of personalities than many people with DID have,[119][118][120] and misrepresenting people with DID as having theatrical and blatant switches between very conspicuous and different alters.[121] Some movies are parodies and ridicule DID, for instance, Me, Myself & Irene, which also incorrectly states that DID is schizophrenia.[122] In some stories, DID is used as a plot device, e.g. in Fight Club, and in whodunnit stories like Secret Window.[123][122] United States of Tara was reported to be the first US television series with DID as its focus, and a professional commentary on each episode was published by the International Society for the Study of Trauma and Dissociation.[124][125] A number of people with DID have publicly spoken about their experiences, including comedian and talk show host Roseanne Barr, who interviewed Truddi Chase, author of When Rabbit Howls; Chris Costner Sizemore, the subject of The Three Faces of Eve, Cameron West, author of First Person Plural: My life as a multiple, and NFL player Herschel Walker, author of Breaking Free: My life with dissociative identity disorder.[119][126] In The Three Faces of Eve (1957) hypnosis is used to identify a childhood trauma which then allows her to fuse from three identities into just one.[118] However, Sizemore's books I'm Eve and A Mind of My Own revealed that this did not last; she later attempted suicide, sought further treatment, and had twenty-two personalities rather than three.[118][120] Sizemore re-entered therapy and by 1974 had achieved a lasting recovery.[118] Voices Within: The Lives of Truddi Chase portrays many of the 92 personalities Chase described in her book When Rabbit Howls, and is unusual in breaking away from the typical ending of integrating into one.[121][122] Frankie & Alice (2010), starring Halle Berry was based on a real person with DID.[123] In popular culture dissociative identity disorder is often confused with schizophrenia,[127] as was true of the 1958 episode "The Case of the Deadly Double" of the Perry Mason TV series, where a woman shown as having two very distinct personas is described as being schizophrenic [128] On the other hand, some movies advertised as representing dissociative identity disorder may be more representative of psychosis or schizophrenia, for example Psycho (1960).[117][123] In his book The C.I.A. Doctors: Human Rights Violations by American Psychiatrists, psychiatrist Colin A. Ross states that based on documents obtained through freedom of information legislation, a psychiatrist linked to Project MKULTRA reported being able to deliberately induce dissociative identity disorder using a variety of highly aversive and abusive techniques, creating a Manchurian Candidate for military purposes.[129][130] In the USA Network television production Mr. Robot, the protagonist Elliot Alderson was created using anecdotal experiences of DID of the show's creator's friends. Sam Esmail said he consulted with a psychologist who "concretized" the character's mental health conditions, especially his plurality.[131] In M. Night Shyamalan's Unbreakable superhero film series (specifically, the films Split and Glass), Kevin Wendell Crumb is diagnosed with DID, and that some of the personalities have super-human powers. Experts and advocates say the films are a negative portrayal of DID, and the films promote the stigmatization of the disorder.[132] In the 1997 Japanese role-playing game Final Fantasy VII, the protagonist Cloud Strife is shown to have an identity disorder involving false memories as a result of post-traumatic stress disorder (PTSD). Sharon Packer has identified Cloud as having DID.[133] In Marvel Comics, the character of Moon Knight is shown to have DID. In the TV series Moon Knight based on the comic book character, protagonist Marc Spector is depicted with DID; the website for the National Alliance on Mental Illness appears in the series' end credits.[134] Main article: Multiplicity (subculture) A DID community exists on social media, including YouTube, Reddit, Discord, and TikTok. In those contexts, the experience of dissociative identities has been called multiplicity.[135] High-profile members of this community have been criticized for faking their condition for views, or for portraying the disorder lightheartedly.[135] Psychologist Naomi Torres-Mackie, head of research at The Mental Health Coalition, has stated "All of a sudden, all of my adolescent patients think that they have this, and they don't ... Folks start attaching clinical meaning and feeling like, 'I should be diagnosed with this. I need medication for this', when actually a lot of these experiences are normative and don't need to be pathologized or treated."[136] Some advocates consider DID to be a form of neurodiversity, leading to advocacy in recognizing 'positive plurality' and the use of plural pronouns such as "we" and "our".[119][137] Advocates also challenge the necessity of integration.[138][139] Timothy Baynes argues that forcing people to undergo it as a treatment is "seriously immoral".[140] A DID Awareness Day takes place on March 5 annually, participants displaying a multicolored awareness ribbon, based on the idea of a "crazy quilt."[141][142] Informational notes ^ Most of the published clinical case series are focused on chronic and complex forms of dissociative disorders. Data collected in diverse geographic locations such as North America [2], Puerto Rico [3], Western Europe [4], Turkey [5], and Australia [6] underline the consistency in clinical symptoms of dissociative disorders. These clinical case series have also documented that dissociative patients report the highest frequencies of childhood psychological trauma among all psychiatric disorders. Childhood sexual (57.1%–90.2%), emotional (57.1%), and physical (62.9%–82.4%) abuse and neglect (62.9%) are among them (2–6). — Sar (2011)[40]:§1, Introduction, p. 1 Citations ^ a b c d e f g h i j k l m n o p American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.). Arlington: American Psychiatric Publishing. pp. 291–298. ISBN 978-0-89042-555-8. ^ Lanius R (June 2015). "Trauma-related dissociation and altered states of consciousness: a call for clinical, treatment, and neuroscience research". Eur J Psychotraumatol. 6: 27905. doi:10.3402/ejpt.v6.27905. PMC 4439425. PMID 25994026. ^ a b c d e f g h i j k "Dissociative identity disorder". MSD Manuals. Psychiatric disorders (Professional ed.). March 2019. Archived from the original on 28 May 2020. 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Dissociative identity disorder (DID), formerly called multiple personality disorder (in previous diagnostic manuals, like the DSM-IV), is a mental illness that involves the sufferer experiencing at least two clear identities or personality states, also called alters, each of which has a fairly consistent way of viewing and relating to the world. Some individuals with DID have been found to have alternate personalities that have distinctly different ways of reacting, in terms of emotions, pulse, blood pressure, and even blood flow to the brain. Health care professionals used to call the disorder multiple personality disorder (MPD), and people often colloquially referred to it as split personality disorder. Statistics regarding this disorder indicate that the incidence of DID is about 1% of all adults (general population) in the United States, from 1%-20% of patients in psychiatric hospitals and is described as occurring in girls equally to boys and up to nine times more often in women compared to men. However, this female preponderance may be due to difficulty identifying the disorder in males. Disagreement among mental health professionals about how this illness appears clinically and controversy about whether DID even exists adds to the difficulty of estimating how often it occurs. Some professionals continue to be of the opinion that DID does not exist. The nature of this skepticism is sometimes due to questions about why many more individuals who have endured the stress of terrible abuse as young children do not develop the disorder, why more children are not diagnosed as having DID, and why some DID sufferers have no history of significant trauma. One explanation for what some believe to be these inconsistencies is that given the highly complex and unknown nature of the human brain and psyche, many of those whom one would expect to develop dissociative identity disorder are spared due to their resilience. Another concern about the diagnosis of DID involves having to rely on the traumatic memories of those who suffer from this disorder. That DID is significantly more often assessed in individuals in North America compared to the rest of the world, for the most part, leads some practitioners to believe that DID is a culture-based concoction rather than a true condition. As with many other mental health issues, symptoms of the same disorder in children look very different from symptoms in adults. Studies that verify the presence of DID using multiple resources add credibility to the diagnosis. Research on individuals with DID that have little to no media exposure to information on the illness lends further credibility to the reliability of the existence of this mental health condition. While there is no proven specific cause of DID, the prevailing psychological theory about how the condition usually develops is as a reaction to severe childhood trauma. Specifically, it is thought that one way that some individuals respond to being severely traumatized as a young child is to wall off altered states of consciousness, in other words to dissociate, those memories. When that reaction becomes extreme, DID may be the result. As with other mental disorders, having a family member with DID may be a risk factor, in that it indicates a potential vulnerability to developing the disorder but does not translate into the condition being literally hereditary. Signs and symptoms of dissociative identity disorder include lapses in memory (dissociation), particularly of significant life events, like birthdays, weddings, or birth of a child; experiencing blackouts in time, resulting in finding oneself in places but not recalling how one got there; being frequently accused of lying when they do not believe they are lying (for example, being told of things they did but do not remember, not related to the influence of any drug or medical condition); finding items in one's possession but not recalling how those things were acquired; encountering people with whom one is unfamiliar but who seem to know them sometimes by another identity; being called names that are completely unlike their own name or nickname; finding items they have clearly written but are in handwriting other than their own; hearing voices inside their head that are not their own; not recognizing themselves in the mirror; feeling unreal (derealization); feeling detached from oneself, like they are watching themselves move through life rather than living their own life (depersonalization); feeling like more than one person. What's Schizophrenia? Symptoms, Types, Causes, Treatment See Slideshow There is no specific definitive test, like a blood test, that can accurately assess that a person has dissociative identity disorder. Therefore, mental health practitioners like psychiatrists, psychoanalysts, or clinical psychologists conduct a mental health interview that gathers information, looking for the presence of the signs and symptoms previously described. Using structured interviews like the Structured Clinical Interview for Dissociative Disorders (SCID-D) is thought to be particularly helpful in distinguishing DID from other mental illnesses. The diagnostic criteria described in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) for dissociative identity disorder are as follows: The presence of two or more distinct identities or personality states (each with its own relatively persistent pattern of perceiving, relating to, and thinking about him or herself and the world) At least two of the identities or personality states repeatedly take control of the person's behavior. An inability to recall important personal information that is too severe to be explained by ordinary forgetfulness The illness is not the result of the direct physiological effects of a substance (for example, blackouts or other abnormal behavior during alcohol or other drug intoxication) or a general medical condition (for example, seizures). In children, imaginary playmates or other fantasy play do not cause the symptoms. Professionals usually gather information about the individual's childhood and ask questions to explore whether the symptoms that the client is suffering from are not better accounted for by another mental health condition, dissociative or otherwise. Other types of dissociative disorders include depersonalization/derealization disorder (feeling detached from themselves or surroundings), dissociative amnesia (memory problems associated with a traumatic experience), other dissociative disorder (episodes of dissociation that do not qualify for one of the specific dissociative disorders just described but the professional determining the diagnosis describes the reason why the criteria for a specific dissociative disorder is not met, as in when a person is in a trance), and unspecified dissociative disorder, formerly called dissociative disorder, not otherwise specified (DD,NOS), which is characterized by episodes of dissociation that do not qualify for one of the specific dissociative disorders just described). As part of the assessment, mental health professionals also usually ask about other mental conditions and ensure that the person has recently received a comprehensive physical examination and any appropriate medical tests so that any physical conditions that may mimic symptoms of DID are identified and addressed. Dissociation, a major symptom of DID, occurs in a number of other mental illnesses. For example, an individual with this disorder may seek to relieve overwhelming trauma-related memories by engaging in the self-mutilation and other forms of self-harm/self-injurious and self-destructive behaviors found in those with borderline personality disorder. Also, feelings and behaviors that may appear to be caused by dissociation, but are not, make it all the more difficult to distinguish DID from other conditions. Somatic symptom disorder, conversion disorder, and schizophrenia are just a few such disorders. Rape and other adult trauma victims are quite vulnerable to developing dissociative symptoms. The controversy about whether DID exists, as well as the overlap of symptoms it has with a number of other conditions, sometimes results in misdiagnosis. Symptoms of some other mental disorders may be mistaken for dissociation. The apparent impulsivity of bipolar disorder or wide mood swings associated with bipolar disorder, borderline personality disorder, or narcissistic personality disorder when triggered by minor slights are examples. People may also confuse the unstable self-image of borderline personality disorder with dissociation. Blackouts related to substance use disorders (formerly described as substance abuse or dependence) are other instances of an individual being unaware of his or her surroundings that mimic dissociation. DID often co-occurs with other emotional conditions, including posttraumatic stress disorder (PTSD), borderline personality disorder (BPD), and a number of other personality disorders, as well as conversion disorder. DID is sometimes feigned by individuals who may be seeking attention, as in Munchausen's syndrome. It has also been appropriately diagnosed as well as feigned in individuals involved in the criminal justice and civil or family court systems (for example, forensic cases). Adding to the diagnostic difficulty is that people like pedophiles and other sex offenders, as well as people with antisocial personality disorder, may legally stand to gain from having DID. While some of those individuals may feign the diagnosis in an effort to benefit legally, others genuinely suffer from significant dissociative symptoms, as well as full-blown DID. In cases where there may be an ulterior motive for being diagnosed with DID, studies show that using a screening test or structured interview may be the best way to determine if the person truly suffers from this condition. Psychotherapy is generally considered the main component of treatment for dissociative identity disorder. In treating individuals with DID, therapists usually use individual, family, and/or group psychotherapy to help clients improve their relationships with others and to experience feelings they have not felt comfortable being in touch with or openly expressing in the past. It is carefully paced in order to prevent the person with DID from becoming overwhelmed by anxiety, risking a figurative repetition of their traumatic past being inflicted by those very strong emotions. Dialectical behavior therapy is a form of cognitive behavior therapy that emphasizes mindfulness and works on helping the DID sufferer soothe him- or herself by decreasing negative responses to stressors. Mental health professionals also often guide clients in finding a way to have each aspect of them coexist, and work together, as well as developing crisis-prevention techniques and finding ways of coping with memory lapses that occur during times of dissociation. The goal of achieving a more peaceful coexistence of the person's multiple personalities is quite different from the reintegration of all those aspects into just one identity state. While reintegration used to be the goal of psychotherapy, it has frequently been found to leave individuals with DID feeling as if the goal of the practitioner is to get rid of, or "kill," parts of them. Hypnosis sometimes helps increase the information that the person with DID has about their symptoms/identity states, thereby increasing the control they have over those states when they change from one personality state to another. This occurs by enhancing the communication that each aspect of the person's identity has with the others. In this age of insurance companies regulating the health care that most Americans receive, having time-limited, multiple periods of psychotherapy rather than intensive long-term care provides what may be another effective treatment option for helping people who are living with DID. Physicians increasingly use eye movement desensitization and reprocessing (EMDR), a type of treatment that integrates traumatic memories with the patient's own resources, in the treatment of people with dissociative identity disorder. It results in enhanced information processing and healing. Medications are often used to address the many other mental health conditions that individuals with DID tend to have, like depression, severe anxiety, anger, and impulse-control problems. However, particular caution is appropriate when treating people with DID with medications because any effects they may experience, good or bad, may cause the sufferer of DID to feel like they are being controlled, and therefore traumatized yet again. As DID is often associated with episodes of severe depression, electroconvulsive therapy (ECT) can be a viable treatment when the combination of psychotherapy and medication does not result in adequate relief of symptoms. As with other mental health conditions, the prognosis for people with DID becomes much less optimistic if not appropriately treated. Individuals with a history of being sexually abused, including those who go on to develop dissociative identity disorder, are vulnerable to abusing alcohol or other substances as a negative way of coping with their victimization. People with DID are also at risk for attempting suicide more than once. Violent behavior has a high level of association with dissociation as well. Other debilitating outcomes of DID, like that of other severe chronic mental illnesses, include inability to obtain and maintain employment, poor relationships with others, and therefore overall lower productivity and quality of life. Research indicates that people with dissociative identity disorder have their best opportunity for living a well-adjusted life if they receive comprehensive treatment for their multiple symptoms. However, differences in how practitioners diagnose and treat this illness make it difficult to quantify or predict outcomes. Given that the origin of dissociative identity disorder in the majority of individuals remains related to exposure to traumatic events, prevention for this disorder primarily involves minimizing the exposure to traumatic events, as well as helping survivors of trauma come to terms with what they have been through in a healthy way. By clicking "Submit," I agree to the MedicineNet Terms and Conditions and Privacy Policy. I also agree to receive emails from MedicineNet and I understand that I may opt out of MedicineNet subscriptions at any time. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR); 2000, Washington,

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The persistence of folly: a critical examination of dissociative identity disorder: Part I. The excesses of an improbable concept. Canadian Journal of Psychiatry; September 2004, 49(9): 592-600. Ramsland, K., Kuter, R. Multiple personalities: crime and defense. Turner Broadcasting System; 2008. Ross, C.A., Keyes, B.B., Yan, H., Wang, Z., Zou, Z., Xu, Y., Chen, J., Zhang, H., Xiao, Z. A cross-cultural test of the trauma model of dissociation. Journal of Trauma Dissociation; 2008, 9(1): 35-49. Sar, V., Akyuz, G., Kundakc, T., Kazaltan, E., Dogan, O. Childhood trauma, dissociation and psychiatric comorbidity in patients with conversion disorder. American Journal of Psychiatry; December 2004, 161: 2271-2276. Sar, V., Kundakci, T., Kiziltan, E., Yargic, I., Tutkun, H., Bakim, B., Bozkurt, O., Ozpulat, T., Keser, V., Ozdemir, O. The axis I dissociative disorder comorbidity of borderline personality disorder among psychiatric outpatients. Journal of Trauma and Dissociation; 2003, 4(1): 119-136. Simone Reinders, A.A.T., Nijenhuis, E.R.S., Quaka, J., Korfa, J., Haaksmab, J., Paans, A.M.J., Willemsen, A.T.M., den Boer, J.A. Psychobiological characteristics of dissociative identity disorder: a symptom provocation study. Biological Psychiatry; October 2006, 60(7): 730-740. Spiegel, D. Recognizing traumatic dissociation. American Journal of Psychiatry; April 2006, 163: 566-568. Spitzer, C., Klauer, T., Grabe, H.J., Lucht, M., Stieglitz, R.D., Schneider, W., Freyberger, H.J. Gender differences in dissociation: a dimensional approach. Psychopathology; 2003, 36(2). Twombly, J.H. "Incorporating EMDR and EMDR Adaptations into the Treatment of Clients with Dissociative Identity Disorder." Journal of Trauma and Dissociation 1.2 (2000): 61-81. van der Kolk, B.A., and O. van der Hart. "Pierre Janet and the Breakdown of Adaptation in Psychological Trauma." American Journal of Psychiatry 146.12 Dec. 1989: 1530-1540. Welburn, K.R., Fraser, G.A., Jordan, S.A., Cameron, C., Webb, L.M., Raine, D. Discriminating dissociative identity disorder from schizophrenia and feigned dissociation on psychological tests and structured interview. Journal of Trauma and Dissociation; 2003, 4(2): 109-130. Dissociative identity disorder (DID) is a psychiatric condition that occurs when a person has multiple identities that function independently. These identities—also called “alters” or “personality states"—have their own consciousness, memories, and even personalities. Researchers estimate that this condition affects approximately 1.5% of the global population. Studies suggest that the leading cause of DID is severe and repetitive childhood trauma. Each alter (identity) often holds different traumatic memories and occasionally displays self-destructive or challenging behaviors. When people with DID switch between their alters, they experience gaps in their memory that can affect their daily functioning. Treatment and support can help those with DID more safely navigate their shifting alters, as well as process different traumatic memories. Healthcare providers often misdiagnose DID—and many people don’t receive a proper diagnosis until later in life. Despite media representation, people with DID are not more prone to violence than the general population, and can live fulfilling lives. While people with DID have a “primary” personality state, they also have different alters that take over their consciousness. The primary personality state is often not aware of the existence of different alters, leading to distressing gaps in memory, impairments in functioning, and a host of other symptoms. Alters have their own identity, memories, behaviors, and even preferences (e.g., favorite foods and clothing items). Most alters often have their own name and can be of different ages and genders. The average number of alters of someone living with DID is 13, but someone can have fewer or much more. Examples of alters include: A small child who cries often, wants to be comforted, and remembers specific traumatic experiences An angry teenager who lashes out and engages in self-destructive behavior A “leader” who holds a central role and is aware of the other alters People with DID involuntarily switch between alters. This switch can happen suddenly and often occurs due to triggers such as stress. Other people may not be able to observe when a switch is happening or has happened. Signs of switching between alters include: Eye blinking or rolling Changes in posture Appearing to be in a trance A person with DID typically has no memory of being in an altered state. These gaps in memory can cause distress and affect functioning, leading to the inability to recall important day-to-day information. Additionally, someone with DID might have large gaps in their childhood memories or have limited memory of the trauma they experienced. Aside from the hallmark symptoms of multiple alters, difficulty functioning, and memory troubles, people with DID can also experience: DID is often the result of severe and repetitive early childhood trauma, including reoccurring physical and sexual abuse. While dissociation (or, the disconnection between one’s body, thoughts, and sense of self) is a common experience for trauma survivors, researchers believe that in people who develop DID, extreme and frequent dissociation causes a breakdown of memory and sense of self. For example, while someone might feel disconnected from their body during a traumatic event to make the experience more tolerable, a child who develops DID takes this survival mechanism a step further, dissociating into different identities (alters) to make their abuse more bearable. It's worth noting that not every person who experiences severe childhood trauma develops DID. According to one theory, these four factors need to be present for someone to develop DID: An ability to dissociateOverwhelming traumatic experiences that distort realityCreation of alters with specific names and identitiesLack of external stability, leading the child to rely on self-soothing Other factors that may increase one's risk of developing DID include: Early onset of trauma (before the age of 5) Abuse at the hands of attachment figures (e.g., parents or guardians) Disorganized attachment style Social isolation Chronic stress On average, people wait five to 12 years before receiving a proper diagnosis. This is partially because diagnosing DID often requires multiple assessments over a long period of time, a detailed personal history from multiple sources (such as friends and family), and medical exams that rule out other possible explanations for the symptoms. Due to gaps in memory, people with DID might have trouble accurately self-reporting their symptoms or recalling their full trauma histories. People with DID often receive a misdiagnosis for other psychiatric conditions like borderline personality disorder and may encounter healthcare providers who are skeptical or ignorant of their condition. To diagnosis DID, there are also several assessment tools a healthcare provider might use, including: Dissociative Experiences Scale (DES)The Dissociation Questionnaire (DIS-Q)The Multidimensional Inventory of Dissociation Dissociative Disorders Interview Schedule (DDIS)Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) The goals of DID treatment can vary from person to person. For some, the purpose of treatment is to integrate their identities and reduce or eliminate the number of alters they're experiencing. For others, the primary treatment goals are to increase cooperation between the alters and improve the person’s overall quality of life. Most mental health professionals who treat DID use a three-phase treatment approach: Establishing safety and stabilization: This phase focuses on managing life-threatening behaviors, like substance use, self-harm, or suicidal behaviors. Mental health providers help a person with DID learn emotional regulation and grounding techniques to aid them in establishing more immediate safety. Confronting and working through traumatic memories: In this phase, a person might work with a provider to process past traumas. This can look like safely accessing traumatic memories by engaging with different alters. Identity integration/cooperation: During this phase, providers focus on a person’s relationship with their “whole” self. The goals of this phase are individualized and depend on the person's needs and interests for healing and recovery. Mental health providers can also use psychotherapy (or, talk therapy) to help someone living with DID manage their symptoms and process traumatic memories. These therapies include: Trauma-focused cognitive behavioral therapy (TF-CBT) Dialectical behavioral therapy (DBT) Eye movement desensitization and reprocessing (EMDR) Most people with DID have experienced repetitive and severe childhood trauma, including physical and sexual abuse, emotional neglect, and a dysfunctional home environment. Considering this, protecting children from child abuse is one way to prevent the development of DID. Early intervention and community support for children who’ve experienced early childhood trauma can also mitigate (or, reduce) the risk of developing DID and other trauma-related disorders. While the causes of child abuse are complicated, some ways to prevent child abuse include: Strengthening economic support for familiesAffordable, high-quality childcareMentoring programs and after-school programsAwareness campaigns about the signs of child abuse DID is a complicated disorder that frequently co-occurs with other health conditions. In general, childhood trauma has been tied to numerous poor health outcomes including substance use, depression, and heart disease. People who develop DID are at risk for developing other conditions related to trauma, including: The prognosis (or, outlook) for people with DID is considered poor without receiving proper treatment. That being said, once someone receives an accurate diagnosis and adequate treatment, they can live fulfilling lives. With the help of a mental health provider, people with DID can attempt to integrate their alters into one, primary identity, or work to create systems that help them safely navigate their shifting alters. For example, this can include strategies for coping with amnesia, like utilizing support systems and writing things down to remember them when their identity switches. Treatment can be intensive and difficult and often involves processing new trauma memories and ongoing safety planning if self-harm or suicidal behaviors are involved. Becoming more familiar with their alters and gaining new information about their past can help people with DID put the pieces of their lives together—and improve their overall functioning and quality of life. Frequently Asked Questions Yes, with proper treatment and support, someone with DID can live a normal life. Unfortunately, it can take 5 to 12 years for someone with DID to receive a proper diagnosis, and treatment is often intensive and long-term. While DID is considered to be a dissociative disorder, borderline personality disorder (BPD) is a personality disorder. Childhood trauma is a contributing factor for both conditions, but people with BPD do not have alters, or “personality states" that act independently of each other. Thanks for your feedback! Reviewed by Psychology Today Staff Dissociative identity disorder, formerly referred to as multiple personality disorder, is characterized by a person's identity fragmenting into two or more distinct personality states. People with this condition are often victims of severe abuse. Dissociative identity disorder (DID) is a rare condition in which two or more distinct identities, or personality states, are present in—and alternately take control of—an individual. Some people describe this as an experience of possession. The person also experiences memory loss that is too extensive to be explained by ordinary forgetfulness. DID was called multiple personality disorder up until 1994 when the name was changed to reflect a better understanding of the condition—namely, that it is characterized by fragmentation or splintering of identity, rather than by proliferation or growth of separate personalities. The symptoms of DID cannot be explained away as the direct psychological effects of a substance or of a general medical condition. DID reflects a failure to integrate various aspects of identity, memory, and consciousness into a single multidimensional self. Usually, a primary identity carries the individual's given name and is passive, dependent, guilty, and depressed. When in control, each personality state, or alter, may be experienced as if it has a distinct history, self-image, and identity. The alters' characteristics—including name, reported age and gender, vocabulary, general knowledge, and predominant mood—contrast with those of the primary identity. Certain circumstances or stressors can cause a particular alter to emerge. The various identities may deny knowledge of one another, be critical of one another, or appear to be in open conflict. article continues after advertisement According to the DSM-5, the following criteria must be met for an individual to be diagnosed with dissociative identity disorder: The individual experiences two or more distinct identities or personality states (each with its own enduring pattern of perceiving, relating to, and thinking about the environment and self). Some cultures describe this as an experience of possession. The disruption in identity involves a change in sense of self, sense of agency, and changes in behavior, consciousness, memory, perception, cognition, and motor function. Frequent gaps are found in the individual’s memories of personal history, including people, places, and events, for both the distant and recent past. These recurrent gaps are not consistent with ordinary forgetting. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Particular identities may emerge in specific circumstances. Transitions from one identity to another are often triggered by emotional stress. In the possession-form of dissociative identity disorder, alternate identities are visibly obvious to people around the individual. In non-possession-form cases, most individuals do not overtly display their change in identity for long periods of time. People with DID may describe feeling that they have suddenly become depersonalized observers of their own speech and actions. They might report hearing voices (a child's voice or the voice of a spiritual power), and in some cases, the voices accompany multiple streams of thought that the individual has no control over. The individual might also experience sudden impulses or strong emotions that they don't feel control or a sense of ownership over. People may also report that their bodies suddenly feel different (like that of a small child or someone huge and muscular) or that they experience a sudden change in attitudes or personal preferences before shifting back. Sometimes people with DID experience dissociative fugue in which they discover, for example, that they have traveled, but have no recollection of the experience. They vary in their awareness of their amnesia, and it is common for people with DID to minimize their amnestic symptoms, even when the lapses in memory are obvious and distressing to others. Are dissociative states seen differently in other cultures? In many parts of the world, possession states are a normal part of cultural or spiritual practice. Possession-like identities often manifest as behaviors under the control of a spirit or other supernatural being. Possession states become a disorder only when they are unwanted, cause distress or impairment, and are not accepted as part of cultural or religious practice. Are suicidal thoughts common in dissociative identity disorder? According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, more than 70 percent of people with DID have attempted suicide at least once, and self-injurious behavior is common among this group. Treatment is crucial to improving quality of life and preventing suicide attempts for those with DID. Why some people develop dissociative identity disorder is not entirely understood, but they frequently report having experienced severe physical and sexual abuse during childhood. The disorder may first manifest at any age. Individuals with DID may have post-traumatic symptoms (nightmares, flashbacks, or startle responses) or post-traumatic stress disorder. Several studies suggest that DID is more common among close biological relatives of persons who also have the disorder than in the general population. Once a rarely reported disorder, the diagnosis has grown more common—and controversial. Some experts contend that because DID patients are highly suggestible, their symptoms are at least partly iatrogenic—that is, prompted by their therapists' probing. Brain imaging studies, however, have corroborated identity transitions. What other dissociative disorders are there? There are other dissociative disorders, all of which concern an individual's disconnection with reality. The person who suffers dissociative amnesia, for example, has difficulty remembering who they are, where they live, and other important personal information. And the person who suffers depersonalized or derealization disorder is detached from their actions. The primary treatment for dissociative identity disorder is long-term psychotherapy with the goal of deconstructing the different personalities and integrating them into one. Other treatments include cognitive and creative therapies. Although there are no medications that specifically treat this disorder, antidepressants, anti-anxiety drugs, or tranquilizers may be prescribed to help control the psychological symptoms associated with it. With proper treatment, many people who are impaired by DID experience improvement in their ability to function in their work and personal lives. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. National Institute of Mental Health Find a Dissociative Disorders (DID) Therapist Get the help you need from a therapist near you–a FREE service from Psychology Today. Atlanta, GA Austin, TX Baltimore, MD Boston, MA Brooklyn, NY Charlotte, NC Chicago, IL Columbus, OH Dallas, TX Denver, CO Detroit, MI Houston, TX Indianapolis, IN Jacksonville, FL Las Vegas, NV Los Angeles, CA Louisville, KY Memphis, TN Miami, FL Milwaukee, WI Minneapolis, MN Nashville, TN New York, NY Oakland, CA Omaha, NE Philadelphia, PA Phoenix, AZ Pittsburgh, PA Portland, OR Raleigh, NC Sacramento, CA Saint Louis, MO San Antonio, TX San Diego, CA San Francisco, CA San Jose, CA Seattle, WA Tucson, AZ Washington, DC Dissociative Identity Disorder (DID) – formerly known as Multiple Personality Disorder – is a relatively common psychiatric disorder that may affect 1-3% of the general population. DID is characterized by a significant disruption of a unified sense of self and continuity of experience, exemplified by two or more personality/identity/self states. In some cultures, this disruption of a unified sense of self may be understood as an experience of possession that is not considered congruent with that culture’s spiritual/religious practices. In addition, individuals with DID experience Dissociative Amnesia (DA): a disruption in memory for important personal information, as well as for current and past personal experience, that is inconsistent with ordinary memory problems. This significant disruption in a unified sense of self and memory can occur in a number of ways that include hard to explain disturbances and/or variability in: Behavior Thoughts Emotions Memory Perceptions Consciousness Bodily sensations or functioning These disruptions and alterations cannot be better explained by the effects of alcohol or drugs, or a medical or brain disorder, such as epileptic seizures. These symptoms must cause significant problems with functioning. Unlike portrayals in the media, the “fascinating”, stereotyped external characteristics of DID self states, such as different names, voice tone, accents, wardrobe, hair-styles, handwriting, and more, are not essential for diagnosis and are secondary factors to the core phenomena of DID. The diagnostic criteria for DID mean that there are two or more relatively separate centers of information processing in the mind. Each information processing center in the mind is characterized by: A sense of personal identity A self-image A set of (state dependent) autobiographical memories A sense of ownership of personal experience Capacity to control/enact behavior These self states may shift, switch, or overlap in a number of ways that lead to the disruption in self and continuity of experience in DID. The individual’s personality/identity/self states are NOT separate people. These are subjective states of the individual’s mind. All of the DID states together make up the whole person and that person’s total personality. Because of this, and unlike descriptions in the popular media, the individual with DID as a whole person is held responsible for behavior, even if experienced with amnesia or a sense of lack of control over one’s actions. The Development of Dissociative Identity Disorder Individuals with DID report the highest rates of childhood trauma, particularly physical, sexual, and emotional abuse – generally beginning before the age of six – of patients with any psychiatric disorder. Because of this, DID can be conceptualized as a childhood onset, posttraumatic developmental disorder in which the traumatized child is unable to complete the normal developmental processes involved in consolidating a core sense of self. Together with disturbed caretaker-child attachment and parenting, repeated early trauma disrupts the development of normal processes involved in the elaboration and consolidation of a unified sense of self. Therefore, the child fails to integrate the different experiences of self that normally occur across different states and contexts. DID has been found in children, adolescents, and adults. Unfortunately, early trauma may be a risk factor for later trauma. DID individuals report very high rates of adult rape, intimate partner violence, and other forms of exploitation, such as being a victim of trafficking. DID is both a disorder and a form of resilience. Psychological compartmentalization of traumatic/overwhelming experiences allows for more normal development of the capacity for clear thinking, intellectual and creative abilities, the ability to understand reality, development of a sense of humor, the capability for attachment to others, and a capacity for insight – all important in the psychotherapy treatment of DID. Symptoms of Dissociative Identity Disorder (DID) The posttraumatic origins of DID mean that anywhere between 80 and 100% of individuals with DID who receive treatment also have symptoms of posttraumatic stress disorder (PTSD - see section on PTSD). Other disorders commonly associated with DID are depression or very rapid “mood swings” that frequently do not (or only very partially) respond to medications; substance abuse; and unexplained medical symptoms with repeated “negative” work ups, typically for apparent seizures or other neurological disorders. One of the most common symptoms of DID is hearing voices, most often within the mind. Because of this, many individuals with DID are unsuccessfully treated with medications for schizophrenia or other psychotic disorders (see section on psychotic disorders). Individuals with DID have very high rates of self-destructive and suicidal behavior and often have multiple, usually unproductive, hospitalizations for mood disorders, personality disorders, and/or psychotic diagnoses. The average individual with DID spends five to 12.5 years in mental health treatment until a correct diagnosis is made. Having suicidal or self-destructive thoughts, impulses, urges, plans or behavior require emergency treatment, including calling 911 or going to the nearest Emergency Department or Mental Health Urgent Care Clinic. A diagnosis of dissociative identity disorder should be suspected if you or your loved one: Receives numerous different psychiatric diagnoses, yet does not respond to many different types of treatments including multiple medications, types of psychotherapy, or neurostimulation treatments like electroconvulsive therapy (ECT) and transcranial magnetic stimulation (TMS). Unlike the stereotype of DID, symptoms of DID are usually subtle and hidden, and individuals with DID do not readily reveal their symptoms without careful examination by a mental health professional. You or your loved ones may notice the person is: Repeatedly very “moody” Highly changeable from time to time, and Has difficulty recalling important personal experiences. This can include a variety of current behaviors and parts of the life history, that are not related to use of substances or medications, or to brain injuries or diseases. These difficulties recalling important personal experiences can include: Significant gaps in memory for life history Experiencing “black outs” or “time loss”: gaps in remembering current life history Lack of recall of complex, witnessed behaviors – even positive behaviors, such as doing well in a presentation at work Not remembering or difficulty remembering important events, such as graduations, birthdays, weddings, and vacations, that other family members recall well Recurring puzzling lack of memory for things that the person has purchased or created Inexplicable alterations in abilities and habits, such as forgetting that one can play a musical instrument, or changing suddenly from a smoker to a non-smoker, then back again Repeated unexplained travel or “getting lost” in familiar places Repeated rationalizations for being “forgetful” or “preoccupied” Other common symptoms of DID include: Hearing voices, particularly inside one’s mind; these are often experienced as having their own sense of self, such as a child’s voice, an angry voice, a caring and supportive voice, among others Seeing things that others do not see, such as people, faces, or visions, including seeing the “people” that one is hearing talking Out of body experiences, as if watching oneself from a distance outside, or even inside oneself, frequently accompanied by the feeling that one can observe, but not control what one is doing Feeling like you are disconnected from the world around you as if seeing through a fog; things seem unreal Experiencing repeated inexplicable, sudden intrusions of thoughts, feelings, urges, or actions that one does not control Experiencing repeated inexplicable, sudden deletion of thoughts, feelings, behavior that one does not control Feeling divided with different senses of self that seem relatively independent of one another, and often are in a conflict or a struggle Inexplicably feeling very different at different times with varying opinions, abilities, habits, and access to memory and learned information Treatment of Dissociative Identity Disorder DID is a treatable disorder once it is properly diagnosed. Clinicians who understand DID symptoms can diagnose DID in the clinical interview. There are also paper and pencil tests that can help clinicians diagnose DID and other dissociative disorders. Studies show that DID symptoms improve over time when treated using Phasic Trauma Treatment. Phasic Trauma Treatment Phasic trauma treatment is a psychotherapeutic treatment that has three phases: Safety and stability Work on traumatic memories Re-integration into life In DID treatment, working directly with the DID identities is crucial to diminish symptoms and to maximize the resilience found in most people with DID. The first phase, safety and stability, is the most important. During this phase, individuals learn how to stabilize symptoms of DID and PTSD, using a variety of psychotherapeutic techniques and sometimes adjunctive/add-on medications. It is critical for the individual with DID to develop safety from suicidal and self-destructive behaviors, substance abuse, eating disorders, high risk behaviors, unsafe people, and other dangerous behaviors and situations. This is because DID develops in a childhood environment of repeated lack of safety and unpredictable danger. Without development of safety, DID treatment will not progress. Not all individuals with DID wish to address his/her traumatic experiences in depth. However, if the individual with DID agrees, and has achieved safety and stability, Phase 2 is focused more on carefully and slowly recalling the life history – which is often experienced as PTSD flashbacks. Therefore, this phase also involves ongoing work on safety and additional stabilization of DID and PTSD symptoms. In Phase 3, the individual’s DID and PTSD symptoms have usually substantially moderated, and the individual with DID may even experience subjective fusion of some or all self states, with complete merging of the characteristics of these subjective identities. This frees up energy for a focus on living better in the present. Adjunctive/Add-On Treatments for Dissociative Identity Disorder Hypnotherapy: Hypnotherapy can be helpful in stabilizing DID and PTSD symptoms. However, hypnotherapy can only be used if the therapist has received certification in using hypnosis and has specialized training in its use in DID and other posttraumatic disorders. Make sure to ask your provider about his/her credentials in using hypnosis. Medications: Medications are adjunctive (add-on) treatments in DID treatment and do not directly affect the basic symptoms of DID. In DID treatment, medications do not have a major direct effect on symptoms unless there are other specific disorders present. For example, there are medications that can substantially improve symptoms of PTSD, although some people cannot take these due to side effects. Medications for depression and mood symptoms usually have limited effects, but may provide some symptom relief as long as the patient and practitioner have carefully identified which symptoms will and will not be helped by medications. Medications for anxiety symptoms can be moderately helpful but must be monitored carefully, especially in individuals with a history of substance abuse. Individuals with DID often have a complex, chronic sleep disturbance with difficulty falling asleep, staying asleep, nightmares, and even complex behaviors that appear to emerge out of sleep. There are medications that can help PTSD nightmares and this may improve sleep, if the patient does not have problematic side effects. Sedating medications often are only partially helpful. Specific DID psychotherapy is often required to assist with fears and flashbacks related to bed, night, and sleep, and nighttime dissociative symptoms. Other Types of Psychotherapy that can Assist with DID Treatment Other forms of psychotherapy such as dialectical behavioral therapy (DBT) and cognitive behavioral therapy (CBT) that is focused on trauma-related cognitive distortions can be helpful as adjunctive/add-on to the phasic psychotherapy for DID. Eye-Movement Desensitization and Reprocessing Therapy (EMDR): Eye-movement Desensitization and Reprocessing Therapy (EMDR) is a treatment that has been found to improve PTSD symptoms, typically in people who have experienced specific adult traumas. EMDR can significantly worsen the symptoms of DID, especially if used before the DID patient is stabilized in treatment. EMDR can be an adjunctive/add-on treatment if the therapist has full training in EMDR and has specialized training in its use in DID and other complex posttraumatic disorders. Group Therapy: Group therapy can be helpful for the stabilization of individuals with DID if they are in a group dedicated to patients with this diagnosis, and the group is facilitated by practitioners that are knowledgeable about DID treatment. Individuals with DID usually do not do well in general therapy groups, even those that focus on PTSD and trauma, but are not designed for severely dissociative patients. In general, DID experts do NOT recommend the use of non-professionally facilitated support groups in the treatment of DID, including online support groups. Both in-person and online “support” groups ultimately may have a severely negative impact on the individual with DID and his/her treatment. Family Involvement: Family treatment, usually with the patient’s spouse, or significant other can be helpful, for education and to help support both the patient and the family during an often long and difficult treatment. In particular, family members are educated to not directly interact with the patient’s varying self states, but should regard their partner as a “whole human being,” and not a group of separate “people.” Specialized couple’s therapy may be helpful if the therapist is knowledgeable about treatment of childhood trauma and its impact on adult relationships. Rehabilitation Therapies: Adjunctive/add-on rehabilitation therapies like art therapy and occupational therapy can be helpful if the therapist has training in the use of these modalities in the treatment of complex posttraumatic disorders like DID. To learn more about dissociative identity disorder, visit The Trauma Disorders Services section of our website and the International Society for the Study of Trauma and Dissociation's website. Dissociative identity disorder comes with a lot of stigma and misunderstanding. We’re here to bust some common myths.Share on PinterestEschCollection/Getty ImagesDissociative identity disorder (DID), previously known as multiple personality disorder, is a dissociative disorder. Many people with DID have a history of severe childhood abuse, which may have caused them to dissociate from their bodies to cope with overwhelming trauma.Symptoms of DID include a sense of feeling detached from one’s sense of self and the presence of at least two other distinct personalities. Many people with DID experience memory gaps when different personalities take over.DID is one of the most misunderstood psychiatric disorders. It’s important to address misconceptions with solid research to spread understanding and reduce the stigma around this disorder.Many people believe that DID isn’t an actual condition or that it was a medical “fad.” But DID has been reported for hundreds of years and makes a strong appearance in medical literature.Research published in 2014 confirms that dissociative identity disorder is a complex but valid condition that can be proven across many markers. Studies show that DID is linked to diverse brain regions and cognitive functions.The symptoms of DID can be easily distinguished from other conditions. The disorder is commonly associated with severe childhood relational trauma.Due to a spike in diagnoses during the 1980s and 1990s and then a decline, DID was called a medical fad. Some believe it was popular to diagnose people with this disorder at one point and that it simply fell out of style.But researchers note that DID cases have been described in medical literature for hundreds of years.In addition, researchers say there were 1,339 research papers about DID between 2000-2014. This suggests an ongoing professional interest in the disorder.Other factors dispelling this myth include:People with DID are consistently identified in inpatient, outpatient, and community samples worldwide.People with DID can be reliably diagnosed through structured/semi-structured interviews and in clinical practice.People with DID often benefit from psychotherapy that addresses trauma and dissociation.DID is easily differentiated from other psychiatric disorders.It’s a general misconception — even in some psychology textbooks — that DID is rare. Prevalence rates in the general population and psychiatric settings suggest otherwise.In fact, DID is more common than schizophrenia.Research shows that DID is present in about 1.1% to 1.5% of community samples. In comparison, schizophrenia is estimated to occur in about 0.25% to 0.64% of adults.In a sample of 658 people from New York, 1.5% met the diagnostic criteria for DID. Similarly, in a study of 628 community women in Turkey, 1.1% had DID.In addition, studies looking at populations with exceptionally high exposure to trauma or cultural oppression show the highest rates of DID. For instance, 6% of repeated admissions in a highly traumatized U.S. inner-city sample were diagnosed with DID.Despite common belief, DID and schizophrenia are different disorders.A persistent myth about schizophrenia is that people with the condition have a “split personality” — the idea that the self is split into various identities.While recent mental health campaigns have aimed to educate people on the difference, the myth still lingers.Another contributor to this myth is that the symptoms of DID often overlap with the positive symptoms of schizophrenia, such as distorted perceptions of reality. But it’s much less common for people with DID to share the negative symptoms of schizophrenia, such as social withdrawal or lack of pleasure.Another important distinction is that people with schizophrenia are less likely to experience dissociative symptoms, such as memory and identity loss. Schizophrenia is also a genetic illness that tends to run in families, and the disorder can result in a gradual decrease in functioning if left untreated. DID is not hereditary but is most often caused by trauma.Some people believe DID is a personality disorder, but this is not the case. DID is identified in the DSM-5 as a dissociative disorder.There are a few reasons people might think DID is a personality disorder. The previous name, “multiple personality disorder” (changed to DID in 1994), still sticks with some people and may cause confusion.While 2014 research shows that the two disorders overlap in symptoms (as many conditions do), they also have distinct features that set them apart. Dissociative disorders may involve memory gaps and a sense of detachment from oneself and the world. Personality disorders are marked by a consistent pattern of traits that interfere with a person’s stable life.Research has not convincingly shown a link between DID and increased violence.Horror movies that feature characters with DID have contributed to this myth and may even be responsible for it. According to 2009 research, DID is a controversial diagnosis because of fear that criminals would not be punished if they claimed another personality committed the crime.But there is no association between DID and increased crime.A 2017 study found that among 173 people in treatment for dissociative identity disorder, their involvement with the criminal justice system was low. Researchers found that only 0.6% had been incarcerated within the past 6 months. In addition, no convictions or probations in the prior 6 months had been reported. Finally, they found that no DID symptoms reliably predicted criminal behavior.The myth that people with DID are dangerous leads to further stigmatizing those with this disorder.DID is a highly misunderstood psychiatric disorder. Tackling pervasive myths can help unravel the stigma that many people with DID experience.For more information about DID or help to find treatment, you can visit the International Society for the Study of Trauma and Dissociation (ISSTD) website.For further support, you can call The National Alliance on Mental Illness (NAMI) HelpLine at 1-800-950-6264 or email at info@nami.org. The symptoms of DID include:Having at least two identities (personality states). These affect your behavior, memory, self-perception and ways of thinking.Amnesia or gaps in memory regarding daily activities, personal information and traumatic events.Different identities affect your ability to function in social situations or at work, home or school.Other mental health symptoms that can (but not always) be found along with DID include:Anxiety.Delusions.Depression.Self-harm.Substance use disorder.Thoughts about suicide (suicidal ideation).What does a person with DID feel like?If you have DID, you might feel or experience the following:Detached from reality, your emotions and your sense of self.Confused by what others may tell you about your behavior.Frustrated about gaps in your memory.Stressed about not being in control.Like a bystander, watching yourself from the outside.It doesn’t feel like you’re “you” with DID. This can look and feel different for each person who experiences it. If something doesn’t feel right or your experiences and memories aren’t lining up, reach out to a healthcare provider for an evaluation.Can someone have DID without knowing?Yes, it’s possible that someone can have DID without knowing. While some people are aware of their identities, many people don’t know when a new identity takes over. When a new identity steps in, you may not remember some events because another personality experienced them. This causes gaps in memory, called amnesia.What causes dissociative identity disorder?DID causes may include:Stressful experiences.Trauma.Abuse.These events typically happen during childhood. DID is a way for you to distance or detach yourself from the trauma.DID symptoms may trigger (happen suddenly) after:Removing yourself from a stressful or traumatic environment (like moving homes).Close relatives or your children reaching the age at which you experienced trauma.A recent traumatic or stressful experience (like a vehicle accident).An abuser passing away or experiencing a life-threatening illness.What are the risk factors for dissociative identity disorder?You may be more at risk of developing DID if you experienced:Physical or sexual abuse.Neglect.Multiple medical procedures during childhood.War or terrorism.What are the complications of dissociative identity disorder?You’re at an increased risk of suicide with DID. More than 70% of people diagnosed with DID attempt suicide or practice self-injury behaviors.If you’re thinking about hurting yourself, call or text 988, the Suicide & Crisis Lifeline (U.S.). You don’t have to be in a crisis to dial 988. Someone is available to talk, no matter your situation, so you can feel better in your time of need. SymptomsCausesTreatmentWhen to see a doctorTakeawayDissociative identity disorder, previously known as multiple personality disorder, is a type of dissociative disorder. Along with dissociative amnesia and depersonalization-derealization disorder, it’s one of the three major dissociative disorders.Dissociative disorders can be found in people of all ages, races, ethnicities, and backgrounds. The National Alliance on Mental Illness (NAMI) estimates that about 2 percent of people experience dissociative disorders.The most recognizable symptom of dissociative identity disorder (DID) is a person’s identity being involuntarily split between at least two distinct identities (personality states). Other symptoms might include:Dissociative amnesia. This is a type of memory loss — beyond forgetfulness — that’s not associated with a medical condition.Dissociative fugue. A dissociative fugue is an episode of amnesia that involves not having memory of certain personal information. It may include wandering off or a detachment from emotion.Blurred identity. This occurs when you feel like there are two or more people talking or living in your head. You might even feel like you’re possessed by one of several other identities.It’s important to note that according to the Diagnostic and Statistical Manual of Mental Disorders, many cultures around the globe include possession as part of a normal spiritual ritual or practice. This isn’t considered a dissociative disorder.If you believe someone you know has DID, you may get the impression that you’re communicating with not one, but several different people, as the person switches between personalities.Often, each identity will have their own name and characteristics. They’ll each commonly have an unrelated detailed background with obvious differences in age, gender, voice, and mannerisms. Some might even have individual physical characteristics such as a limp or poor vision that requires glasses.There are often differences in each identity’s awareness and relationship — or lack thereof — to the other identities.Dissociative identity disorder — along with other dissociative disorders — usually develop as a way to deal with some type of trauma they’ve experienced.According to the American Psychiatric Association, 90 percent of people with dissociative identity disorder in the United States, Canada, and Europe have experienced childhood neglect or abuse.The primary treatment for DID is psychotherapy. Also known as talk therapy or psychosocial therapy, psychotherapy is focused on talking with a mental health professional about your mental health.The goal of psychotherapy is to learn how to cope with your disorder and to understand the cause of it.Hypnosis is also considered by some to be a useful tool for DID treatment.Medication is sometimes used in the treatment of DID, as well. Although there are no medications specifically recommended for the treatment of dissociative disorders, your doctor might use them for associated mental health symptoms.Some commonly used medications are:anti-anxiety medicationsantipsychotic drugsantidepressantsIf you can identify with any of the following, you should make an appointment to see your doctor:You are aware — or others observe — that you involuntarily and unwillingly have two or more personalities or identities that have a distinctly different way of relating to you and the world around you.You experience beyond ordinary forgetfulness, like extensive gaps in your memory for important personal information, skills, and events.Your symptoms aren’t caused by a medical condition or from the use of alcohol or drugs.Your symptoms are causing you problems or stress in important areas such as your personal life and at work.If you identify with the symptoms of dissociative identity disorder, you should make an appointment to see your doctor.If your friend or a loved one is displaying the common symptoms, you should encourage them to seek help. You can also contact the NAMI HelpLine at 1-800-950-6264 or email info@nami.org for support.