DISSOCIATIVE DISORDERS

Dissociative Identity Disorder

DID

DSM-5-TR 300.14 | ICD-10-CM F44.81

Identity disruption by two or more distinct personality states with recurrent amnesia, arising from severe, chronic early childhood trauma.

PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~1.0-1.5% general population	Trauma in childhood; dx in 30s	F>M in clinical samples	Chronic; 6-12 yrs to diagnosis

CLINICAL PICTURE

- The presenting complaint is almost never identity multiplicity; it is depression, self-harm, post-traumatic symptoms or unexplained gaps in memory.
- Amnesia covers everyday events and personal history, and patients find unfamiliar possessions, writing or messages they have no memory of producing.
- Patients describe watching themselves speak or act, with thoughts, impulses and emotions experienced as intrusive and not belonging to them.
- Voices are typically experienced as internal, arguing or commenting, which is regularly misread as schizophrenia and treated with antipsychotics.
- Discontinuities appear in skills, handwriting, food preferences and dress, and collaterals report interactions the patient cannot recall.
- Chronic suicidality and self-injury are near universal, and most patients accumulate several misdiagnoses over 6 to 12 years before identification.

DIAGNOSTIC CRITERIA AT A GLANCE

- Two or more distinct personality states, or an experience of possession, must produce marked discontinuity in sense of self and sense of agency.
- Recurrent gaps in recall of everyday events, personal information or traumatic material must exceed ordinary forgetting.
- DSM-5 broadened the criteria to accept self-reported identity discontinuity rather than requiring observation, and to include non-traumatic amnesia.
- Symptoms must cause distress or impairment and must not be a normal part of an accepted cultural or religious practice, including imaginary play in children.
- Substance effects such as alcoholic blackouts and medical conditions such as complex partial seizures must be excluded before diagnosis.

NEUROBIOLOGY & PHYSIOLOGY

- Smaller hippocampal and amygdalar volumes are consistently reported, with hippocampal reduction scaling with cumulative childhood trauma exposure.
- Identity states differ measurably in heart rate, blood pressure, regional cerebral blood flow and autonomic reactivity to trauma-related scripts.
- Reinders and colleagues found that high fantasy-prone controls simulating identity states could not reproduce these psychobiological patterns.
- Altered default mode and salience network connectivity fits the corticolimbic inhibition model that also explains the dissociative subtype of PTSD.
- HPA axis dysregulation accompanies high somatic morbidity, including functional neurological symptoms, chronic pain and headache.
- Genetic study is limited; dissociation shows modest heritability with the larger share of variance attributable to trauma and environment.

PSYCHOLOGICAL MECHANISMS

- The trauma model holds that chronic, inescapable abuse or neglect before roughly age six prevents normal integration of self-states.
- Structural dissociation theory posits an apparently normal part that maintains daily life alongside emotional parts holding traumatic memory and affect.
- Disorganized attachment to a caregiver who is simultaneously the source of comfort and of fear is the proposed developmental substrate.
- The sociocognitive or iatrogenic model argues that suggestion, media exposure and therapist expectation shape presentations, and it accounts for some cases.
- Fantasy proneness and suggestibility do not explain away the association, which survives statistical control for both and is found in unsuggested samples.

DIFFERENTIAL & COMORBIDITY

- Schizophrenia is distinguished by external hallucinations, formal thought disorder and negative symptoms; DID voices are internal with reality testing intact.
- Borderline personality disorder and complex post-traumatic presentations overlap heavily, and a third to a half of DID patients also meet borderline criteria.
- Seizure disorders, traumatic brain injury, substance blackouts and factitious or malingered presentations must be excluded, especially in forensic settings.
- Comorbidity is the rule: post-traumatic stress disorder in most patients, plus depression, substance use, eating and somatic symptom disorders.
- Suicide attempt rates exceed 70% and self-injury is near universal, so safety planning is a standing agenda item rather than a crisis response.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- No medication treats dissociation itself; pharmacotherapy targets comorbid post-traumatic stress, depression, anxiety and sleep disturbance.
- **SSRIs** and **SNRIs** at standard antidepressant doses are first line for comorbid PTSD and depression, with partial response the usual outcome.
- **Prazosin 1-15 mg at bedtime** reduces trauma nightmares; titrate slowly and monitor for orthostatic hypotension and first-dose syncope.
- Avoid benzodiazepines, which worsen amnesia and dissociation, and resist the polypharmacy that accumulates across years of misdiagnosis.
- Reserve antipsychotics for genuine comorbid psychosis or severe agitation rather than prescribing them for internally experienced voices.

PSYCHOTHERAPY

- ISSTD adult guidelines specify **phase-oriented treatment**: safety and stabilization, then trauma processing, then integration and rehabilitation.
- Phase one occupies most of treatment for most patients, and premature memory work reliably destabilizes, increasing self-harm and hospitalization.
- **DBT**-informed skills, grounding and containment techniques manage dissociation, self-injury and affect dysregulation during stabilization.
- Naturalistic prospective studies of phased treatment show reduced dissociation, self-harm and hospitalization with improved functioning over several years.
- Avoid suggestive memory-recovery techniques and hypnotic exploration aimed at retrieving evidence; recovered material is unreliable for forensic purposes.

ADJUNCT & SUPPORTIVE

- Screen with the **DES-II** using a cutoff near 30, then confirm with a structured interview such as the SCID-D or the Multidimensional Inventory of Dissociation.
- Write a safety plan in plain language that names grounding strategies and contacts, and that any self-state can locate and use.
- Coordinate emergency, primary care and inpatient teams around one consistent, boundaried plan to prevent fragmented and contradictory care.
- Favor brief crisis stabilization over prolonged inpatient stays, using specialized trauma or dissociative disorders units when they are available.
- Regular consultation or supervision is essential for the clinician, since vicarious traumatization and gradual boundary drift are common in this work.

CLINICAL PEARLS

- Voices are internal and dialogic with insight intact; that is not schizophrenia.
- Stabilize before processing. Early memory work reliably makes patients worse.
- Screen with the DES-II, confirm with SCID-D; mean delay to diagnosis is 6-12 years.

References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Brand, B. L., Sar, V., Stavropoulos, P., Kruger, C., Korzekwa, M., Martinez-Taboas, A., & Middleton, W. (2016). Separating fact from fiction: An empirical examination of six myths about dissociative identity disorder. *Harvard Review of Psychiatry, 24*(4), 257-270. https://doi.org/10.1097/HRP.0000000000000100

Dorahy, M. J., Brand, B. L., Sar, V., Kruger, C., Stavropoulos, P., Martinez-Taboas, A., Lewis-Fernandez, R., & Middleton, W. (2014). Dissociative identity disorder: An empirical overview. *Australian and New Zealand Journal of Psychiatry, 48*(5), 402-417. https://doi.org/10.1177/0004867414527523

International Society for the Study of Trauma and Dissociation. (2011). Guidelines for treating dissociative identity disorder in adults, third revision. *Journal of Trauma & Dissociation, 12*(2), 115-187. https://doi.org/10.1080/15299732.2011.537247

Loewenstein, R. J. (2018). Dissociation debates: Everything you know is wrong. *Dialogues in Clinical Neuroscience, 20*(3), 229-242. https://doi.org/10.31887/DCNS.2018.20.3/rloewenstein

Lynn, S. J., Lilienfeld, S. O., Merckelbach, H., Giesbrecht, T., & van der Kloet, D. (2012). Dissociation and dissociative disorders: Challenging conventional wisdom. *Current Directions in Psychological Science, 21*(1), 48-53. https://doi.org/10.1177/0963721411429457

Reinders, A. A. T. S., Willemsen, A. T. M., Vos, H. P. J., den Boer, J. A., & Nijenhuis, E. R. S. (2012). Fact or factitious? A psychobiological study of authentic and simulated dissociative identity states. *PLoS ONE, 7*(6), e39279. https://doi.org/10.1371/journal.pone.0039279

Sadock, B. J., Sadock, V. A., & Ruiz, P. (2021). *Kaplan & Sadock's synopsis of psychiatry* (12th ed.). Wolters Kluwer.

NOTE

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