When to Suspect and How to Diagnose Dissociative Identity Disorder

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Previously undiagnosed dissociative identity disorder (DID) may be present in individuals being assessed for eye movement desensitization and reprocessing (EMDR). Previously undiagnosed DID was present in 3.9% of 1,529 general adult psychiatric inpatients in 10 studies conducted in 6 different countries. In this article, a case of likely DID that was missed in a published case report is presented, and guidelines for when to suspect and how to diagnose DID are provided. Such guidelines are missing from the training of many mental health professionals.

Keywords: dissociative identity disorder; diagnosis; eye movement desensitization and reprocessing (EMDR)

In 10 studies conducted in 6 countries, dissociative identity disorder (DID) affected 3.9% of 1,529 general adult psychiatric inpatients (Ross, Duffy, & Ellason, 2002). These were individuals who had not received a prior diagnosis of DID, had never received treatment for it, and did not claim to have it. The procedure in these studies, which were conducted in Canada, the United States, Turkey, Norway, Switzerland, and Germany, was to screen inpatients with the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986) and then interview high scorers with one of two structured interviews: the Dissociative Disorders Interview Schedule (DDIS; Ross, 1997; Ross & Halpern, 2009) or the Structured Clinical Interview for *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*) Dissociative Disorders (SCID-D; Steinberg, 1995). Based on this epidemiology, DID should be part of the differential diagnosis for many psychiatric patients, including patients being assessed for eye movement desensitization and reprocessing (EMDR) as emphasized by Shapiro (1995, 2001).

Recent literature has addressed the need to assess for DID and other complex dissociative disorders in EMDR practices (Fine et al., 2001; Gomez, 2012; Gonzalez & Mosquera, 2012; Paulsen, 2009; Ross, 2012). The current level of interest in complex trauma, dissociation, and EMDR is reflected in the number of presentations on the topic at the most recent EMDR Internation Association conference (Goldberg, 2014; Gomez, 2014; Korn & Leeds, 2002; Leeds & Mosquera, 2014; Madere, 2014; Ross, 2014). Whether or not the standard protocol for EMDR is sufficient for treatment of DID has not been proven or disproven by randomized controlled trials. However, the consensus of opinion is that, at least for history and preparation, modifications are required (Fine & Berkowitz, 2001; Forgash & Copeley, 2008; Gomez, 2012; Gonzalez & Mosquera, 2012; Leeds & Mosquera, 2014; Paulsen, 1995, 2008, 2009; Twombly, 2000; Young, 1994). Work may need to be done on system stabilization, grounding, interpersonality communication and cooperation, co-consciousness, and orientation of alter personalities to the body and the present, for example.

Although there is a clinical literature on EMDR for complex dissociative disorders, as yet, there is no validated standard protocol for these disorders. Questions to be addressed in developing such a protocol include are fractionation techniques (Kluft, 2013) required for selection of targets and preparation for desensitization, should there be direct and/or indirect communication with alter personalities during preparation and desensitization, and what treatment techniques should be imported from the DID literature? The unanswered question is whether a modified EMDR protocol is required for DID: if so, once validated by controlled trials, this protocol could then itself become a standard protocol for DID.

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TABLE 1. Common Misconceptions About Dissociative Identity Disorder (DID)

The Myth	The Fact
Rare	Undiagnosed DID affected 3.9% of 1,529 psychiatric inpatients in six studies in 10 countries.
Always iatrogenic	Can be diagnosed based on preexisting symptoms
Cannot be reliably diagnosed	Reliability is good—kappa values greater than .70.
Diagnosis leads to deterioration.	An uncontrolled, prospective treatment outcome literature demonstrates a good prognosis in many cases.
No specified treatment or standard of care.	Treatment is well described in many sources.

Given the aforementioned considerations, when should DID be suspected and how can it be diagnosed? This article provides answers to those two questions. Recent literature on disagreements about the validity and reliability of DID are not the focus here (Boysen & vanBergen, 2013a, 2013b; Brand & Loewenstein, 2014; Brand, Loewenstein, & Spiegel, 2013a, 2013b, 2014; Dalenberg et al., 2012; Dorahy et al., 2014; Lynn et al., 2012; Martínez-Taboas, Dorahy, Sar, Middleton, & Krüger, 2013; Paris, 2012, 2013; Ross, 2013; see Table 1). For guidelines and standards of care on treatment of DID, the reader is referred to several sources (Brand & Loewenstein, 2014; Chu et al., 2004; Ross, 1997; Silberg et al., 2011).

Concerning DID: (a) its diagnosis should be based on preexisting symptoms, derived from direct history and, when possible, collateral history; (b) factitious disorder and malingering should be considered in forensic contexts and anytime there is potential secondary gain; (c) the symptoms of DID, including the existence of alter personalities, are symptoms of a mental disorder, not literal facts about the person; and (d) having DID does not automatically absolve a person of moral, personal, ethical, or legal responsibility for his actions.

DSM-5 Diagnostic Criteria for Dissociative Identity Disorder

DID is included in the dissociative disorders section of *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013). The *DSM-5* criteria are included in the DDIS (Ross, 1997; Ross & Halpern, 2009) as follows:

XIV. Dissociative Identity Disorder

127. Have you ever felt like there are two or more distinct personality states within yourself, which may be described in some cultures as an experience of possession? The personality states result in disruption in your sense of self accompanied by disruptions in feeling, behavior, consciousness, memory, perception, thinking, or sensation.
Yes = 1 No = 2 Unsure = 3 [ ]

128. Have you experienced inability to recall important personal information or traumatic events that is too extensive to be explained by ordinary forgetfulness?
Yes = 1 No = 2 Unsure = 3 [ ]

129. Have the symptoms caused significant distress or impairment in your social, occupational, or other areas of functioning?
Yes = 1 No = 2 Unsure = 3 [ ]

130. Is the problem with different identities or personalities because of substance abuse (e.g., alcohol blackouts) or a general medical condition?
Yes = 1 No = 2 Unsure = 3 [ ]

When to Suspect Dissociative Identity Disorder

Although DID is more frequently diagnosed in women, studies show that the female–male ratio of undiagnosed DID is no greater than 2:1 (Dorahy et al., 2014; Ross, 1997; Ross et al., 2002); therefore, gender is not in and of itself a significant risk factor. A typical presentation for previously undiagnosed DID is provided in Table 2 and in the following case history.

Case Example

The following case history from *Current Psychiatry* (Francois, Agakar, & Kotbi, 2012) contains many of the elements of previously undiagnosed DID:

> Ms. T., age 20, is brought to the emergency room (ER) by her father because she refuses to eat and drink, is unable to function at home, lies

TABLE 2. When to Suspect Dissociative Identity Disorder

Trauma	A reported history of extensive, severe childhood trauma
	Does not have to be corroborated
	Does not have to include sexual abuse
BPD	Prior diagnosis of BPD
	Criteria for BPD currently met or subthreshold
	Comorbid depression and PTSD are also common.
Voices	Auditory hallucinations—usually chronic
	Voices may have known names and ages.
	Voices often meet *DSM-IV* Criterion A for schizophrenia.
Blank spells	Discrete periods of missing time lasting minutes, hours, or days not because of drugs, alcohol, or a known medical condition
Switching	Sudden changes of behavioral state
Prior diagnoses	History of extensive contact with the mental health system
	Numerous prior diagnoses—often including BPD, bipolar disorder, schizophrenia, schizoaffective disorder, PTSD, substance abuse

Note. BPD = borderline personality disorder; PTSD = posttraumatic stress disorder; *DSM-IV* = *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.).

in bed all day, and does not attend to her activities of daily living (ADLs).

In the ER, she initially is uncooperative and mute and then suddenly becomes agitated and has a seizure-like episode characterized by jerking of her trunk followed by random, asymmetrical movements of her legs and arms, closing both eyes, weeping, foaming at the mouth, moaning, and marked unresponsiveness. The episode lasts for more than 5 minutes.

In the psychiatric unit, Ms. T. initially is irritable and disorganized with poor oral intake and regressed behavior; she often is found in the fetal position, crying, and talking in a childish manner.

Her outpatient psychiatrist describes a history of physical and sexual abuse starting at age 7. At age 9, after her mother died from breast cancer, Ms. T. and her siblings were moved to foster care, where she was physically abused by the staff. She remained in foster care until age 18.

Ms. T.'s father said his daughter had been hospitalized several times for episodes characterized by pelvic thrusting, stuttering, and pseudosleep . . .

We also considered conversion disorder and dissociative disorder . . .

The diagnosis of pseudoseizures made by the authors in this case is technically correct but does not account for the full clinical picture. Although a dissociative disorder was considered, there is no evidence that DID was ruled out systematically. It would be interesting to interview Ms. T. with the DES (Bernstein & Putnam, 1986), a widely used self-report measure, and the DDIS (Ross, 1997; Ross & Halpern, 2009) and then to have her assessed by a clinician skilled in the diagnosis of DID. Both the DES and the DDIS are public domain documents with established reliability and validity (Ross, 1997; Ross & Halpern, 2009). Both measures are included in the American Psychiatric Association's *Handbook of Psychiatric Measures* (Rush, First, & Blacke, 2007).

Rather than simply being pseudoseizures, Ms. T.'s epileptic-like episodes could well have been abreactions of childhood rapes by a child alter personality. DID would account for the sudden changes of behavioral state, the crying and talking in a childish voice, and the pseudosleep. The sexual abuse history would account for the pelvic thrusting component of the pseudoseizures. How could Francois et al. (2012) have pursued the diagnosis of DID in Ms. T. during a clinical interview?

How to Diagnose Dissociative Identity Disorder

The procedure and approach for diagnosing DID are the same as for any other mental disorder. DID can be suspected but cannot be diagnosed in someone who is floridly psychotic with a severe thought disorder, intoxicated, delirious, uncooperative, mute, or otherwise unable to participate in a psychiatric interview. Assessment includes all the standard elements of a psychiatric evaluation including collateral history and mental status examination. However, additional questions are required that are not part of most clinical practices (see Table 3).

TABLE 3. How to Diagnose Dissociative Identity Disorder

Open-ended	Any problems with your memory?
Blank spells	Periods of missing time—lasting minutes, hours, or days
	Abrupt onset and offset
	Recurrent
	No drugs or alcohol
Coming out of blank spells	Coming to in a different location; don't know how you got there
Disremembered events	People tell you about things you've done that you don't remember—describe you behaving very differently.
Strangers knowing you	People you don't recognize seem to know you—may call you by a different name.
Objects missing/present	Objects are either missing or present that you cannot account for—not minor forgetting—for example, find recently purchased clothes in your closet in a style you would never wear.
Different handwriting	Find writing in a different script you do not remember doing: may be childish, angry, talking about you
Voices	Hear voices—may speak to you or to each other; may be more than one; may have known ages, names, or genders
Other "people"	Does it feel like there may be another person or persons inside? If so, do they ever take control of your body?
Collateral history	Family/friends may report sudden changes of behavior with amnesia, may know parts by name, may corroborate trauma history, or report that they were abused by the same perpetrators.

Two studies (Putnam, Guroff, Silberman, Barban, & Post, 1989; Ross, Norton, & Wozney, 1989) demonstrated that, in the 1980s, multiple personality patients spent an average of just under 7 years in the mental health system prior to their dissociative disorder being diagnosed. There is no evidence that this delay has been shortened since then, despite the emergence of a substantial literature on DID in the ensuing 25 years. Although some DID cases may be difficult to diagnose, the bulk of the delay is likely because of failing to take an adequate and specific history.

When the necessary questions are asked, DID can often be diagnosed in a single assessment. Like any disorder, however, the diagnosis can take time in some cases and may require the formation of a treatment alliance. Usually, in such cases, a provisional *DSM-5* diagnosis of unspecified dissociative disorder can be made (American Psychiatric Association, 2013). Specific questions about "other people inside" should be reserved for late in the interview, after the other symptoms in Table 3 have been explored.

As in any interview, one begins with open-ended questions and narrows down to more closed-ended questions. People with DID rarely volunteer their symptoms. There may be prolonged periods of remission during which the alter personalities have been quiescent or dormant, and therefore none of the symptoms in Table 3 have been present. Usually, however, this is not the case when the person is in crisis and has presented to the mental health system.

If one assumes the existence of other "people" inside who take control of the body, plus the presence of amnesia, the symptoms in Table 3 follow logically. There is often extensive amnesia for childhood, for example, inability to remember anything before age 13 years, or amnesia for a specified time period such as age 8–12 years when a stepfather was living in the home. In other cases, the childhood amnesia is patchy and more difficult to distinguish from normal forgetting. The hallmark of DID, however, is ongoing discrete blank spells in the absence of drugs or alcohol. In marginal cases, this may be hard to differentiate from normal forgetting or zoning out, but in most cases, it is not.

Many DID symptoms exist on a continuum. The symptoms of DID can be difficult to differentiate from normal or from less severe dissociative disorders on initial assessment. However, when a person describes voices with known names, ages, and genders talking inside her head, coming out of 2-day–long blank spells in unfamiliar locations (such as in bed with a stranger), severe childhood trauma, and a feeling that there are other people inside, the likelihood of DID is high.

There is no mystery as to why many clinicians do not see cases of DID. They do not ask about the symptoms or consider DID in their differential diagnoses. Systematic inquiry as outlined in this article, or use of the DES and DDIS, should readily identify cases of DID in samples of 100 psychiatric inpatients in most facilities. Similarly, undiagnosed cases of DID should not be hard to find in EMDR practices. These will be patients who have never received the diagnosis, have never received treatment for it, and are not claiming to have it. This is a testable scientific hypothesis that has already been replicated in six different countries (Ross et al., 2002). Previously undiagnosed DID can be expected among individuals being assessed for EMDR because they commonly have trauma histories.

Generally, DID is likely to be diagnosed more easily in an emergency department or inpatient setting because the individual is in crisis, destabilized, less organized, less grounded, and more likely to have had florid symptoms in the immediate past. Also, the containment, support, and structure of the inpatient setting make the risk of disclosing symptoms easier to take. In an outpatient setting, such as an EMDR practice, however, it is likely that cases will take longer to diagnose. Outpatients are, in general, more stable, more organized, and more functional; therefore, they are less likely to be experiencing blank spells, voices, and the other symptoms of DID. It may take longer to make the diagnosis because the DID personality system is more quiescent or shut down. In addition, more time may be required to build a sufficient therapeutic alliance for the person to take the risk of disclosing symptoms. Regardless of the setting, however, the same clinical interview, supplemented by the DES and DDIS is an effective way to evaluate an individual for DID or another chronic, complex dissociative disorder.

In conclusion, if randomized, controlled trials of EMDR for DID are to be conducted in the future, a standard protocol will be required. Whether the standard EMDR protocol for treatment of DID should contain modifications of the existing standard protocol, awaits the outcome of controlled studies. Whatever the protocol, however, a systematic assessment for previously undiagnosed DID will be required. Guidelines for the clinical assessment of DID are presented in this article and in other sources referenced herein; supplementation of the clinical interview with the DES and DDIS is recommended.

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