Dissociative Identity Disorder (DID) Diagnosis in Adolescents and Young Adults

UTAH CENTER FOR EVIDENCE BASED TREATMENT

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Continuing Education Presentation- May 19th, 2023

Statements

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- Conflict of Interest
  - The presenters of this talk have no conflicts of interest to report
  - Proceeds from this talk will support sliding scale and pro bono services at UCEBT

- Accuracy, Utility, and Risk
  - The presentation discusses clinical principles based on recent research and clinical experience of the presenters
  - As with all clinical procedures, attendees should be thoughtful about applying these skills and strategies without appropriate training and supervision
  - There are no known risks associated with attending, though misapplication of materials could result in non-compliance with applicable laws and ethics codes.

Agenda

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Definitions and Etiology

Barriers to Accurate Diagnosis

Assessment of DID and Dissociation

Evidence-Based Treatment of DID and Dissociation

Dissociation and DID: Definitions and Etiology

International Society
for Traumatic Stress Studies

International Society
for the Study of Trauma
and Dissociation

TRAUMATIC STRESS
INSTITUTE

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What is Dissociation?

PROBLEMS WITH MEMORY, IDENTITY, EMOTION, PERCEPTION, BEHAVIOR AND SENSE OF SELF. DISSOCIATIVE SYMPTOMS CAN POTENTIALLY DISRUPT EVERY AREA OF MENTAL FUNCTIONING.

THERE ARE THREE TYPES OF DISSOCIATION:

- **DEPERSONALIZATION/DEREALIZATION-** "I FEEL NUMB", "I'M TRAPPED IN AN INVISIBLE BUBBLE", "I FEEL LIKE MY MEMORIES AREN'T MINE", "TIME SEEMS TO STAND STILL".
- **DISSOCIATIVE AMNESIA**- "WHEN DID I BUY THAT", "I DON'T REMEMBER THAT HAPPENING", "THEY ACTED LIKE WE'VE MET BEFORE".
- **DISSOCIATIVE IDENTITY DISORDER-** "I'M UNSURE WHAT'S GOING ON WITH ME", "I HAVE THESE WEIRD EPISODES", "I DON'T REMEMBER MY CHILDHOOD".

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DISSOCIATION CHART

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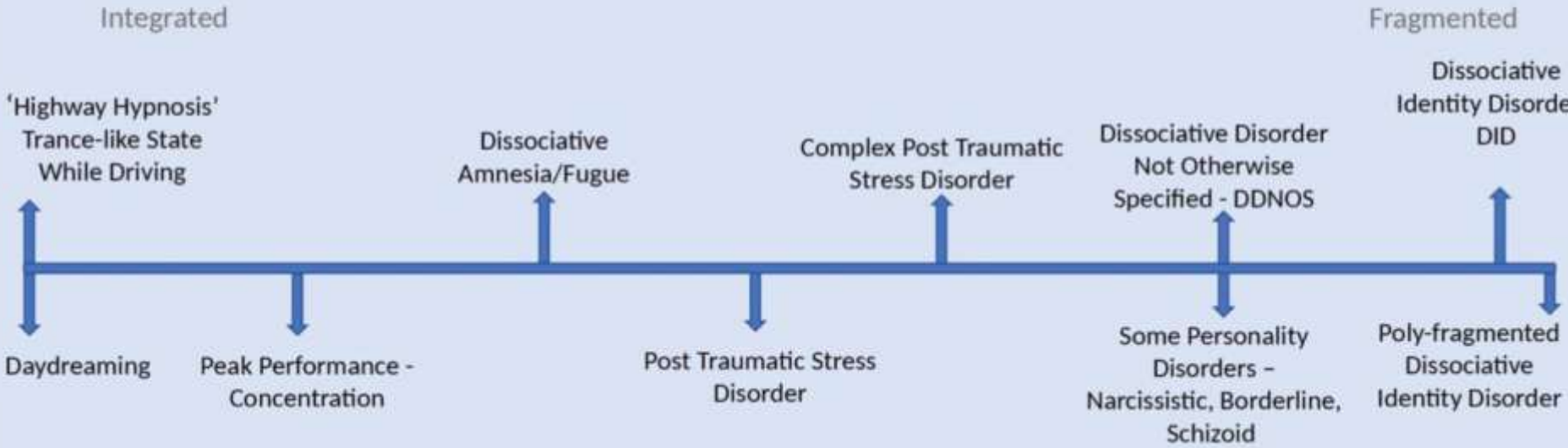
The Dissociative Spectrum

Dissociation is on a spectrum from more integrated to more fragmented



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Recognition of Dissociation in Session

- Sudden shift in experience
- Become overwhelmed
- Unable to maintain dual awareness
- Presence of child-like self-states
- Sudden shift in affect
- Unresponsive; stare off/fall asleep
- Unable to follow instructions
- Sudden headaches
- Unable to maintain co-consciousness between self-states

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Breaking Down Diagnostic Criteria

Criterion A- Disruption of identity characterized by two or more distinct personality states

- Discontinuity in sense of self and agency
- Related alterations in affect, bx, consciousness, memory, perception, cognition, sensory-motor function
- May be observed by others OR reported by the individual

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Breaking Down Diagnostic Criteria

Criterion B- Memory gaps inconsistent with ordinary forgetting

- Everyday events
- Personal information
- and/or traumatic events

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Breaking Down Diagnostic Criteria

Criterion C: Causes significant distress and impairment

Criterion D: Not part of a broadly accepted cultural or religious practice

Criterion E: Not attributable to substance use or medical condition (i.e. seizures)

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What is DID? Terms

- Alter(s)
- Host or Core Identity
- Apparently Normal Parts (ANPs)
- Emotional Parts (EPs)
- System
- Switch

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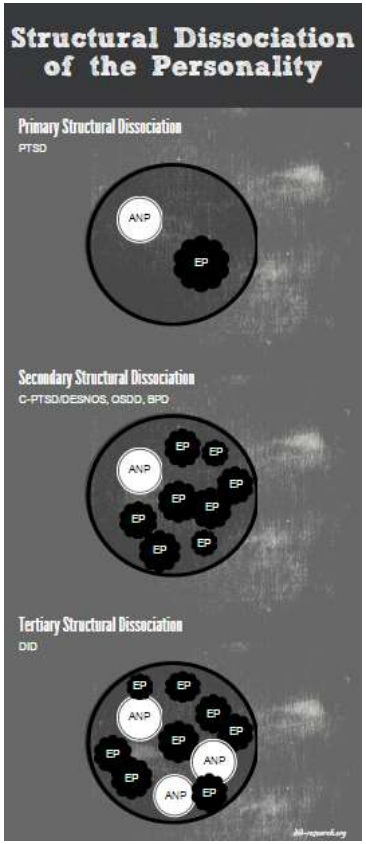
Structural Dissociation (Trauma) Model

- Assumes no one is born with a fully integrated self
- Trauma disrupts the developmental process of personality integration
- In DID this happens before ages 6-9



Types of Structural Dissociation

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- Primary: When a person has 1 ANP (Apparently Normal Part) that is “in charge” most of the time, but certain triggers can bring the EP (Emotional Part) forward.
- Secondary: When a person has 1 ANP and many EPs, each with their own trauma response. Indicates a more traumatic childhood.
- Tertiary: When a person has many ANPs that can overpower each other and multiple EPs.

Evidence for Structural Dissociation

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Physiological markers distinct between ANPs and EPs

ANPs: Present-oriented parts that handle day-to-day functioning. They are in charge of social interactions, taking care of others, work, play, learning, and taking care of physical needs.

ANPs need to appear that they are high functioning and avoid EPs at all costs by limiting emotions and triggering situations/discussion.

EPs: Part that contain the traumatic material such as memories, perceptions, beliefs, learned responses, body sensations, etc. These parts become present with a trauma trigger. These parts can be adults or children.

EPs have heightened emotions and flashbacks, are unaware of the present, are reactive, can be compulsive; these parts are the survivors.

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Iatrogenic/Sociocognitive or Suggestion Models

- Iatrogenic- DID results from suggestion or coercion from mental health providers
- Sociocognitive- DID is caused by environmental influence, including friends, family, social media, etc.

Suggestion Models in Research

- Fantasy proneness
- Malingering
- Environmental influence

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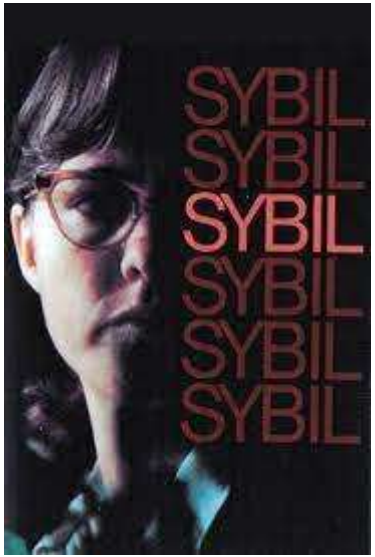
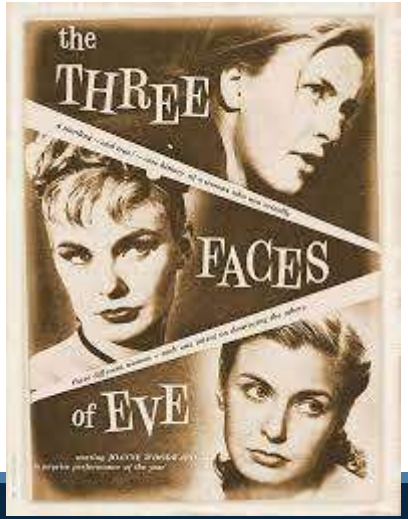
Comparing the Two Models

- Evidence supports distinguishing factors for traumagenic DID compared to suggestion models or malingering
- DID patients do get better in treatment (lack of support for iatrogenic)
- Red flags for malingering:
  - Exaggeration, persistent lying, lack of prior dissociation, a need to assume a sick role, legal motivation, demanding attitudes towards caregivers, lack of previous psychiatric history, lack of consistencies in symptoms, lack of observed symptoms, refusing collateral interviews or testing

Barriers to Accurate Diagnosis

Media Depictions





Common Misconceptions

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Most people presenting with DID are faking it

- DID is an empirically validated diagnosis
- Prevalence rates
- Malingering occurs across ALL mental (and physical) health disorders and rates of malingering in DID are not higher than other conditions

Common Misconceptions

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People with DID are unaware of their past trauma and alter states

- This is not consistent with the diagnostic criteria
- Signs of alters and dissociation are often present, even if the individual doesn't understand what it means
- Co-consciousness

Common Misconceptions

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People cannot hide DID because switches are obvious to others

- Only an estimated 5% of DID population have overt switches between alters
- DID develops as an adaptation to trauma- obvious behavior could be dangerous

Common Misconceptions

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Alters represent specific role types or archetypes

- Possible but not always
- Forcing alters to fit a specific role is unproductive
- There's not an "evil alter" that secretly kills people without the awareness of the system (thanks, Hollywood)
- Alters can be any gender/age/sexuality/race etc.
- Alters don't necessarily have to be human

Common Misconceptions

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DID is a Western phenomenon

- Prevalence rates are fairly consistent worldwide
- Dissociation disorders may be more common in developing countries
- Culture may influence presentation

Social Media and TikTok

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- Lots of anecdotal examples- limited research
- Major themes in the DID social media community arise:
  - Describing DID
  - Boundaries
  - Intersecting identities

Adolescence and Identity Development

- Self-diagnosis and social media engagement aligns in some ways with normative identity development processes
  - Effects of COVID-19 period of time on developmental process
  - Lack of access to resources and control in their environment
- Parental trauma and dissociation may affect how their trauma presents

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Social Media Literacy

- Parents and providers can support teens in evaluating resources
- Providers can create or elevate quality accessible resources

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Cultural Influence on Presentation

Culture-Bound Dissociation

- “Possession” experiences closely mirror DID symptoms
- amok, bebainan, latah, pibloktoq, ataque de nervios, shin-byung, Zar and djinnati

DID in BIPOC Individuals

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- Vulnerabilities to chronic exposure to trauma contribute to increased risk of PSTD/dissociative symptoms
- BIPOC individuals may be more likely to be misdiagnosed
  - Dx with schizophrenia, conduct disorders, substance abuse
  - Also missed comorbidities
- Presentation (in western countries) is similar to that of white individuals

Common Comorbidities

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- Posttraumatic Stress Disorder/Complex PTSD
- Reactive Attachment Disorder
- Conversion Disorder
- Borderline Personality Disorder
- Major Depression
- General Anxiety
- Feeding and Eating Disorders

Assessment of DID and Dissociation

Multidimensional Inventory of Dissociation (MID)

- 218 item self-report with 28 dissociative diagnostic scales (short version too)
- Adolescent version as well
- Norm comparison groups
- Validity Scales!
- Cross-cultural validity

FREE at:
https://www.mid-assessment.com/

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Multidimensional Inventory of Dissociation
The MID Report

Paul F. Dell, PhD

Version 5.2 (PC): October 1, 2020

Client ID: None
Sex: Unspecified
Age: 28

Date: 5/16/2023
Race: Unspecified
Education: Unspecified

MID Initial Impressions and Observations

*Diagnostic Impressions**

Explicit Post-Traumatic Stress:	Posttraumatic Stress Disorder, Dissociative Sub-type
Pathological Dissociation:	Unspecified Dissociative Disorder
Somatization:	Clinically sub-elevated, but possibly therapeutically relevant, somatization reported
Borderline (BPD) Traits:	Clinically insignificant (or no) borderline traits reported

***Symptom features must be substantiated by supporting evidence prior to applying any diagnosis indicated by these impressions.**

Mean MID Score Indications

A MID Score of 15-20: PTSD may be present if Flashbacks, Depersonalization, and Derealization scales are elevated.

Observations Based on Validity and Characterological Scales Scoring

Defensiveness / Minimization may be elevated in relation to the Mean MID Score. Compare Validity and Characterological Scales with overall results, as well as test-taker's known trauma history and presentation. Investigate 'passed' items in Criterion A, B, and C and compare to activity reported in other scales relevant to self-state activity to rule out possible under-reporting of symptom features.

One or more Characterological Scales appear to be elevated, suggesting clinically relevant personality traits (overt or covert). Evaluate 'passed' items in these scales, consult the BPD-DID Comparison Scales Graphs, and consider the potential relevance of self-state activity.

Elevation is evident in Rare Symptoms and/or the Psychosis Screen; evaluate 'passed' items on these scales to rule out mis-reporting or psychosis.

The I Have DID Scale is elevated relative to the I Have Parts Scale. Evaluate indicators of distorted self-report/response bias or clinically relevant personality traits as reflected in the Validity and Characterological Scales, as well as the Functionality and Impairment Scales.

Validity and Characterological Scales

Scale	Items 'Passed'	Mean Score (0-100 scale)
Defensiveness / Minimization:	2 of 12	70.0
Rare Symptoms:	2 of 12	10.8
Emotional Suffering:	6 of 12	49.2
Attention-Seeking Behavior:	1 of 7	21.4
Factitious Behavior:	0 of 7	2.9
Manipulativeness:	0 of 4	5.0
BPD Index:	n/a	8.2
'Ten' Count:	9 of 218 items scored '10'	

Pathological Dissociation Scales

Scale	Mean Score (0-100 scale)
Mean MID Score:	19.2
Mini-MID Score:	18.4
I Have DID Scale:	65.0
I Have Parts Scale:	20.0
Mean Amnesia Score:	5.2
Amnesia Symptoms:	4 of 31 items 'passed'
Severe Dissociation:	57 of 168 items 'passed'
Dissociative Symptoms:	7 of 23 symptoms

Functionality and Impairment Scales

Scale	Items 'Passed'	Mean Score (0-100 scale)
Critical Items:	2 of 10	17.0
Cognitive Distraction:	1 of 12	30.0
Psychosis Screen:	0 of 4	0.0
First-Rank Symptoms:	2 of 8	21.1

Self-State and Alter Activity Scales

Scale	Mean Score (0-100 scale)
Child:	22.9
Helper:	100.0
Angry:	12.5
Persecutor:	0.0
Different Gender:	0.0

Criterion A: General Post-Traumatic Dissociative Symptoms		3 of 6 symptoms
Scale	*Mean Score (0-100 scale)*	*Clinical Significance (at score of 100+)*
Memory Problems:	**2.5**	**0**
Depersonalization:	**43.3**	**175**
Derealization:	**20.0**	**150**
Flashbacks:	**24.2**	**140**
Somatoform Symptoms:	**5.0**	**75**
Trance:	**13.3**	**40**
Criterion B: Partially-Dissociated Intrusions		***4 of 11 symptoms***
Child Voices:	**0.0**	**0**
Voices/Internal Struggle:	**16.0**	**67**
Persecutory Voices:	**0.0**	**0**
Speech Insertion:	**6.7**	**0**
Thought Insertion:	**38.0**	**67**
'Made' / Intrusive Emotions:	**10.0**	**25**
'Made' / Intrusive Impulses:	**0.0**	**0**
'Made' / Intrusive Actions:	**31.1**	**175**
Temporary Loss of Knowledge:	**20.0**	**100**
Experiences of Self-Alteration:	**47.5**	**200**
Puzzlement about Oneself:	**25.0**	**133**
Criterion C: Fully-Dissociated Actions (Amnesia)		***0 of 6 symptoms***
Time Loss:	**7.5**	**50**
"Coming to":	**0.0**	**0**
Fugues:	**0.0**	**0**
Being Told of Disremembered Actions:	**0.0**	**0**
Finding Objects Among Possessions:	**7.5**	**50**
Finding Evidence of One's Recent Actions:	**0.0**	**0**

Schneiderian First-Rank Symptom Scales	
Scale	*Mean Score (0-100 scale)*
Voices Arguing:	**0.0**
Voices Commenting:	**0.0**
'Made' Feelings:	**18.3**
'Made' Impulses:	**16.0**
'Made' Actions:	**20.0**
Influences on the Body:	**45.0**
Thought Withdrawal:	**20.0**
Thought Insertion:	**47.5**

Clinician's Pre-MID Assessment Summary

Current Diagnosis

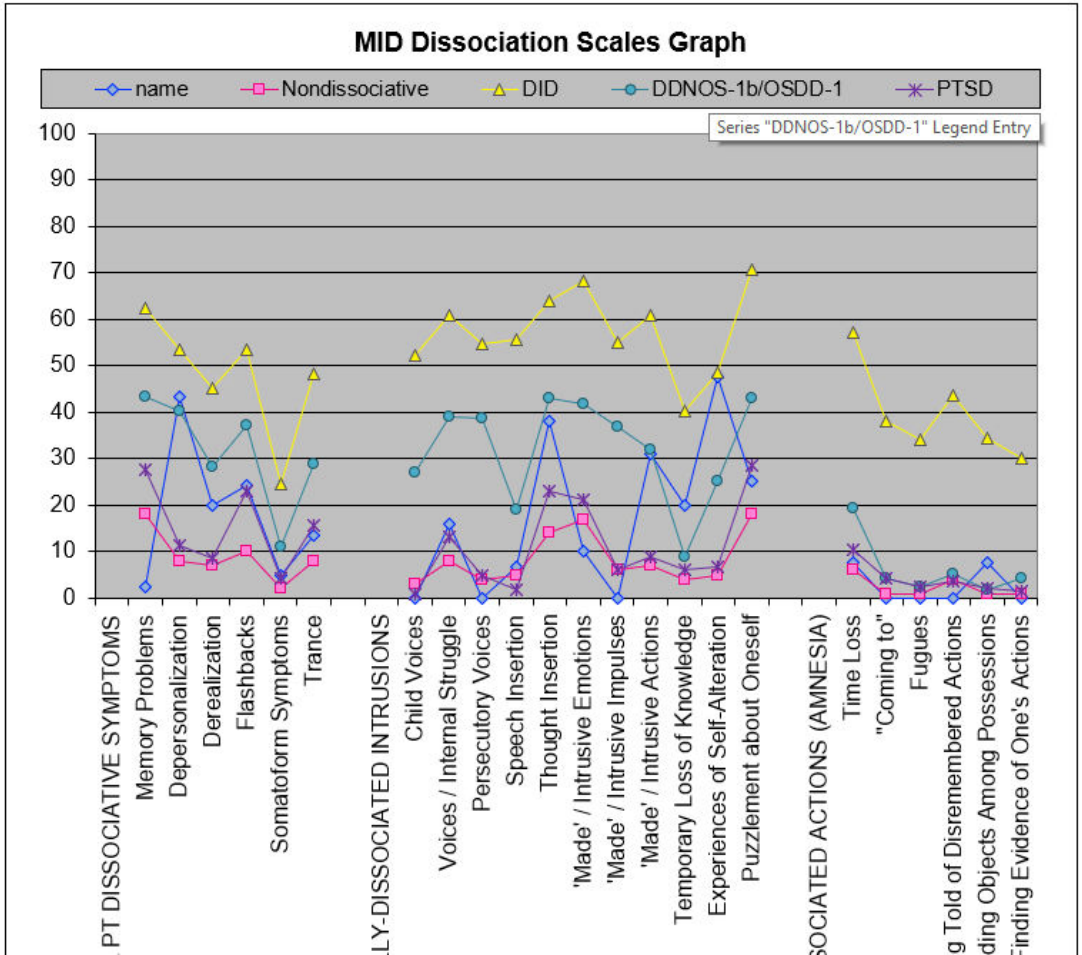
None provided

Comments/Observations

None provided

The MID Report: Line Graphs

Version 5.2 (PC): October 1, 2020



The MID Report: Bar Graphs

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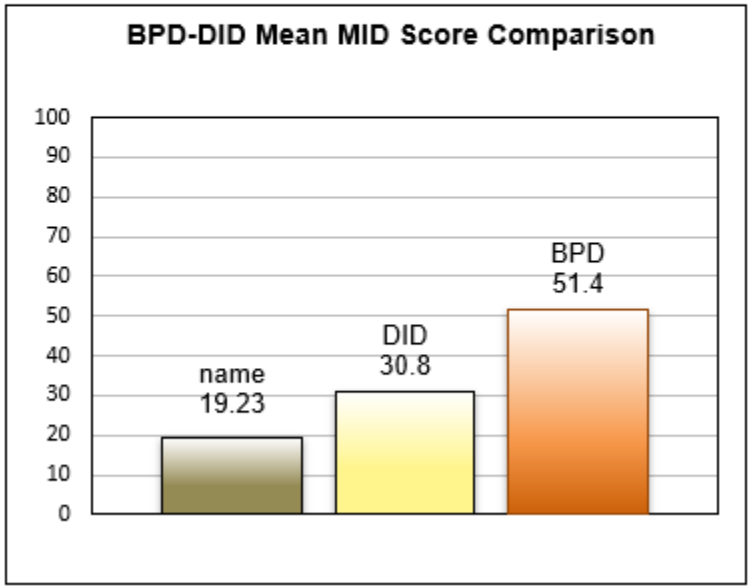
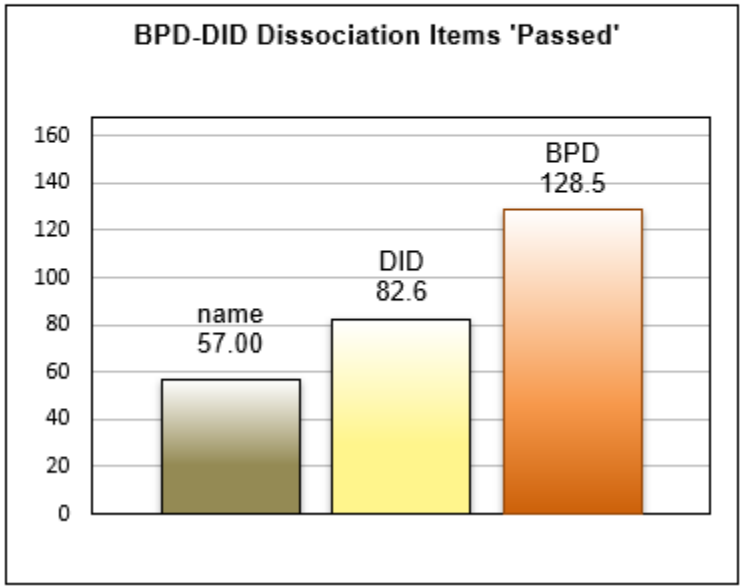
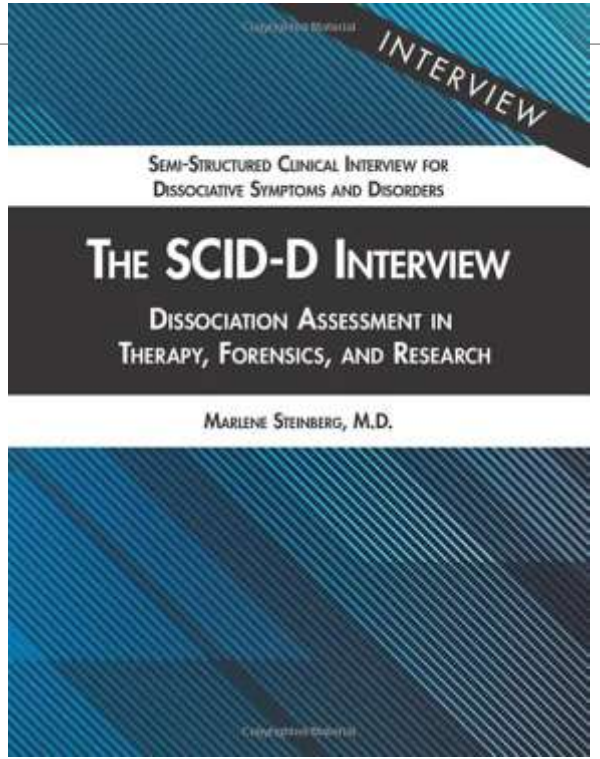




Structural Clinical Interview for DSM-V Dissociation (SCID-D)

- Semi-structured interview
- Updated for DSM-5-TR
- Adolescents and Adults



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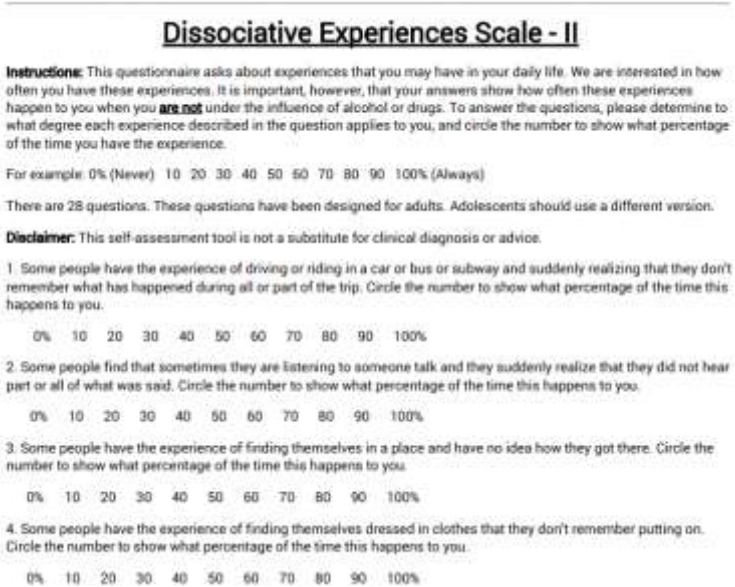
Dissociative Experiences Scale (DES-II)

- 28 question screening tool
- Adolescent version (A-DES)
- Clinical threshold ~30 for DID patients
- Useful to determine if more assessment is needed and to start a conversation about dissociation, but not a diagnostic tool



Dissociative Experiences Scale - II

Instructions: This questionnaire asks about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you **are not** under the influence of alcohol or drugs. To answer the questions, please determine to what degree each experience described in the question applies to you, and circle the number to show what percentage of the time you have the experience.

For example: 0% (Never) 10 20 30 40 50 60 70 80 90 100% (Always)

There are 28 questions. These questions have been designed for adults. Adolescents should use a different version.

Disclaimer: This self-assessment tool is not a substitute for clinical diagnosis or advice.

1. Some people have the experience of driving or riding in a car or bus or subway and suddenly realizing that they don't remember what has happened during all or part of the trip. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part or all of what was said. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

3. Some people have the experience of finding themselves in a place and have no idea how they got there. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

4. Some people have the experience of finding themselves dressed in clothes that they don't remember putting on. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

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Trauma Assessment

- Clinician-Administered PTSD Scale (CAPS-5)
  - PTSD Checklist for DSM-5 (PCL-5)
- Traumatic Stress Inventory
  - Self report for adults
  - Validity scales
- UCLA PTSD Assessment for Child/Adolescent- parent and child report
- Trauma Symptom Checklist for Children (TSCC)
  - Parent measure, ages 8-16

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Assessment Tools for Personality

- Minnesota Multiphasic Personality Inventory (MMPI-3)
  - MMPI-A
  - Includes validity scales
  - Research distinguishes genuine from malingered DID profiles
- Millon Clinical Multiaxial Inventory (MCMI-IV)
  - MACI
  - MPACI
  - Profiles identified in DID patients- also profiles changed after integration

Assessment of Perception and Fantasy-Proneness

Rorschach

- Patients respond to 10 inkblots
- Multiple scoring systems
- Ages 5 and up
- Research supports use to distinguish from PTSD and BPD

Thematic Apperception Test

- Patients generate narratives to up to 32 cards
- Ages 4 and up

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Tests of Malingering

- Test of Memory Malingering (TOMM)
  - Visual recognition test
  - Ages 16-84
- Miller Forensic Assessment of Symptoms Test (M-FAST)
  - 25-item screening interview for adults
  - Increasing the cut-off to 7 increased sensitivity while maintaining specificity
- Structured Inventory of Malingered Symptomology (SIMS)
  - 72-item self report screen for adults
  - High sensitivity but low specificity

Important Rule-Outs

- Other Specified Dissociative Disorder
  - Chronic and recurrent syndromes of mixed dissociative symptoms
  - Identity disturbance due to prolonged and intense coercive persuasion
  - Acute dissociative reactions to stressful events
  - Dissociative trance
- Neurodivergence
- Seizures

Treatment of DID and Dissociation

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Evidence Based Treatment

Phase-Oriented Treatment Approach

1. Focuses on safety, stabilization, and symptom reduction.
2. Processing of the trauma.
3. Helps the client adjust to a new sense of self and well-being.

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Phase 1: Prep

Addressing clients safety from others and self, addressing risks in environment, or addressing destructive alters.

Stabilizing the client in their environment and themself.

Reducing symptoms to be able to move into the trauma work.

- Psychoeducation
- CBT: Skills building/Impulse Control
- DBT: Emotional regulation/Interpersonal Effectiveness
- Internal Family Systems (IFS)
- Jim Knipe, back of the head scale
- Grounding techniques: 4 elements, medicine ball, fidget toys, throwing a ball, sensory based, re-orienting, movement.

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Phase 2: The Work

Prolonged Exposure (PE)

Trauma-Focused CBT(TF-CBT)

Cognitive Processing Therapy (CPT)

Psychodynamic Therapy

Eye Movement Desensitization and Reprocessing (EMDR)

Phase 3: The New Norm

Integration

Partial

Full

Continued work to adjust to their new understanding, changes in relationships, new stressors, their integrated state.

How to not react like this

Listen

Gain Understanding

Educate

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Recommended Reading

- *The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization* by Onno van der Hart, Ellert R.S. Nijenhuis, Kathy Steele
- *Coping with Trauma-Related Dissociation: Skills Training for Patients and Therapists* by Onno van der Hart, Kathy Steele, Suzette Boon
- *The Stranger in the Mirror: Dissociation-The Hidden Epidemic* by Marlene Steinberg, Maxine Schnall
- *Introduction to the Internal Family Systems Model* by Richard Schwartz
- *No Bad Parts: Healing Trauma and Restoring Wholeness with the Internal Family Systems Model* by Richard Schwartz, Alanis Morissette
- *Parts Work: An Illustrated Guide to Your Inner Life* by Tom Holmes, Sharon Eckstein, Lauri Holmes
- *Healing the Unimaginable: Treating Ritual Abuse and Mind Control* by Alison Miller

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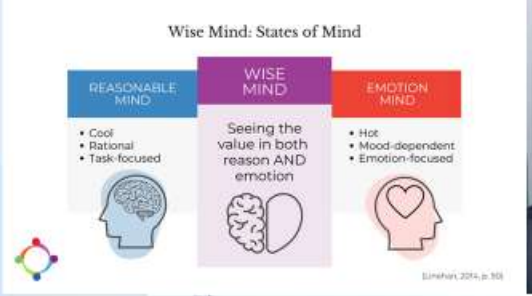

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