DID PREVALENCE, DIAGNOSIS AND KEY INDICATORS

—by Myron Walters, MA, CMT, LMFT

Dissociative Identity Disorder (DID), previously called Multiple Personality Disorder, is typically thought of as a fairly rare disorder. Prevalence studies in multiple countries have indicated otherwise, with estimates ranging from 1 to 3.1% across the general population, and 3.3 to 14% across clinical populations (Richardson, 2009, pp. 19–23).

Doing my own reality check on this, I've seen just over 100 clients in my career thus far, with 8 fairly certain DID diagnoses and two more probable DID diagnoses. This is about 8 to 10% of my clinical population, well within the 3.3 to 14% previously reported.

DID clients typically have 6 to 7 psychiatric diagnoses before they get diagnosed with DID (Ross, 1997, p. 122)—in order of prevalence: mood disorders, personality disorders, anxiety disorders, schizophrenia, substance abuse, adjustment disorder, somatization disorder, eating disorder and an organic mental disorder. In other words, if a client, or potential client, has many diagnoses, especially with a number of failed therapies, it would be prudent to get interested in the possibility of a dissociative disorder being present.

Unfortunately, most psychiatrists tend not to diagnose DID—psychiatry still seems to be recovering from Freud's 1905 public rejection of the seduction theory, which linked dissociative symptoms to sexual abuse (Richardson, 2009, p. 5). It also doesn't help that DID is not a mental health parity diagnosis, whereas schizophrenia, bipolar and depression are parity diagnoses.

Diagnosing DID is not easy, even for the clinician experienced in dissociative disorders. A rigorous workup is required. Many times it is not possible to make a quick diagnosis because the client is intentionally or unintentionally hiding the key parameters needed for a clinician to make the diagnosis. In many respects, the functional purpose of DID is to hide from view. This makes sense from and an etiology point of view, when one considers the high degree of correlation of DID with childhood abuse (physical, sexual, emotional and neglect) (Putnam, 1989, pp. 46-50).

The gold standard for diagnosing DID is the Structured Clinical Interview for DSM-IV Dissociative Disorders, otherwise known as SCID-D (Steinberg & et. al., 1993), but this takes about 3 ½ hours for a trained clinician to administer.

I can also highly recommend Lowenstein's excellent and detailed office mental status for dissociative symptoms and DID (Lowenstein, 1991).

A rapid screening, self-report tool for a dissociative disorder is the Dissociative Experience Scale (DES) (Carlson & Putnam, 1993). Although not perfect, this 28 question tool can give a quick indication if further investigation would be helpful.

Another self-report tool that I've found useful is the Multidimensional Inventory of Dissociation v.6.0 (MID-6) (Dell, 2006). This has 218 questions and gives a dissociative mapping for the client.

The MID-6 and DES are both available from the International Society for the Study of Trauma and Dissociation (ISSTD).

The presence of two or more distinct identities or personality states is the key criterion for DID in the DSM-IV-TR (APA, 2000). Unfortunately, this key criterion is rarely seen in or disclosed by a client until a strong therapeutic alliance has been established. This is one of the contributing factors to a firm DID diagnosis sometimes taking years.

Below are some of the key features I have found beneficial to check during my initial client intake. If I get a hit on a constellation of these, I definitely want to look closer for a dissociative disorder, e.g., I would then give the DES and/or MID-6.

1. Multiple previous diagnoses (see above)
2. Multiple failed previous therapies (see above)
3. Time loss or time gaps which are not accounted for by use of drugs, alcohol or medical reasons (e.g., epilepsy), especially large gaps of memory from childhood. This is actually one of the DSM-IV-TR criteria, so I give this one high importance.
4. Suicidality
5. Self-harm activities
6. Inner voices that are ego-dystonic to the client –generally, I won't learn about this though until a sufficient therapeutic alliance has been established.
7. PTSD symptoms, such as hyper vigilance, intrusive thoughts, flashbacks, etc.
8. An extensive childhood trauma history
9. A client who does a hypnotic eye-roll, where the client rolls their eyes up into the top of their head showing the whites of their eyes (see Figure 1)—this typically happens during a switch.

Figure 1: *Hypnotic Eye Roll*

Summarizing, because DID tends to be a hidden disorder that actually has a fairly high prevalence, wreaks havoc on the client and can result in many failed therapies, it is important for a clinician to begin to gain some awareness around when to suspect DID.

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About the Author

Myron Walters, MA CMT, Licensed Marriage and Family Therapist, has private practice offices in Mill Valley and Cotati. Myron works somatically, being both trauma and attachment informed. Myron's specialty is working with adults who have experienced severe childhood trauma, complex PTSD and dissociative disorders. Myron has training in trauma resolution (Somatic Experiencing), hypnosis (SCEH & ASCH), and in DID psychotherapy (ISSTD). Myron welcomes your calls and referrals at (415) 686-3445.

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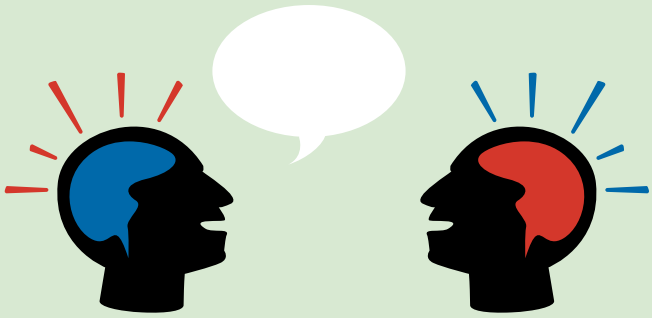

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