

Diagnosing Dissociative Identity Disorder

Understanding and assessing manifestations can help clinicians identify and treat patients more effectively.

Dissociative identity disorder (DID) is a complex chronic posttraumatic dissociative disorder. Its *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (*DSM-IV-TR*),¹ diagnostic criteria are given in Sidebar 1 (see page 634). Beyond these core phenomena, this group of patients usually gives accounts of severe childhood trauma and may have a full range of comorbid posttraumatic stress disorder symptomatology.

Patients with DID commonly suffer severe concomitant anxiety, exhibit both affective and somatoform symptoms, and demonstrate phenomena associated with a high degree of hypnotizability. They often manifest phenomena associated with borderline personality disorder. In some instances, borderline personality disorder appears to be a true comorbid diagnosis, while in others the appearance of its features is an epiphenomenon of conflict and switching generated by

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EDUCATIONAL OBJECTIVES

1. Identify the components of the "Dissociative Surface."
2. List seven conditions to consider in the differential diagnosis of dissociative identity disorder (DID).
3. Describe the most common screening instrument and diagnostic interview for the diagnosis of DID.

the alter system intrinsic to DID itself and has not shown the consistent, long-standing, and enduring pattern of a personality disorder.²

DID is the delivery and maintenance system for achieving an intrapsychic multiple reality disorder, the purpose of which is the patient's internal effort to carry on with the semblance of a normal life when contending with life's actual realities has proven impossible.^{3,4} In the effort to find a series of rationales to preserve the hope of safety, and to preserve the perception, hope, or illusion that certain crucial relationships are or can become positive and loving, the overwhelmed child desperately "thinks outside of the box" and develops ingenious and resourceful fantasies that undo or modify what the mind cannot accept.

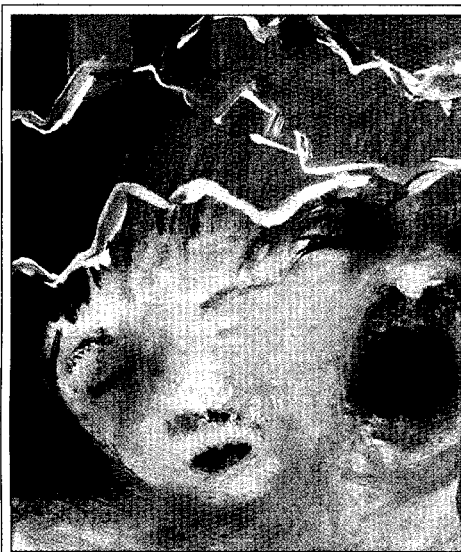
An aspect of this adaptation is the development of alternate identities and

selves that act in accordance with these adaptive fantasies. In an often masochistic fashion, these identities may live within the "terms of endearment" that prevailed in the child's dysfunctional childhood circumstances — that is, concepts of safety and goodness are understood in terms of what best (or what they thought best) protected them from further danger and harm. These alters often interact among themselves in an inner world, which may be close to the group of alters that function in the day to day external world. They may intrude into or comment on external world events, or they may be relatively aloof from and diffident toward the external world and the alters that cope with it.^{3,4}

Over time, the patient with DID partakes of and participates in what I have termed "the three realities." The first is the historical reality, as accurately as it has been perceived and can be recalled. The second is the historical reality as its perception and recollection is modified and revised by distortions, fantasies, misperceptions, transferences, projections, misinformation, post-event influences, and contaminations. The third reality is one in which events enacted within the inner world of the alters may intrude into and be misperceived as events that have occurred in external historical reality.^{3,4}

These observations, clinically derived, can be illustrated by examining the personality system of Lois. Lois is a woman raised by two good but rather cold, strict, and rigid parents. The joy of her life was her uncle, Ben, who was warm, funny, indulgent, playful, generous with his hugs and words of praise, and always ready to take Lois on fun-filled adventures. Over time, Ben moved from warm to subtly seductive, to overtly seductive ("our special games"), and finally to brutally exploitive. Lois was in the position of being betrayed, hurt, and eroticized by the person who was most important to her emotionally.

Her personality system (Table, see page 635) illustrates the many strategies she devised to continue to have a warm and affectionate relationship with her perpetrator, defending against the loss of the Uncle Ben that she loved and who was so important to her sense of being loveable, worthwhile, and cared about. The price paid for preserving this affectionate tie was the defensive and multiple reconfiguration of her self and her identity that served her well in preserving her relationship with her uncle, and proved utterly self-defeating elsewhere, (eg, "the sitting duck syndrome").⁵ Her masochistic submissiveness and turning of all blame on herself so she would be



SIDEBAR 1.

DSM-IV-TR¹ Criteria for Dissociative Identity Disorder*

- A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
- B. At least two of these identities or personality states recurrently take control of the person's behavior.
- C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
- D. Not due to direct physiological effects of a substance (eg, blackouts or chaotic behavior during alcohol intoxication) or a general medical condition (eg, complex seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

*Formerly called multiple personality disorder.

liked, her acceptance of the notion that she was responsible to make things go well and responsible for both causing and repairing things when they did not, and her unexamined strong attachment to men like her uncle Ben, all enacted by her cadre of alters, combined to make her life painful and humiliating.

Once established, this dissociative style of coping usually remains quite covert to the outside observer, although confusing, humiliating, and painful to the patient with DID. DID is, as Gutheil noted, “a psychopathology of hiddenness.”⁶ Although one would think from the *DSM-IV-TR* criteria that the presence of this condition should be self-evident, a study of 236 patients with DID demonstrated that the condition was most commonly clandestine, with few, minor, or intermittent manifestations.⁶ The study found that only 6% of patients with DID were overt in their manifestations and insistent on calling them to the attention

The average patient with DID has been in the mental healthcare delivery system an average of 6.8 years and has received more than three other diagnoses, reflecting either misdiagnoses or comorbidities, before receiving an accurate diagnosis of DID.

of others in their lives. Twenty percent, including the 6% noted above, were actively DID with overt switching most of the time, but 70% of this 20% were quite adept at concealing and dissimulating their conditions. Eighty percent of the studied group demonstrated either no overt dissociative manifestations or

TABLE.

Coping Strategies and Alter Formation^{3,4}

Coping Strategy	Alter Created
This did not happen.	A Lois who knows, and a Lois who does not.
I must deserve it.	Bad Lois, whose behavior would explain trauma as punishment.
I must have wanted it.	A sexual alter, Sherry.
I can control it better if I take charge.	An aggressively sexual alter, Vickie.
I would be safe if I were a boy.	Louis, Lois' male "twin."
I wish I were a big man who could prevent this.	Big Jack, based on some person of power.
I wish I were the one who could hurt someone and not be hurt.	Uncle Ben, or a more disguised identification with the aggressor.
I wish I could feel nothing.	Jessie, who endures all yet feels nothing.
I wish someone would replace me.	"The Girls," who encapsulate specific experiences of trauma unknown to Lois.
I wish someone would comfort me.	Angel, with whom Lois imagines herself to be while the body is being exploited and "The Girls" are experiencing the trauma.

symptoms that only qualified them for the diagnosis of dissociative disorder not otherwise specified most of the time.

Most patients with DID, whose manifestations were generally subtle or easily concealed most of the time, exhibit “windows of diagnosability” during which the manifestations became more overt. These windows were associated with psychosocial stressors, intercurrent traumatization, deaths or major events in the lives of those who had abused them, reexposure to traumatizers or locations associated with their traumatization, injuries or threats to their loved ones — especially their children, with special emphasis on perception of threat to their children when the children reached the age at which the patient with DID had been traumatized — or intercurrent medical events (eg, closed head injury, anesthesia, severe infection, painful injuries or conditions).

These observations are consistent with and partially explanatory of the findings of Putnam et al.,⁷ now replicated many times, that the average patient with DID has been in the mental healthcare deliv-

ery system an average of 6.8 years and has received more than three other diagnoses, reflecting either misdiagnoses or comorbidities, before receiving an accurate diagnosis of DID.⁷ This information raises serious concerns about how to diagnose a condition that is so well-hidden and difficult to discern.^{6,8-10}

Addressing these concerns begins with appreciating how DID might manifest itself short of overt switching among clearly distinct alters. More often than not, DID is dissimulated and camouflaged, so it is important to understand that, although its processes and structures may be active and powerful, its manifestations may be subtle.⁶ These mechanisms and phenomena may be described as creating the “dissociative surface” (Sidebar 2, see page 636). This is what one actually encounters when interacting with a patient with DID when one is not dealing with overt and apparently definitive switches of executive control.

Understanding the potential composition of this dissociative surface introduces the clinician to the differential diagnosis of what may be going on in the patient

The Dissociative Surface

The Host, or the "Usual Patient"

The Semblance of the Host or "Usual Patient"

- Passing For the Host
- Isomorphism
- Tag-Teaming

Copresence Combinations

- Mixed Presentations
 1. Cooperations
 2. Clashes
 3. Vectors
 4. Temporary Blendings

Fluctuating Presentations

One-Plus Presentations

Shifting One-Plus Presentations

Instructed Behavior

Intrusions

1. Simple
2. "Up the Food Chain"
3. From the "Third Reality"

Imposed or "Made" Behavior

1. Simple
2. "Up the Food Chain"

Switching, Rapid Switching, and Shifting



ent from its usual presentation due to another alter's influence, and may show noteworthy differences over time as still other personalities influence it from behind the scenes.¹¹ At times, an alter clearly is present, but its behavior and utterances are not typical of it because it is hearing and reacting to inner instructions, even commands or threats, from another alter. Further, alters sometimes are intruded into by others, and act as if taken over or hijacked by those others. Intrusions may come from a particular alter, an alter ordered to do so by a more powerful alter, or from the alters of the inner world that never directly emerge. Alters also may manifest ego-alien imposed or "made" behavior, which are passive influence experiences generated by similar sources.

Typical manifestations of alter-switching processes at work in the dissociative surface are listed in Sidebar 3 (see page 637). When very rapid switching or shifting¹² (incomplete changes in executive control) is at work, the patient may be so disrupted that, despite a reasonably unchanging presentation, he or she may have difficulty completing a thought or a sentence without losing track of his or her thoughts or changing the conversation's subject or direction. Should a clinician inquire about the patient's experience when such phenomena are noted, the patient often will feel detached from what is going on, with a sense of depersonalization, derealization, or being influenced by something outside of his or her control. These experiences can approximate many of the first-rank symptoms associated with schizophrenia.¹¹

At times, awareness of such phenomena may cause a clinician to initiate an evaluation for DID. For example, one patient in whom I had not suspected DID elicited some countertransference exasperation when she repeatedly requested explanations of issues I had reviewed with her time and time again. I observed to her that it was as if she had not heard

with DID, largely below the surface but intruding upon it. Such awareness enables the clinician to begin to think about and notice subtle manifestations of covert processes and become more skilled at the diagnosis and treatment of DID. It helps the clinician consider and notice the ways that the inner structure of the mind of a patient with DID can express itself without becoming overt.

In addition to the host (the personality most often in apparent executive control over a given period of time), one encounters alters who pass themselves off as the host, either by imitating the host or because they are virtually isomorphic with the host. Sometimes a group of alters shares the role of supporting or being the host, relieving one another either periodically, thematically, or when an alter in apparent executive control is tiring. Executive control often is shared

by co-present alters, who may cooperate with or oppose one another, or who may make a presentation that is the vector of



Sometimes a group of alters shares the role of supporting or being the host, relieving one another either periodically, thematically, or when an alter in apparent executive control is tiring.



their differences. In addition, sometimes alters temporarily blend or join.

Sometimes it is clear that a single personality is in apparent executive control, but it shows it is somewhat differ-

what I had been telling her. She assured me that she did, and that her request was sincere. A few sessions later we repeated this sequence of events. Now I asked if I was talking to "Donna," the patient's given name. I was assured that I was talking to Donna. I then asked if I was talking to the same Donna who usually came to sessions. She said that "I" was not. I came to learn that the patient was very threatened by the issues I had reviewed, so that whichever alter heard the explanation would leave the surface and be replaced by an alter who was unaware of what I had said. Of course, the alter that shared this insight was upset by the information as well and rapidly left the scene, restoring a situation in which the upsetting information was disavowed.

BARRIERS TO THE DIAGNOSIS OF DID

DID often is viewed with both fascination and skepticism within the mental health professions. Controversy continues to surround many aspects of its epidemiology, etiology, phenomenology, and treatment.⁴ Many longstanding beliefs about DID are in fact misconceptions. These background considerations are capable of infiltrating and contaminating both the diagnosis and the differential diagnosis of this condition. Sidebar 4 lists some of these considerations. The diagnostic situation is further complicated because the patient may be encountered in a personality state that either does not have access to or will not share the data necessary for the diagnosis to be suspected or made, or that may not feel secure enough with the interviewer to open up.

It is important to realize that numerous studies in North American, European, Hispanic, and Asian centers have demonstrated that when psychiatric patient populations are systematically screened for dissociative disorders in general and then with structured instruments of high reliability and validity for

SIDEBAR 3.

Typical Manifestations of Dissociative Surface Processes At Work

1. Brief amnesic moments, apparent amnesia or forgetfulness about matters under discussion or subjects of ongoing concern within the treatment, or abrupt changes of the subject of discourse.
2. Derailing of an ongoing conversation by the patient's appearing spacey, perplexed, or surprised by what is coming out of his or her mouth.
3. Transient anxiety or distress.
4. Palpable but difficult to characterize alterations in the manifestations of an alter.
5. Changes in the attitude, emotions about, and stance taken toward matters under discussion.
6. Fluttering of the eyelids or rolling of the eyes (suggesting an autohypnotic process).
7. Apparent distraction by or attention to internal stimuli.
8. Appearances that suggest a "double exposure" in which one alter's characteristic appearance seems superimposed upon or rapidly oscillating with the appearance of another, or gives the appearance of blending of two known alters' patterns of expression.
9. One aspect of facial expression being discordant with the others, such as smiling while the face otherwise expresses fear or sorrow, or one side of the face (or the ocular region compared with the oral region) expressing one affect while the other side (or region) expresses another.

SIDEBAR 4.

Barriers to the Diagnosis of DID

1. The unfamiliarity of many clinicians with clinical DID.
2. The belief that DID is rare.
3. The belief that DID is iatrogenic.
4. The belief that DID is an attention-seeking malingered or factitious disorder.
5. The belief that DID is not an autonomous mental disorder, but an atypical manifestation of some more common disorder that can be treated with a paradigm more familiar and congenial to the clinician.
6. The authority and influence of respected authorities who subscribe to one or more of the above beliefs, and may insist that the diagnosis not be made by those associated with them.
7. Institutional or individual unwillingness to provide the type of treatment recommended for DID, creating a bias against making the diagnosis.
8. The inconsistency of DID with many prevalent paradigms and models.
9. Fear of the patient with DID, the difficulty of treating DID, or the problems (and potential litigation) associated with dealing with memories of abuse.



SIDEBAR 5.

Suggestive Signs of DID^{4,15,16}

1. Prior treatment failure.
2. Three or more prior diagnoses.
3. Concurrent psychiatric and somatic symptoms.
4. Fluctuating symptoms and levels of function.
5. Severe headaches and other pain syndromes.
6. Time distortion, time lapses, or frank amnesia.
7. Being told of unremembered behaviors.
8. Others noting observable changes.
9. The discovery of objects, productions, or handwriting in one's possession that one cannot account for or recognize.
10. Hearing voices (80% or more within the head) that are experienced as separate, often urging the patient toward some activity.
11. The patient using "we" in a collective sense or making self-referential statements in the third person.
12. The eliciting of other entities through hypnosis or a drug-facilitated interview.
13. A history of child abuse.
14. An inability to recall childhood events from ages 6 to 11.

patient to ineffective treatment, and the Charybdis of overdiagnosis, which does the same.

DIAGNOSTIC APPROACHES

The traditional basic clinical interview and mental status examination were not designed to explore dissociative phenomena in depth, and few of their inquiries will yield crucial data.^{4,8,9} In recognition of this, early in the modern era of work with DID, clinicians began to screen patients for signs suggestive of DID (Sidebar 5), and follow up signs endorsed by the patient with further inquiries.^{4,15,16}

The rationale behind these indicators generally is self-evident, but items 12 and 14 may appear perplexing. It is possible to elicit ego state and allied phenomena in patients who do not have DID. Ego states are "organized systems of behavior and experience that are bound together by some common principle, and which are separated from other such states by a boundary that is more or less permeable."¹⁷ Also, while some patients may understand inquiries about alters as suggestions to enact what they believe is being requested, others may respond as if they had alters but actually are talking about quite literal notions of introjection and identification. Transient ego states based on recently lost love objects also may be encountered in grieving individuals. Therefore, eliciting an apparent alter does not mean that one has encountered a true alter.

Also, we regard amnesia for the first few years of life as normal and expectable, but it is less common for a person's autobiographic memory to be spotty or more or less absent between ages 6 and 11. Such a finding raises the level of suspicion for dissociation during childhood, which is characteristic for DID.⁴

Loewenstein's special mental status examination for complex chronic dissociative disorders offers a useful battery of questions with which to make inquiry

DID in particular, previously undiagnosed DID is found in between 2% and 5% of those studied.^{4,13} While it is clear that DID can be complicated or worsened by a therapist's interventions, there is no convincing evidence (although there are vehemently expressed opinions) that the condition can be created in an adult patient by suggestive influences. Therefore, the contemporary clinician is well advised to be prepared to assess for the presence of DID and allied conditions.

The diagnosis and differential diagnosis of DID is best approached with neither skepticism nor enthusiasm, using what I call "The Rule of Clouseau." In the 1963 movie *The Pink Panther*, Inspector Clouseau explains his stance as a detective: "I suspect everyone, and I suspect no one."¹⁴ In other words, a diagnosis will be made most expeditiously

by the clinician who includes the consideration of DID in every patient he or she encounters but who is not driven by a passion to find it everywhere. This stance

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positions the clinician at a safe distance from both the Scylla of underdiagnosis, which condemns the misdiagnosed

about dissociative phenomena.¹⁸ Taking into account both the covert nature and natural history⁶ of DID and the fact that diagnosticians often complained that it was difficult to find the DID behind a bewildering myriad of symptoms, he reasoned that those myriad symptoms were, in fact, the typical presentation of DID. His battery examines six symptom areas (Sidebar 6). A patient with positive findings in all six areas is a good candidate for the diagnosis of DID.

When DID is suspected but proves difficult to confirm in a standard interview, it is often useful to ask the patient to journal 20 to 30 minutes a day. Other alters may make entries. Also, because patients with DID have been found to switch more frequently than is evident in brief encounters, a prolonged interview increases the chances that the clinician will observe a spontaneous switch.⁴ Clinical experience and research¹⁹ suggest that most patients with DID, even if they are dissimulating, will show an actual switch or signs of a pressure toward switching after 2.5 to 3 hours. This is very useful in forensic evaluations. General psychological testing often may be helpful, but it has not reached a level of reliability or validity in making the diagnosis of DID.

When many signs indicate the probable presence of DID and the spontaneous emergence of an alter is not witnessed, a direct request to meet an alter may be considered.²⁰ This is most commonly attempted while exploring a puzzling or out of character event that the patient knows has occurred but for which the patient lacks autobiographic memory. This strategy may succeed, but it may be greeted with denial, disavowal, or apprehension. The patient may show visible discomfort; exploration of this discomfort may provide additional data or the emergence of an alter either later in the same session or subsequently.⁴

In the past, both hypnosis and drug-facilitated interviews were used fre-

SIDEBAR 6.

Symptom Areas to Examine in DID Diagnosis¹⁸

1. Indications of the DID process at work (eg, differences in behavior, linguistic indications, switching/shifting)
2. Signs of the patient's high hypnotic potential (eg, enthrallment, trance logic, out-of-body experiences)
3. Amnesia
4. Somatoform symptoms
5. Posttraumatic stress disorder symptoms
6. Affective symptoms

SIDEBAR 7.

Instruments Useful in the Diagnosis of DID

Measures of Dissociation

Dissociative Experiences Scale (DES) — Bernstein & Putnam, 1986²¹
 Perceptual Alterations Scale (PAS) — Sanders, 1986²²
 Questionnaire of Experiences of Dissociation — Riley, 1988²³
 Dissociation Questionnaire (DIS-Q) — Vanderlinden et al., 1993²⁴
 Clinician-Administered Dissociation Scale (CADSS) — Bremner et al., 1998²⁵
 Multiscale Dissociation Inventory (MDI) — Briere, 2002²⁶
 Somatoform Dissociation Questionnaire (SDQ-20) — Nijenhuis et al., 1996²⁷

Structured Diagnostic Interviews

Dissociative Disorders Interview Schedule (DDIS) — Ross, 1989²⁸
 Structured Clinical Interview for the Diagnosis of DSM-IV Dissociative Disorders, Revised (SCID-D-R) — Steinberg, 1994²⁹

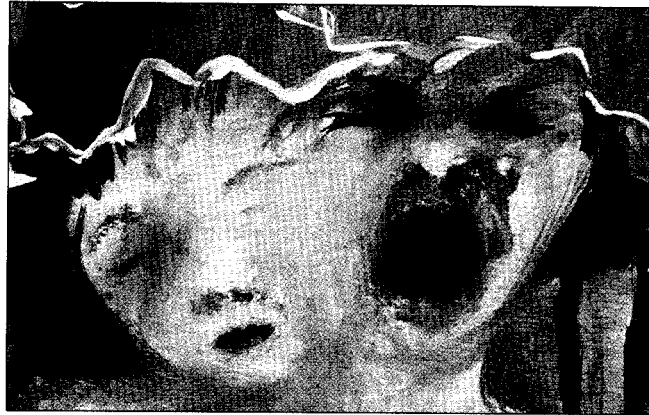
quently for diagnosis. Currently, many of the cautions appropriate to the use of these modalities for memory retrieval have been overextended to cause misgivings about their diagnostic use as well. However, the circumspect and cautious diagnostic application of these interventions remains valuable. The clinician is sometimes forced to choose between using a technique that some colleagues regard with misgivings and leaving a diagnostic situation unresolved, rendering the choice of the appropriate therapeutic approach a matter of guesswork.

THE USE OF SCREENING AND DIAGNOSTIC INSTRUMENTS

Sidebar 7 lists most available instru-

ments for screening patients for dissociative phenomena, including structured diagnostic interviews. While the psychometric qualities of the screening and diagnostic instruments are comparable, only one representative of each group, the one most widely used by students of dissociation, will be discussed here. It is my practice to use both the original version of the Dissociative Experiences Scale (DES) and the Structured Clinical Interview for *DSM-IV* Dissociative Disorders, Revised (SCID-D-R), whenever possible.

The DES, authored by Bernstein and Putnam,²¹ is the most widely used instrument for the screening of patients for dissociative difficulties. A self-administered test, it consists of 28 questions, each of which inquires about the percentage of



SIDEBAR 8.

Approaches to the Differential Diagnosis of DID⁴

DID vs. Other Dissociative Disorders

1. Dissociative amnesia, dissociative fugue, and depersonalization disorder usually do not demonstrate the polysymptomatic presentation of DID, although forms of dissociative disorder – not otherwise specified (DDNOS) that resemble DID may.
2. Other dissociative disorders (apart from dissociative fugues with alternate identities and forms of DDNOS resembling DID) do not score high on the identity alteration scale of the SCID-D-R.
3. In other dissociative disorders (excluding forms of DDNOS resembling DID), episodes of amnesia are relatively isolated and infrequent.
4. Because many forms of DDNOS resemble DID, and much of the time DID patients appear to be DDNOS, distinguishing DID from DDNOS often becomes a matter of clinical judgment.

DID vs. Psychotic Disorders

1. First-rank symptoms are more common in DID than schizophrenia and are not useful differential diagnostic indicators of psychosis.
2. Incoherence, true loosening of associations, and true negative symptoms are not associated with DID.
3. Deteriorated behavior is uncommon in DID absent long hospital stays in the company of chronic psychotic patients.
4. Auditory hallucinations in DID usually refer to a traumatic scenario, an inner conversation among alters, or alters' attempts to influence the identity in apparent executive control. They are usually coherent. When they are fragmentary, it is because they have not been heard completely.

5. Auditory hallucinations of DID patients are heard (or experienced as very vivid thoughts) emanating from inside the head in more than 80% of cases. In patients with schizophrenia, more than 80% of auditory hallucinations are heard as emanating from outside of the head.
6. Hypnotizability scales are useful, especially the brief Hypnotic Induction Profile,³⁰ which usually is high in DID and low in schizophrenia.
7. Suggestive techniques often can modify "psychotic" symptoms in DID quite readily.

DID vs. Affective Disorders

1. Posttraumatic despair and general misery, as well as unrecognized shame reactions, may be confused with an affective disorder.
2. The co-occurrence of dissociative and affective disorders is very common.
3. The presence of identities and amnesia in DID are crucial distinctions.
4. It is useful to ascertain the occurrence of affective symptoms in all alters or an increasingly large number of alters in order to avoid mistaking a "depressed personality" for an affective disorder.
5. Mood shifts in DID tend to be mercurial rather than rapid and often are associated with switches.
6. Affective symptoms without comorbid affective disorders usually respond at least transiently to suggestive measures.

DID vs. Borderline Personality Disorder

1. These disorders are not mutually exclusive. Both often occur in the aftermath of trauma.
2. Dissociative phenomena in pure borderline personality disorder are relatively unstructured.
3. More patients with DID manifest the phenomena of borderline personality disorder than prove actually borderline in psychological structure or in behavior once DID treatment gets under way.
4. The effect on the alter ostensibly in control by other alters behind the scenes, or the covert switching of alters, may give the appearance of borderline phenomena in a patient with DID who, in fact, does not have a stable borderline character adaptation.
5. Because DID and borderline phenomena overlap, it is important to study the longitudinal course of the symptomatology to determine whether they are consistent with a character disorder or with DID (bearing in mind that both may coexist).
6. A crude but useful rule is to withhold the borderline diagnosis or to consider it tentative unless its manifestations are present within several personalities, rather than emerging from alters' interactions and conflicts.

DID vs. Partial Complex Seizures

1. Partial complex seizures usually are brief (30 seconds to 5 minutes) and rarely are chronic or more prolonged.
2. Dissociative phenomena associated with seizures are usually variants of depersonalization.
3. Attempts to elicit alters associated with the symptoms in question may be helpful.
4. Hypnosis may be used to modify the symptoms as they occur, or to recreate the symptoms.
5. Drug-facilitated interviews should be considered to facilitate the differential diagnosis.
6. Combined electroencephalograms and observations in specialized (telemetric) monitoring facilities may prove useful.

DID vs. Factitious Disorders

1. One should ascertain whether seeking the patient role is reasonable given the patient's distress (ie, is it legitimate help-seeking behavior?).

2. Studies have demonstrated the presence of signs suggestive of DID in Munchausen's syndrome. It is important to appreciate that, due to the "third reality" of DID patients, they too may present with fantastic stories to explain their difficulties.
3. It is helpful to use objective measures of dissociation, dissociative phenomenology, and hypnotizability. Because true patients with DID (if cooperative and relatively calm) usually have high scores on objective measures of dissociation and hypnotizability, low scores would suggest that the patient is feigning the core symptoms of DID but is unlikely to actually have the condition.
4. All available sources of data should be used.
5. Classic core symptoms without ancillary or lesser known findings suggest a simulation based on lay sources.
6. Dissimulation rather than simulation is characteristic of patients with DID.

DID vs. Malingering

1. Many DID and malingering behaviors overlap, similar phenomena being generated by different dynamics. Therefore, the utility of many of the usual indicators of malingering may be compromised.
2. Malingers usually enact polarized good-bad differences across apparent alters, while the adaptive function of their purported alter systems is likely to be unhelpful in facilitating either coping or the retention of important object relations, as is seen in actual DID.
3. Most malingered cases involve fewer alters than are found in contemporary DID cases.
4. Most malingered cases are less consistent and competent in demonstrating DID signs and symptoms in areas remote from their forensic concerns.
5. All available sources of data should be used.
6. Classic core symptoms without ancillary and less well-known symptoms suggest a simulation based on lay sources.
7. Dissimulation rather than simulation is characteristic of patients with DID. One should suspect the legitimacy of the patient who is eager to demonstrate psychopathology (unless needed treatment has been withheld; some patients with DID will become quite florid to demonstrate that they need help).
8. Use forensic guidelines for any hypnotic or drug-facilitated interviews.

time a particular phenomenon is experienced by an individual. While the DES is vulnerable to both malingering and dissimulation, it nonetheless is useful in making an initial inquiry about a patient's experiences of dissociative phenomena.

The person taking the test is asked to make a vertical slash along a 100 mm horizontal line to indicate the extent to which each experience applies to that individual. In another version, the DES-II, the person is asked to circle a number (eg, 0, 10, 20) to indicate the percentage of the time each item is experienced. The DES is scored by measuring the locations of the slashes on the lines for each item in millimeters, adding up the values of all 28 items in millimeters, and then dividing by 28. In the DES-II, the percentages circled for each item are added and the sum divided by 28.

On the DES, it is typical for people with DID and allied forms of dissociative disorders to endorse all items to some extent, and to have average scores of 30 or more across all items. In the DES-II, which does not allow percentages below 10, it is less likely that all items will be endorsed. In clinical practice, the score of 20, or even a few items with high scores, often is used to trigger further evaluation for a dissociative disorder. Note that while the DES score is officially rendered in millimeters, those millimeters translate into the percentage of the time that a particular experience prevails.

The SCID-D-R²⁹ is a semi-structured diagnostic interview administered by a clinician reading standard stem questions and constructing follow-ups from a menu of questions with components derived from the original responses. It usually takes from 1 to 3 hours to administer. It is considered 90% to 95% sensitive to populations of patients with dissociative disorders, and recent research allows for its use in the identification of malingerers. False positives are rare.

The SCID-D-R obtains some back-

ground information and studies five core dissociative features: amnesia, depersonalization, derealization, identity confusion, and identity alterations. These five are scored from 1 to 4. The score of 1 indicates the phenomenon is absent; 2 indicates it is minimally present; 3 indicates it is moderately present; and 4 indicates it is strongly present. Thus, a minimal score of 5 would indicate no dissociative phenomena whatsoever, and a score of 20 would indicate maximal scores in all core features. Scores of 16

The typical differential diagnosis for DID includes other dissociative disorders, psychoses, affective disorders, borderline personality disorder, partial complex seizures, factitious disorder, and malingering.

and above are characteristic of a severe and chronic or recurrent dissociative disorder. Scores of 8 or less are characteristic of normal populations. Scores up to 12 to 13 are found in mixed groups of psychiatric patients.

The SCID-D-R also elicits phenomena associated with DID and allied forms of dissociative disorders. Also, the format of the SCID-D-R moves on to the closer observation of two areas of inquiry in greater depth, the two to be chosen by the interviewer based on which of nine particular areas of inquiry have elicited the answers most suggestive of the presence of alter personalities. It also allows for the recording of the clinician's observations of dissociative phenomena, and making the tentative diagnosis of a dissociative disorder.

DIFFERENTIAL DIAGNOSIS

Patients with DID often meet the diagnostic criteria for several other conditions.^{4,13,20} It can be difficult to discern whether their diagnostic criteria are met by epiphenomena of the DID or represent autonomous co-occurring diagnoses.^{2,4} Both situations may be encountered in a single patient (ie, DID chaos creating apparent borderline personality disorder, and an independent bipolar II disorder).

The typical differential diagnosis for DID includes other dissociative disorders, psychoses, affective disorders, borderline personality disorder, partial complex seizures, factitious disorder, and malingering.^{2,4,13,18,20} Sidebar 8 (see pages 640-641) offers considerations to facilitate the clinician's making such diagnostic distinctions. When the diagnostic criteria for DID are met, without definitive proof of factitious disorder or malingering, the DID diagnosis should be made. The underdiagnosis and misdiagnosis of DID are well-documented findings, and characteristically lead to years of suboptimal treatment and excess morbidity. The overdiagnosis of DID certainly can occur, but there is no solid evidence (despite strongly-voiced opinions) that it is a widespread phenomenon.

SUMMARY

The current state of clinical knowledge and recently developed diagnostic instruments make it possible for the contemporary clinician to approach the diagnosis of DID in a more expeditious and effective manner than has been possible in the past. Their effective application should reduce the problems of underdiagnosis and misdiagnosis that have proven barriers to the straightforward identification and treatment of DID.

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