

Redefining Dissociative Identity Disorder: An Exploration of Diagnostic Criteria

SYDNEY ALTIERI, B. A.
University of New Haven

This article is an investigation of the current diagnostic criteria set for dissociative identity disorder. Advancements in scholarly research have resulted in the current diagnostic criteria not reflecting new insights gathered since its most recent update. An examination of the progression of diagnostic criteria reveals the need for continual updates, including the proposed stipulation that while distinct, personalities seen in individuals diagnosed with dissociative identity disorder are fragmentations of a singular core, or host, personality. Recommendations for the application of the proposed amendments and its strengths and limitations are discussed.

Keywords: dissociative identity disorder, diagnostic criteria, multiple personalities, childhood sexual trauma, dissociation, divergence

Cet article est une enquête sur les critères diagnostiques actuels établis pour le trouble dissociatif de l'identité. Les progrès de la recherche scientifique ont fait en sorte que les critères de diagnostic actuels ne reflètent pas les nouvelles connaissances recueillies depuis sa dernière mise à jour. Cet article examine les divergences entre les résultats de la recherche et les critères diagnostiques actuels. De plus, cet article propose une modification afin de mieux s'adapter aux perceptions et aux connaissances modernes entourant le trouble, ce qui pourrait amener à réduire les écarts découverts par la recherche.

Mots-clés : trouble dissociatif de l'identité, critères diagnostiques, personnalités multiples, traumatisme sexuel de l'enfance, dissociation, divergence

Over the last two decades, mental health issues have become publicly discussed and destigmatized. As this process of destigmatization has occurred, people have become more open about their struggles with mental health issues, especially when discussing disorders that were not discussed often in the past, such as dissociative identity disorder. Formally known as multiple personality disorder, dissociative identity disorder is a psychiatric disorder characterized by an individual experiencing the occurrence of multiple, distinct personalities, often coupled with dissociation, amnesia, and fugue (American Psychiatric Association [APA], 2013). In the same light, while the concept of multiple personalities has been discussed since the early 1800s, focus and research has grown exponentially within the last three decades (Chu, 2011; Herman, 1992; van der Kolk, 2014).

The author would like to sincerely thank Dr. Ryan Crawford for his encouragement regarding the development of this manuscript, as well as his unwavering belief in the abilities of the author. Additionally, the author extends her thanks to the editorial team at JIRIRI for their time and feedback. Any correspondence regarding this manuscript should be sent to the author, Sydney Altieri (salt1@unh.newhaven.edu). Address for physical copy: 74 Pent Road, Branford, CT 06405.

The concept of false-positive diagnoses, made by clinicians, is not new when discussing any psychological disorder, but in regards to dissociative identity disorder being very controversial within the field, the implications of false diagnoses must be considered (Fraser, 2005). Investigation into false-positive diagnoses of dissociative identity disorder have been carried out since the early 1990s, wherein the validity of different measures was examined in regards to the identification and diagnosis of dissociative identity disorder. Carlson et al. (1993) examined the application of the *Dissociative Experiences Scale* against a sample of over 1,000 psychiatric patients, identifying that in instances where those previously diagnosed with dissociative identity disorder did not meet the cutoff score of 30 within the measure, a more accurate diagnosis would be either a dissociative disorder other than dissociative identity disorder or post-traumatic stress disorder.

Pietkiewicz et al. (2021) examined 85 individuals who were a part of a larger sample investigating dissociation within a clinical setting. Through analysis of qualitative data collective through semi-structured interviews, 6 participants previously suspected of having dissociative identity disorder were found to not

meet the diagnostic criteria, representing a 7.05% rate of false diagnosis, albeit in an extremely small sample. The study further examined noted features of false positive diagnoses caused by imitated cases of dissociative identity disorder, highlighting the expectation for a diagnosis, incorporating the diagnosis into one's identity, and other, all of which were cited to play a role in the possible iatrogenic presentation of dissociative identity disorder-like symptoms that could be misinterpreted through diagnosis. In this context, iatrogenic describes the presentation of illness symptoms directly relating to psychological assessment and diagnosis (Pietkiewicz et al., 2021). While no true empirical figure has been established regarding rates of false diagnoses of dissociative identity disorder, the ever-changing nature of knowledge regarding the disorder as well as mixed clinical opinions on its existence and presentation demonstrate a likelihood for false positive diagnoses (Chu, 2001; Herman, 1992; Pietkiewicz et al., 2021; van der Kolk, 2014).

False diagnoses of any mental health disorder pose negative implications for the diagnosed individual, as even with the increasingly open discussion surrounding mental health issues, diagnoses still carry the weight of stigmatization. The type of diagnosis received regarding psychological disorders can impact impacts the treatment an individual can receive and their own self-image, but more globally, a diagnosis carries social weight that can place the individual into the role of self-burden (Corrigan, 2007; Wakefield, 2010). If an individual is falsely diagnosed with dissociative identity disorder, they may begin to associate themselves with the diagnosis as an aspect of their self, possibly impacting their medical, personal, and social life.

Special consideration must also be paid to the concept of self-diagnosis of dissociative identity disorder. Diagnostic criteria, while providing a framework for clinicians to use in order to work towards a diagnosis, is also available to the public, creating scenarios where individuals may use said criteria to diagnose themselves as a result of numerous factors. One significant factor contributing to self-diagnosed dissociative identity disorder is the amount of time it can take to receive a diagnosis, with Brand et al. (2014) reporting that patients may spend anywhere from 5 to 12.5 years receiving treatment before receiving an official dissociative identity disorder diagnosis. Individuals may feel the need to receive a diagnosis, even an unofficial one, in order to fully understand their experiences, in turn relying on self-diagnosis. Another factor is the disproportionality of access for mental health care within the United States. Marginalized communities, minorities, and individuals of low socioeconomic status all have

limited access to mental health care when compared to their counterparts, demonstrating a correlation between these factors and increased reliance on self-diagnosis (Ani et al., 2008). Because self-diagnoses are not a direct result of the current diagnostic criteria for dissociative identity disorder, and due to the accessibility of an official diagnosis varying widely, no stipulation of the necessity for an official diagnosis will be discussed as an amendment to the current criteria.

This paper is proposing the modification of the current diagnostic criteria for dissociative identity disorder found in the *Diagnostic and Statistical Manual of Mental Disorders*, or *DSM*, to form more narrowly defined guidelines for diagnosis, thus reducing the number of false positive diagnoses, and aiding in the diagnosis process of dissociative identity disorder. This modification will include amending the current criteria to include that 'alter' personalities are subsystems of one personality, with each holding its own thoughts, memories, feelings, and behavioral patterns. This amendment will keep with the trend of the *DSM* updating their diagnostic criteria as issues and solutions come to light, mirroring the need for an updated set of criteria to reflect the increasingly open conversation surrounding mental health issues.

Background

To understand why the current diagnostic criteria for dissociative identity disorder is not a sufficient reflection of modern perceptions and findings related to the disorder, previous criteria need to be examined in order to establish a baseline level of knowledge for how perception of the disorder has shifted over time. By considering the diagnostic criteria used within the United States, published by the American Psychiatric Association, or APA, within the *DSM*, the trend of advancing criteria can be corroborated to determine the best approach for modifying the current criteria to best fit modern scholarship.

DSM-I and II

While the first edition, or *DSM-I*, mentioned a dissociative reaction wherein a person may experience "symptomatic expressions, such as depersonalization, dissociated personality..." the classification of these symptoms appeared under an umbrella diagnosis of psychoneurotic reactions (APA, 1952, p. 32). The second edition, published in 1968, was the first publication of diagnostic criteria for mental disorders that specified a major aspect of dissociative identity disorder: the prevalence of distinct personality states. Conversely, the second edition separates the presentation of distinct personalities into a sub-diagnosis, classified as hysterical neurosis, dissociative type (APA, 1968). While brief, the

criteria presented in the *DSM-II* includes possible presentations of symptoms for the specification of hysterical neurosis, dissociative type, establishing symptoms of “amnesia, somnambulism, fugue, and multiple personality” occurring as a direct result of an altered state of consciousness (APA, 1968, p. 40). Due to the broad and nondescript nature of the diagnostic criteria presented both in the *DSM-I* and *DSM-II*, dissociative identity disorder was not characterized as a disorder, nor was it investigated in order to develop a more refined set of features that could present in order to lead to a formal diagnosis.

DSM-III and III-R

Multiple personality disorder was first recognized in the third edition of the *DSM*, compared to the previous two editions where similar symptoms were grouped as a typing under a different disorder. While the terminology ‘multiple personalities’ is not used in modern context to describe dissociative identity disorder, aspects of the diagnostic criteria present in the *DSM-III* continue to be presented in more recent editions. This edition included three specifications for diagnosing an individual with multiple personality disorder, alongside specifications of the age of onset, predisposing factors, sex ratio, and differential diagnoses that occur within the disorder. The criteria presented includes:

- (a) The existence within the individual of two or more distinct personalities, each of which is dominant at a particular time; (b) the personality that is dominant at any particular time determines the individual's behavior; and (c) each individual personality is complex and integrated with its own unique behavior patterns and social relationships (APA, 1980, p. 257-259).

The specification of three criteria that had to be met for a diagnosis to be given worked to allow for clinicians to have clearer guidelines for diagnosis, especially with a disorder that was considerably new and under-researched at the time.

Seven years after its release of the *DSM-III*, the American Psychiatric Association released a revised version of the *DSM-III*, known as the *DSM-III-R*. While the changes from the previous edition were not extreme, the diagnostic criteria presented in this revised edition made for clearer-cut guidelines in diagnosing multiple personality disorder. The new criteria outlined were as follows:

- (a) The existence within the person of two or more distinct personalities or personalities states (each with its own relatively enduring pattern of perceiving, relating to, and thinking

about the environment and self); and (b) at least two of these personalities or personality states recurrently take full control of the person's behavior (APA, 1987, p.14).

The updated criteria worked to clarify issues surrounding the aspect of one personality being dominant or dormant, misconceptions that were heightened by the criteria in the *DSM-III*. Dormancy and dominance continue to be discussed in updated criteria, but concepts relating to recurrence outlined in the *DSM-III-R* have since been omitted.

DSM-IV and IV-TR

As a major change to the previous editions, the fourth edition of the *DSM* included a significant revision in the renaming of multiple personality disorder to its modern nomenclature, dissociative identity disorder. Both the *DSM-IV* and *DSM-IV-TR*, or text revision, include the same criteria and additional information for dissociative identity disorder, but the presented criteria include modifications to the one present in the *DSM-III-R*. In both editions, four specific aspects were present within the criteria, including:

- (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; and (d) the disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or a general medical condition (e.g., complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play (APA, 2000, p. 484).

An important facet of this criteria was the specification that the disorder was not resulting from either psychological presentation of a substance, or a physiological condition that could result in similar symptoms. Similarly, the note that presentation of dissociative identity disorder in children was not resulting from play was significant, as a leading theory in the formation of dissociative identity disorder is that it stems from incidence of childhood trauma, a feature that will be discussed as part of the proposal for updated criteria. This is akin to the idea of cultural differences, wherein the presentation of multiple personalities may be a result of religious or cultural

contexts rather than the presence of dissociative identity disorder or another mental health condition.

DSM-V and V-TR

The fifth publication of the *DSM* includes an updated version of diagnostic criteria for dissociative identity disorder that shows considerable changes from the previous criteria of preceding editions of the *DSM*, with five specifications for what entails diagnosable symptom presentation. While some aspects of this updated criteria are similar to previous editions, the updated version worked to limit rates of false-positive diagnoses that had resulted from ambiguous aspects of the previous criteria, with this being accomplished through the following specifications:

- (a) Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual;
- (b) recurrent gaps in the recall of everyday events, important personal information, and/ or traumatic events that are inconsistent with ordinary forgetting;
- (c) the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning;
- (d) the disturbance is not a normal part of a broadly accepted cultural or religious practice. Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play;
- and (e) the symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures) (APA, 2013, p. 292).

With the additional criteria presented here, clinicians have been able to narrow down instances where dissociative identity disorder may be appearing as a differential diagnosis, but also, to ensure presentations are not fictitious or iatrogenic in nature. While being successful to a degree, there are still flaws within the current diagnostic criteria, mainly surrounding the fact that perceptions on mental health disorders have shifted remarkably within the last decade, and the current diagnostic criteria do not reflect both public perceptions and new findings related to dissociative identity disorder.

Although the *DSM-V-TR* shows the same diagnostic criteria as the *DSM-V*, the additional information provided about dissociative identity disorder was updated to reflect recent opinions in the clinical circle examining the disorder. In reviewing environmental factors that may increase risk of developing dissociative identity disorder, the *DSM-V-TR* discusses the relationship between early life trauma, occurring before the age of 5–6, and the later development of dissociative identity disorder, identifying that approximately 90% of individuals with the disorder report multiple instances of maltreatment or abuse in their early childhood (APA, 2022). This change is significant, as it reflects the updating of criteria to reflect ideas put forward by researchers relating directly to the disorder’s genesis.

Proposed Amendment to Diagnostic Criteria

Through the thorough review of available literature concerning the diagnostic criteria of dissociative identity disorder, a discrepancy between the current criteria and recent research was revealed concerning resulting false-positive diagnoses (Pietkiewicz et al., 2021; Tyrer, 2019). Through a modification of the current diagnostic criteria for dissociative identity disorder present in the *DSM*, made through an amendment of the current criteria, these instances of false-positive dissociative disorders will hopefully decrease.

Symposium of Alters

Dissociative identity disorder is, at its core, a reaction to childhood trauma that impedes the development of one's personality, resulting in multiple personalities, or alters, living within one person (Morgan, 2021). Each alter usually takes on a specific role associated with a trait or behavior, such as acting as a protector or being the caretaker of the body. While the fragmentation of these personalities does exist, each in itself is not a separate personality (Gleaves, 1996; Pietkiewicz et al., 2021; Gleaves, 1996). Simply put, the alters are subsystems of one’s a personality, with each showing its own distinct memories, thoughts, feelings, and behavioral patterns. Considering terminology often associated with dissociative identity disorder, the amendment could be read as follows: “Alter personalities are conceptualized as fragmented aspects of an individual’s whole, or core, personality.”

Due to the lack of specification of this quality in the current diagnostic criteria for dissociative identity disorder, many clinicians who are unfamiliar with the disorder have misinterpreted its clinical presentation, resulting in instances where imitated cases are falsely diagnosed since they present multiple personalities

rather than dissociative parts of one personality. This lack of specification has resulted in a gap within the current diagnostic criteria, leading to increased instances of false-positive diagnoses from clinicians not properly trained to look beyond the diagnostic criteria to critically examine each possible case of the disorder separately, avoiding generalization.

Review of Current Literature

The misconception that those with dissociative identity disorder have completely different personalities living within one body has spurred a conversation of the validity of the disorder, adding to opponent's ability to discredit current findings. By implying that the separate personality states are just that, states of personality, each taking on an aspect of a fragmented personality at the core of the individual diagnosed, these misconceptions would be reduced and further prevented. Pietkiewicz et al. (2021) explains the separate personality states as subsystems of a cohesive personality, a description best suited for removing these misconceptions and aiding in the diagnostic process. Hartmann and Benum (2019) established this idea to an additional extent, formulating a baseline of fragmentation by using psychological testing to determine differences in two personality states of an individual diagnosed with dissociative identity disorder. The personality states showed remarkable differences, such as distinct levels of intelligence and cognitive abilities, giving the appearance of completely distinct test-takers. Through interpretations of the findings from psychological testing, researchers were able to determine that while distinct, the personalities' specific scores were attributed to be a result of the fragmented aspects of a single core personality, rather than stemming from separate beings whose personalities are completely in opposition with each other. By specifying that the personalities of a person with dissociative identity disorder are fragmentations of different aspects of a singular personality, misconceptions arising from current diagnostic criteria can prevent the disorder from being viewed as invalid or fictitious.

Discussion

Initially, the current diagnostic criteria for dissociative identity disorder were explored in order to identify discrepancies that did not reflect current findings relating to the disorder. Once these gaps were identified, a possible solution was investigated that would best fit with current literature and opinions on the discrepancies that were discovered in the initial search. At this time, the proposal has been developed, with the solution included in a thorough review of literature and evidence to best support their necessity moving forward. The need for continuous modification to the diagnostic criteria presented in the

DSM stems from continuously advancing ideas regarding dissociative identity disorder. Nester et al. (2021) compared diagnostic rates between the diagnostic criteria in the *DSM-IV-TR* and the *DSM-V*, identifying that while 83.85% of patients examined met the criteria from both editions, 6.21% met only the *DSM-V* criteria and 9.94% met only the *DSM-IV-TR* criteria. Updated language in the *DSM-V* criteria was hypothesized to have contributed to this difference, but however, another reasoning could surround the increasingly narrow definition of what constitutes dissociative identity disorder as the criteria is amended.

Strengths

Although fully theoretical in nature, this manuscript does pose an innovative perspective on dissociative identity disorder diagnostic criteria that has yet to have been explored in depth. Aiding clinicians in the diagnostic process by explaining the specific feature of dissociative identity disorder to present within an individual as alter personalities existing as fragments of a singular core personality can work to provide clarity to otherwise broad diagnostic criteria, especially when discussing a disorder that many clinicians have not seen in a clinical setting. While similar ideas regarding the concept of alter personalities being fragments of one core personality have been posed by other researchers (Gleaves, 1996; Hartmann & Benum, 2019; Pietkiewicz et al., 2021), no recommendation for the concept's application into the *DSM* or other psychological manual has been made. Thus, this proposal provides a compelling insight into ideas regarding dissociative identity disorder that have been established but not applied past a theoretical standpoint, progressing the criteria as findings have become more developed and refined with research.

Keeping with the trend of the *DSM* to update frequently to reflect new research findings, this manuscript provides a concise history of the diagnostic criteria for dissociative identity disorder as well as relevant literature and research that support the proposed criterion, summarizing past and recent literature to both identify a discrepancy within the current criteria and to suggest the additional amendment. The intention of this publication is to function as an addition to the literature as a narrative review to educate researchers and psychologists in training in regards to the current consensus in the dissociative identity field.

Limitations

While the process to modify the current diagnostic criteria for dissociative identity disorder will not be a

simple feat, it is a necessary step that must be taken to prevent the number of false-positive cases of dissociative identity disorder from. Issues that may be faced in this process of modification must be discussed, as their impact on the process could be substantial if not addressed properly. One possible issue that could be faced would be based on the unknown publication date of the next edition of the *DSM*, with no possible publication date being discussed at the time of this proposal. As the most recent edition of the *DSM*, the *DSM-V-TR*, was published in March of 2022, the application of the proposed amendment would be included in the sixth edition at the earliest due to the timeline followed by the APA in regard to updating the manual. While this factors into the overall release of the modified criteria discussed in the proposal, it would not prevent the criteria from being released to the community of psychologists who specialize in dissociative and personality disorders, thus allowing for feedback to be gained and for the criteria to be implemented in a smaller setting in order to view its impact on the rates of false-positive cases.

While discussing the amendment's relation to rates of false diagnoses, the potential that the amendment could result in increased rates of false diagnoses must be raised as well. Any modification of diagnostic criteria can impact diagnostic rates, especially when pertaining to a disorder that many clinicians are unfamiliar with outside of basic information presented within the *DSM*. Criteria in the *DSM* is kept somewhat broad to ensure that the process of diagnosis is objective, and that only quantifiable symptoms may be coded directly into the criteria. In adding another criterion, the strictness of the criteria would narrow, carrying both positive and negative implications. As for positive implications, a narrower definition for what constitutes as dissociative identity disorder may result in less instances of false positive diagnoses if individuals do not meet all the presented criteria. On the contrary, tightening the diagnostic criteria for dissociative identity disorder could lead to individuals who have previously been diagnosed not meeting the updated criteria. Although this does pose an issue, one solution would be for clinicians with clients diagnosed with dissociative identity disorder to reevaluate their diagnosis on a case-by-case basis to ensure there is no disproportionality in diagnostic rates within marginalized communities, an issue seen frequently with regards to mental health.

Implications and Significance

Rates of dissociative identity disorder have increased exponentially in the last seven years, with the *DSM* citing a rate of 1.5% of the population in 2013, but a more recent statistic found the rate to exist

“anywhere from 0.01% to 15% of the population” (APA, 2013; Morgan, 2021). These rates coincide with the movement to destigmatize mental health issues that has occurred over the last three decades, showing a correlation between the increasing acceptance and increasing rates. Without discounting the positive impacts, the destigmatization of mental health issues have had on those with genuine diagnoses, one must be open to reviewing the negative impacts, with these increasing rates of diagnosis coming from available diagnostic criteria and gaps in said criteria. Through modifying the diagnostic criteria of dissociative identity disorder to specify certain aspects that are necessary to entail a diagnosis, these increasing rates will flatten out without affecting the movement to accept mental health issues in society.

Application Into DSM-VI

By posing this modified criterion to the American Psychiatric Association with a recommendation that it is considered for publication into the sixth edition of the *DSM*, it is anticipated that rates of incidences of false-positive diagnoses of dissociative identity disorder will decrease. This presumption stems from previous modifications to other diagnostic criteria resulting in a similar impact, wherein clinicians are able to further specify what entails sufficient presentation of symptoms for a diagnosis, ensuring that cases where some but not all symptoms are present do not receive an inaccurate diagnosis. This will follow the trend of previous editions of the *DSM* modifying diagnostic criteria as well, keeping with public perception and advancing knowledge of mental disorders as research homes in on specific aspects of symptom presentation.

Foreseen Impact

While no specific impact can be predicted without reasonable doubt, viewing similar situations where the diagnostic criteria for dissociative identity disorder was modified in other nations can lead to a plausible presumption of the impact modifying the *DSM* diagnostic criteria would have on diagnosis rates. Subsequently, this proposal will be presented to multiple voices within the community discussing dissociative identity disorder, gaining feedback and alternate perspectives on the amended criteria to ensure it reflects current opinions and scholarly knowledge. After the feedback has been considered and the criteria refined, the proposal will be published, and ideally, will be used within the sixth edition of the *DSM* at the time of its eventual publication.

Because diagnosis rates continue to rise due to increasing access to mental health services as well as an increasingly positive public perception on seeking support for mental health struggles, it would be

illogical to presume that this modified criterion would lead to a decrease in diagnosis rates of dissociative identity disorder within the United States, as well as countries around the globe who implement the *DSM* into their diagnostic processes. However, a plausible prediction for the impact these modifications would have is the idea of a tapering effect on the increasing rates, wherein the rates of diagnosis continue to increase, just at a more level rate without significant jumps. No prediction can be certain, but based on current knowledge, this is the best estimate for the impact the proposed amendments of the diagnostic criteria of dissociative identity disorder would have on diagnosis rates within the United States, and on a larger scale, globally.

Conclusion

The current diagnostic criteria for dissociative identity disorder presented in the fifth edition of the *DSM* provides a solid basis for diagnosis, but its lack of updates to mirror increasing rates of diagnosis and the destigmatization of mental health disorders over the last decade leaves it open for false positives. Through modification of these current diagnostic criteria, made through additions and amendments of certain aspects that currently exist, instances of false-positive cases of dissociative identity disorder will decline. Application of this amendment should be presented in the sixth edition of the *DSM* at the time of its publication, broadening its reach to practicing clinical psychologists operating under the guidelines of the American Psychiatric Association.

References

- American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders: DSM-ITM* (1st ed.). American Psychiatric Publishing, Inc.
- American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders: DSM-IITM* (2nd ed.). American Psychiatric Publishing, Inc.
- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders: DSM-IIITM* (3rd ed.). American Psychiatric Publishing, Inc.
- American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders: DSM-III-RTM* (3rd ed. rev.). American Psychiatric Publishing, Inc.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TRTM* (4th ed. text rev.). American Psychiatric Publishing, Inc.
- American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders: DSM-VTM* (5th ed.). American Psychiatric Publishing, Inc. <https://doi.org/10.1176/appi.books.9780890425596>
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders: DSM-V-TRTM* (5th ed. text rev.). American Psychiatric Publishing, Inc. <https://doi.org/10.1176/appi.books.9780890425787>
- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed. text rev.). Washington, DC: Author.
- Ani, C., Bazargan, M., Bazargan-Hejazi, S., Andersen, R. M., Hindman, D. W., & Baker, R. S. (2008). Correlates of self-diagnosis of chronic medical and mental health conditions in under-served African American and Latino populations. *Ethnicity & Disease, 18*, 105–111. <https://www.jstor.org/stable/48667205>
- Brand, B. L., Loewenstein, R. J., & Spiegel, D. (2014). Dispelling myths about dissociative identity disorder treatment: An empirically based approach. *Psychiatry, 77*(2), 169–189. <https://doi.org/10.1521/psyc.2014.77.2.169>
- Carlson, E. B., Putnam, F. W., Ross, C. A., Torem, M., Coons, P., Dill, D. L., Loewenstein, R. J., & Braun, B. G. (1993). Validity of the Dissociative Experiences Scale in screening for multiple personality disorder: A multicenter study. *The American Journal of Psychiatry, 150*(7), 1030–1036. <https://doi.org/10.1176/ajp.150.7.1030>
- Chu, J. A. (2011). *Rebuilding shattered lives: Treating complex PTSD and dissociative disorders* (2nd ed.). John Wiley & Sons, Inc.
- Corrigan, P. W. (2007). How clinical diagnosis may exacerbate the stigma of mental illness. *Social Work, 52*(1), 31–39. <https://doi.org/10.1093/sw/52.1.31>
- Dissociative identity disorder (DID). (2022, November 18). *SANE Australia*. <https://www.sane.org/information-and-resources/facts-and-guides/dissociative-identity-disorder>
- Fraser, G. A. (2005). Re: The persistence of folly: A critical examination of dissociative identity disorder. *The Canadian Journal of Psychiatry / La Revue Canadienne de Psychiatrie, 50*(12), 814. <https://doi.org/10.1177/070674370505001219>
- Gleaves, D. H. (1996). The sociocognitive model of dissociative identity disorder: A reexamination of the evidence. *Psychological Bulletin, 120*(1), 42–59. <https://doi.org/10.1037/0033-2909.120.1.42>
- Hartmann, E., & Benum, K. (2019). Rorschach assessment of two distinctive personality states of a person with dissociative identity disorder. *Journal of Personality Assessment, 101*(2), 213–228. <https://doi.org/10.1080/00223891.2017.1391273>
- Herman, J. L. (1992). *Trauma and recovery*. New York: Basic.
- Morgan, R. (2021). Dissociative identity disorder (DID). *SANE Australia*. <https://www.sane.org/>

information-stories/facts-and-guides/dissociative-identity-disorder

- Nester, M. S., Schielke, H. J., Brand, B. L., & Loewenstein, R. J. (2021). Dissociative identity disorder: Diagnostic accuracy and DSM-5 criteria change implications. *Journal of trauma & dissociation: the official journal of the International Society for the Study of Dissociation (ISSD)*, 23(4), 1–13. <https://doi.org/10.1080/15299732.2021.1989123>
- Pietkiewicz, I. G., Bańbura-Nowak, A., Tomalski, R., & Boon, S. (2021). Revisiting false-positive and imitated dissociative identity disorder. *Frontiers in Psychology*, 12, 1-13. <https://doi.org/10.3389/fpsyg.2021.637929>
- Tyrer, P. (2019). Dissociative identity disorder needs re-examination: Commentary on... Dissociative identity disorder. *British Journal of Psychiatry Advances*, 25(5), 294-295. <https://doi.org/10.1192/bja.2019.39>
- Van der Kolk, B. A., (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Viking, New York.
- Wakefield, J. C. (2010). False positives in psychiatric diagnosis: Implications for human freedom. *Theoretical Medicine and Bioethics*, 31, 5–17. <https://doi.org/10.1007/s11017-010-9132-2>

Received May 20, 2022

Revision December 4, 2022

Accepted December 7, 2022 ■

Table 1
DSM Diagnostic Criteria Progression, Dissociative Identity Disorder

<i>DSM Edition^a</i>	Diagnostic Criteria ^b
<i>DSM-I</i>	<p>This reaction represents a type of gross personality disorganization, the basis of which is a neurotic disturbance, although the diffuse dissociation seen in some cases may occasionally appear psychotic. The personality disorganization may result in aimless running or "freezing." The repressed impulse giving rise to the anxiety may be discharged by, or deflected into, various symptomatic expressions, such as depersonalization, dissociated personality, stupor, fugue, amnesia, dream state, somnambulism, etc. The diagnosis will specify symptomatic manifestations.</p> <p>These reactions must be differentiated from schizoid personality, from schizophrenic reaction, and from analogous symptoms in some other types of neurotic reactions. Formerly, this reaction has been classified as a type of "conversion hysteria." (APA, 1952, p. 32).^c</p>
<i>DSM-II</i>	<p>Hysterical neurosis, dissociative type</p> <p>In the dissociative type, alterations may occur in the patient's state of consciousness of in his identity, to produce such symptoms as amnesia, somnambulism, fugue, and multiple personality. (APA, 1968, p. 40).</p>
<i>DSM-III</i>	<p>Multiple personality disorder</p> <p>A. The existence within the individual of two or more distinct personalities, each of Which is dominant at a particular time.</p> <p>B. The personality that is dominant at any particular time determines the individual's behavior.</p> <p>C. Each individual personality is complex and integrated with its own unique behavior patterns and social relationships. (APA, 1980, p. 257-259).</p>
<i>DSM-III-R</i>	<p>Multiple personality disorder</p> <p>(a) The existence within the person of two or more distinct personalities or personalities states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self); and (b) at least two of these personalities or personality states recurrently take full control of the person's behavior. (APA, 1987, p.14)</p>
<i>DSM-IV & DSM-IV-TR</i>	<p>Dissociative identity disorder</p> <p>(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; and (d) the disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play. (APA, 2000, p. 484)</p>
<i>DSM-V & DSM-V-TR</i>	<p>Dissociative identity disorder</p> <p>(a) Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual; (b) recurrent gaps in the recall of everyday events, important personal information, and/ or traumatic events that are inconsistent with ordinary forgetting; (c) the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning; (d) the disturbance is not a normal part of a broadly accepted cultural or religious practice. Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play; and (e) the symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (., complex partial seizures) (APA, 2013, p. 292).</p>