UNDERSTANDING DISSOCIATIVE IDENTITY DISORDER (DID)

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Introduction

- DID is a complex mental health condition with two or more distinct identity states.
- Previously known as Multiple Personality Disorder (MPD).
- Strongly linked to severe childhood trauma.
- Involves memory gaps, amnesia, and identity disruptions.

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Historical Perspective

- 16th century: Early mentions in historical texts.
- 1890s: Pierre Janet described 'dissociation' as a defense mechanism.
- 1980: DSM-III recognized MPD as a disorder.
- 1994: DSM-IV renamed it Dissociative Identity Disorder (DID).

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Prevalence of DID

- Affects 1-2% of the population.
- More common in women, underdiagnosed in men.
- Strongly linked to childhood trauma.
- Often misdiagnosed as schizophrenia or personality disorders.

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DSM-5-TR Criteria for DID

1. Two or more distinct identity states.
2. Recurrent memory gaps.
3. Significant distress or impairment.
4. Not part of cultural or religious practices.
5. Not due to substance use or medical conditions.

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The Complexity of DID

- Alters may have different names, ages, genders, and speech patterns.
- Memory disruptions and identity shifts occur spontaneously.
- Derealization & depersonalization are common.
- Maintaining a coherent sense of self is difficult.

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Psychological Tools for Assessment

- Dissociative Experiences Scale (DES-II)
- Structured Clinical Interview for Dissociative Disorders (SCID-D)
- Minnesota Multiphasic Personality Inventory (MMPI-2)
- Clinical Interviews & Trauma History Analysis

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Differential Diagnosis

- Schizophrenia – DID lacks persistent hallucinations unrelated to identity states.
- Bipolar Disorder – Mood shifts in DID are identity-dependent.
- Borderline Personality Disorder – Lacks distinct alters and memory gaps.
- PTSD – May share symptoms but lacks multiple identities.

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Comorbid Psychiatric Conditions

- PTSD – Trauma-related symptoms.
- Depression & Suicidal Ideation – High risk of self-harm.
- Anxiety Disorders – Generalized anxiety, panic attacks.
- Substance Use Disorders – Coping mechanism for dissociation.

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Neurobiology of DID

- Amygdala & Hippocampus – Reduced volume (emotion & memory regulation).
- Prefrontal Cortex – Altered activity (affecting impulse control).
- Brain imaging studies show distinct neurological patterns in DID.

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Treatment Overview

- DID requires long-term therapy.
- Goal: Improve identity communication & reduce distress.
- No 'one-size-fits-all' treatment.
- Trauma-focused approaches are key.

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Psychotherapy – The Mainstay of Treatment

Phase-Oriented Therapy:

1. Stabilization & Safety – Coping strategies.

2. Trauma Processing – Addressing past trauma.

3. Integration & Rehabilitation – Enhancing self-coherence.

Therapeutic Approaches:

CBT, DBT, EMDR, Internal Family Systems.

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Medication in DID

- No Health Canada-approved medication for DID.
- Medications target comorbidities:
  - Antidepressants (SSRIs) – Treat depression & PTSD.
  - Mood stabilizers – Manage emotional dysregulation.
  - Antipsychotics – Address severe dissociation or paranoia.

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Challenges in Treatment

- Misdiagnosis – Many clinicians misunderstand DID.
- Therapeutic resistance – Alters may distrust therapy.
- High suicide risk – Frequent self-harm behaviors.
- Social stigma – Media misrepresentations.

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Myths vs. Facts

Myth: DID is the same as schizophrenia.

Fact: DID is a dissociative disorder, not psychotic.

Myth: DID is extremely rare.

Fact: Affects 1-2% but is underdiagnosed.

Myth: People with DID are dangerous.

Fact: More likely to be victims than perpetrators.

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The Importance of Awareness

- Education reduces stigma.
- Recognizing signs early leads to better outcomes.
- Trauma-informed care improves treatment success.

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Conclusion

- DID is a complex but treatable disorder.
- Requires specialized assessment & therapy.
- Public awareness is key to improving support & treatment.

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Questions?

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