UPI Journal of Pharmaceutical Medical, and Health Sciences

Content Availabe at www.uniquepubinternational.com **ISSN: 2581-4532**

Review Article

A review on dissociative identity disorder

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Article History

Received on: 15-01-2020
Revised on : 02-03-2020
Accepted on : 05-03-2020

Keywords

Dissociative identity disorder, epidemiology, Complex disorder, Multiple Personality Disorder.

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https://doi.org/10.37022/jpmhs.v3i1.17

Abstract

A brief description of factors related to diagnosis and treatment is presented with epidemiology, risk factors, socio-cultural aspects of dissociative identity disorder which was previously known as multiple personality disorder. It highlights the points on the current research and particular recommendations which should also be done in the future involving studies that will elaborate on research already completed and provide a more detailed analysis of characteristics of this unique and complex disorder.

INTRODUCTION

Dissociative identity disorder is a fascinating disorder that is probably the least extensively studied and most debited psychiatric disorder. In the history of diagnostic classification there is also notable lack of consensus among mental health professionals regarding views of diagnosis and treatment. These conditions involved a person being separated from reality or feeling separate from their own body, thoughts and behavior [1]. These symptoms can affect their part of their life.

The prevalence and type of dissociative disorders in considered varying across cultures and overtime [2]. The prevalence of this disorder is about 0.15/1000 patients per year were reported in India [3]. In the psychiatric populations 15% have a dissociative disorder and 4-5% have DID [4]. Female are more likely to receive a diagnosis of DID at a ratio of 9: 1.

Etiology and Risk Factors

There is no specific etiology, some of the physicians interpret by the major etiological factors are identity, memory and post traumatic condition from abuse o traumatic childhood experience [5]. Child's exposure to trauma was found as a major risk of developing a dissociative disorder. Hereditary factors mostly does not show a risk of prevalence. Psychiatric comorbidity have high rate of risk chances which may prevent clinicians from recognize the dissociative disorder in the overall population [6]. Other risk factors include lack of socio and familial support, inter personal and environmental stresses.

Signs, Symptoms & Diagnosis

The usual condition of switching of alters are unaware to the patient who is experiencing the symptoms and these alters are changes in the characteristics, memories, sense of identity and emotions. The signs and symptoms of DID are non-existent in many people. The symptoms mostly observed in the patients includes in the table 1 [7]. Diagnosis criteria majorly includes

clear noticing of alters, it is usually easier for a psychiatrist to find othe alters once the first alter has been found [8]. There is a high proportion of misdiagnosis in DID patients, because symptoms often overlap with other psychiatric conditions like major depressive disorder, bipolar disorder, post-traumatic stress disorder, psychotic disorders like schizophrenia, borderline personality disorder, conversion disorder, seizures (complex partial seizures).

Tab 1: List of Signs &Symptoms

General memory problems	Made or intrusive feelings and emotions
Depersonalization	Made or intrusive impulses
Derealization	Made or intrusive actions
Posttraumatic flashbacks	Temporary loss of well-rehearsed knowledge or skills
Somatoform symptoms	Disconcerting experiences of self-alteration
Trance	Profound and chronic self-puzzlement
Child voices	Coming to
Two or more voices or parts that converse, argue, or struggle	Fugues
Persecutory voices that comment harshly, make threats, or command self-destructive acts	Being told of disremembered actions
Speech insertion (unintentional or disowned utterances)	Finding objects among their possessions
Thought insertion or withdrawal	Finding evidence of one's recent actions

Did Which May Misdiagnose As

- MAJOR DEPRESSIVE DISORDER, which is often called as depression is mostly common in people with DID, but both depressed mood and depressive thoughts fluctuate because of their alters.
- BIPOLAR DISORDER especially bipolar–II changes in mood occurs in dissociative identity disorder due to switching between alters.
- POST TRAUMATIC SRESS DISORDER (PTSD) and DID have some overlapping features. PTSD is commonly comorbid with DID. The common symptoms of PTSD and DID involve self-injury, frequent suicidal behavior (70%), dissociative flashbacks, alterations in attentions.
- PSYCHOTIC DISORDERS (schizophrenia) hearing (due to alter) and symptoms of partial flashbacks like feeling touched when nobody is there may be mistaken for psychotic hallucination.
- BORDERLINE PERSONALITY DISORDER has dissociative symptoms and identifies disturbances within its diagnostic criteria. Self-injury and self-destructive behavior is common in both DID and Psychotic disorders.
- CONVERSION DISORDERS (Neurological symptom disorder) are common in people with DID.

Diagnosis using "diagnostic and statistical manual of mental disorders" (DSM)

DSM was the handbook used by health care professionals in United States and other countries as authoritative guide for diagnosis of mental disorder. There are few versions of DSM mentioned in the table 2. In that DSM 5 is mostly used by the clinicians.

DSM -5

The newest guide used in psychiatry to diagnose mental disorders is DSM-5 released by American Psychological Association APA in 2013. The DSM-5 gives the following diagnostic criteria:

- Continuity in sense of self and sense of agency, accompanied by related alterations in effect, behavior, consciousness, memory, perception, cognition and sensory-motor functioning.
- Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic Disruption of identity characterized by two or more distinct personality states. It is a marked event.
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The disturbance is not a normal part of a broadly accepted cultural or religious practice.
- The symptoms are not attributable to the physiological effects of a substance or another medical condition (E.g.: complex partial seizures) [9].

Tab 1 HISTORY FOR DSM CRITERIA IN DID

CRITERIA	DSM III (MPD) -1980	DSM IV (DID/DONOS 1994)	DSM V (DID-OSDD) -2013
Plurality & multiplicity	The existence of two or moredistinct personalities.	The presence of two or more distinct identities or personality states; each with its own relatively	Disruption of identity characterized by two or more distinct personality states, which may be described in the some cultures as an experience of possession.

	Each personality is unique with its own behavior patterns and relationships.	enduring pattern of perceiving, relating to and thinking about the environment and self.	The disruption in identity involves marked discontinuity in sense of self, sense of agency accompanied by related alterations in effect, behavior, consciousness, memory, perception, cognition and/orsensorymotor function.
	The personality that is dominant at any particular time determines the individual's behavior.	At least two of these identities or personality states recurrently take control of a person`s behavior	
Memory		Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.	Recurrent gaps in the recall of every day events, important personal information and /or traumatic events that are inconsistent with ordinary forgetting.
Exclusion Criteria		The disturbance is not due to the direct physiological effects of the substance or a medical condition; in children the symptoms are not attributable to theimaginary playmates or other fantasy play.	The symptoms are not attributable to the effects of substance or other medical condition. 2. The disturbance is not a normal part of the broadly accepted cultural or religious practice.
Pathology			The symptoms cause significant distress or impairment in social, occupational or other important area of functioning.
Self-report			The signs and symptoms may be observed by others or reported by individual.

Diagnostic Tools

- The Dissociative Experience Scale (DES) is a self-assessment screening tool (questionnaire) which should only be made by a qualified clinician.
- Somatoform Dissociation Questionnaire (SDQ) is a screening tool measure physical symptoms and symptoms assessed include sensory disturbances (E.g.: Tunnel vision, Psychogenic blindness, numbness) , conversion disorder symptoms (E.g.: psychogenic paralysis and non-epileptic seizures), genital symptoms (E.g.: difficulty urinating , genital pain during intercourse) [10].
- Dissociative Disorder Interview Schedule (DDIS) uses some observation from a clinicians and a structured interview. It has been later updated for DSM -5 [11].
- Structured Clinical Interview (SCI) for dissociative disorder is regarded as the gold standard diagnostic tool for DID. It is a semi structured clinical interview that uses observation from trained clinicians [12].
- Multidimensional Inventory of Dissociation (MID) only assesses the pathological dissociations [13].

Treatment

Treatment for DID involves psychotherapy, medication, integrative treatment plan.

Psychotherapy

The comprehensive plan of this disorder integrates with the underlying and the associated phenomenon of the personalities and multiple comorbid disorders, recovered traumatic experiences.

The most common treatment follows a framework of

1. Safety, stabilization and symptoms reduction.
2. Working directly and in past traumatic memories.
3. Identity integration and rehabilitation.

The patient of DID or disorder accompanied with amnesia the physician should teach their impulse control with some form of cognitive or integration of their personalities. in this case therapist should view alter not as a problem to removed but as the client creative response to trauma. As the major r key role for the treatment the physician should understand the relation between the alter and should be able to communicate with the alters.

Medication

There were no particular randomized trials done for the treatment of DID. Some surveys suggest the most favored treatment involving anxiolytics and antidepressants [14].Along with this carbamazepine for electroencephalograph abnormalities, prazosin for nightmare and naltrexone for self-injurious behavior are mostly given. Antipsychotics drugs that block both dopamine and serotonin receptors may be of use in treating complex trauma cases with psychotic features [15].

Tab 2: Medication used in DID

CLASS	DRUGS	DOSE	FREQUENCY	USE
Selective serotonin receptor inhibitor	Citalopram	20mg	OD	Depression, social anxiety, mood symptoms.
	Fluoxetine	20mg	OD	
	Paroxetine	20mg	OD	
Serotonin receptor antagonist	Mittazapine	15mg	BD	
Tricyclic antidepressants	Amoxapine	200-300mg	BD	
	Clomipramine	100mg	BD	
	Doxepin	75-150mg	OD	
Atypical or second generation antipsychotics	Amisulpride	400-800mg	BD	
	Haloperidol	0.5-2mg	BD	
Mu and kappa opioids	Morphine	2.5-5mg	BD	Analgesia
Central alpha antagonists	Clonidine	0.1-0.2mg	OD	Reducing nightmares, comorbid anxiety.
Alpha blockers	Prazosin	1mg (initial), 2-3mg	BD	
Opioid antagonist	Naltrexone	25mg	OD	Intrusive symptoms, hyperarousal, anxiety, mood instability.
Monoamine oxidase inhibitors	Isocarboxazid	10mg	BD	
Beta blockers	Propranolol	40mg	OD	
Anticonvulsants	Acetazolem	30mg	OD	
Benzodiazepines	Clonazepam	0.25mg	BD	
	Carbamazepine	100-400mg	OD	

Integrative Treatment Plan

Once the stability is achieved after a social support as a preventive factor for a patient all the efforts should be made to know the sources of support[16]. Group psychotherapy is considered to be one of the best therapies to achieve the goal. It is most powerful mostly in the type of homogenous DID patients. Advantages of this group psychotherapy include an acceptance by the group members which makes the patient feel safe and comfortable and these information to the maintained with secrecy regarding the familial or ritual abuse.

The Treatment Stages Include

1. The acceptance of the diagnosis.
2. Learning that talking with them helps [17].

Conclusion

DID is a pathological disorder the patient suffering with DID have been found to have alterations in the brain morphology. Amygdala and hippocampus have been found to be affected in DID and moreover studies show that the reduction of blood flow to the orbitofrontal cortex results in the functioning. These kind if findings are more

important for a physician to diagnose and rule out the solution for such unique disorders.

Current Research

The current research trends to focus on the points such as differences between alters and the alter which suppress such information on these results indicate the different alter demonstrate differences in emotional, sensorimotor, cardiovascular and regional cerebral blood flow to traumatic memories. Another study was applied to know about the related disorders o DID. The etiology of stress have demonstrated the reduction in hippocampus volume. As the comparison of imaging done results show that the volume of hippocampus of patients with DID has 19.2 % smaller and amygdala has 31.6 % smaller than normal controls.

Future Directions

Additional research is necessary to clarify and investigate the nature of DID research that has been done on the disorder still leaves many unanswered questions. Multicultural research is necessary to determine how sociocultural factors affect the development and clinical presentation of DID. More studies should be done on differences evident among alters and how genetic and environmental factors contribute to this disorder.

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