Types of DID

Latent DID – The alters are generally inactive but may be triggered by stressors which are somehow symbolic of the traumatic event. Examples of this are when the patient's children reach the age of the patient during the trauma, or the perpetrator becomes ill or dies. During such time the alters may emerge for the first time publicly, which provides a window of diagnosability.

Posttraumatic DID – Symptoms are not present until the patient experiences an overwhelming contemporary event such as a great loss, rape, combat, or a head trauma sufficient to cause organic amnesia.

Extremely Complex or Polyfragmented DID – Presence of such a wide variety of alter personalities with such frequent switching between alters that it is difficult to discern the outline of DID and the multiplicity actually disguises itself.

Epochal or Sequential DID – When an alter emerges it takes over for a long period of time before the next alter takes over for another long period of time. While one alter is out, the others go dormant.

Isomorphic DID – Several very similar alters take control as a group and try to pass as one. The only overt signs may be a fluctuating level of function, unevenness of memory, or inconsistencies in the patient's personality. Kluft's example is "she's quite bright, but what an airhead!"

Co-conscious DID – The alters know about one another so there is no demonstrated time loss or memory gaps.

Possession Form DID – The most evident alter presents as a demon or devil. This can be seen more commonly in cultures where religion or rituals have to do with demons and can easily be mistaken for psychotic conditions.

Reincarnation/Mediumistic DID – Alters who are experienced by the patient as having a supernatural quality and communicate with the patient in such a manner.

Atypical DID
A group of patients that is rarely diagnosed.

Private DID – Alters are aware of one another and have consciously adapted to pass as one.

Secret DID
Closely related to Atypical DID . The host is unaware of the alters, who only emerge when the host is alone. One might suspect this in a patient who cannot account for his or her private time.

Ostensible Imaginary Companionship DID – The patient has an adult version of the imaginary companion who is friendly and supportive with the other socially constricted host.

What the patient is not aware of is that this entity does assume executive control and that there are other alters present as well.

Covert DID
This is the form most characteristic of patients with DID . Alters contend for control and influence without assuming full executive control. To patients it feels as though their lives are out of control and that their actions are imposed upon them by a power unseen rather than selected by them.

Puppeteering or Passive-Influence Dominated DID – The host is dominated by alters that rarely emerge. If the host is unaware of these alters he/she feels like the victim of influences that force behaviour in a direction not chosen.

Phenocopy DID – The most important of the covert forms. Occurs when the alter's interactions with, and influences on the host and each other, create phenomena that are similar in appearance to the manifestations of other mental disorders. For example, alters who are in conflict and are insistent on their thoughts while cancelling out one another's actions can imitate obsessive compulsive disorder. When a patient has alters who harass one another, it appears to the onlooker as though the patient is hallucinating, which would resemble an acute schizophrenic episode. Alters with different moods can have the appearance of an affective disorder. Alters in contention may create the chaotic appearance of borderline personality disorder.

Somatoform DID – Very common. The pain or discomfort of a traumatic event which was experienced by an alter, is felt physically by the host, who has no memory of the trauma. Examples are pain in the rectum or vaginal area, numbness or tingling in the extremities from being tied up during abuse, a sense of choking or nausea associated with forced oral sex. This should be suspected when there is no apparent physiological explanation for the pain.

Orphan Symptom DID – Closely related to all of the covert categories. This is the phenomenon of unexplained and spontaneous feelings, sensations, actions, or intrusive traumatic imagery which manifests in the host, is not understood by the host, and which has been triggered by a contemporary stimulus that relates to the childhood trauma.

Miscellaneous Presentations Of Did

Switch-Dominated DID – Most commonly seen in the patient with a large number of alters. The switching process is so rapid and frequent that the patient appears bewildered and forgetful. Patients are often misdiagnosed with an affective disorder, psychosis, and organic mental syndrome, or seizure disorder.

Ad Hoc DID – Very rare. A helper alter creates a series of alters that function briefly and then cease to exist. This can be suspected when the patient's history may suggest DID or recurrent fugues, but no alter can be found to explain the missing time.

Modular DID – Very uncommon. This occurs when usually autonomous ego functions split and different personalities are reconfigured from their elements. When an alter is encountered it may have a vague feeling to it, and may never be seen in exactly the same way again. These

patients have been seriously abused, and are brilliant and quite creative. Kluft has also found an unusual computer literacy since childhood among these patients.

Quasi-Role-Playing DID – In this case the patient is attempting to disavow the diagnosis of DID . One alter acts out when it knows of the other alters, and then informs the clinician that he/she has been feigning DID . The patient states they have willfully generated this behaviour. In the 11970's and 1980's this was seen exclusively in mental health professionals. Now it is also found in sophisticated lay persons.

Pseudo False Positive DID – This presentation was common in the 1970's and 1980's and is now uncommon. In this case a patient would adopt the behaviour of a widely publicised or Hollywood movie type of case, one that is very flamboyant in appearance. The purpose of this was a desperate attempt to convince the clinician of the presence of DID , while the patient anticipated incredulity on the part of the clinician. Now that DID is accepted as a valid diagnosis, this presentation is rarely seen.